

Chief Executive's Report to the NHS

May 2005



Chief Executive's Report to the NHS: May 2005

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1. Preface from the NHS Chief Executive

We are halfway through implementing the *NHS Plan*. This is the fifth year of continuous improvement. The innovations and reforms we are introducing are beginning to take effect.

The headlines are:

- **big improvements in the speed and convenience of services**
 - almost everyone is seen and treated or admitted in A&E within four hours
 - maximum three month waits for heart bypass grafts and cataract operations
 - lowest ever numbers on the waiting list, with far fewer people waiting more than six months for inpatient admission or three months for an outpatient appointment
- **improvements in quality and in health**
 - continuing falls in premature deaths from cancer, coronary heart disease and suicide
 - better monitoring and management of disease in primary care
 - a new drive to promote health and prevent disease
- **innovation and reform are starting to take effect**
 - all patients are offered choice if they wait six months and many already have a choice of hospital at the point of referral
 - service redesign and innovation is now widespread
 - NHS Foundation Trusts and independent sector providers are bringing innovation and new capacity to bear
- **improving value for money**
 - reduction in overheads
 - better procurement and supply chain management
 - contributions to the health and prosperity of the country: with a healthier population, investment in regeneration areas and major contributions to research and British industry.

The pressures of the year

These achievements are particularly impressive because the NHS has been under real pressure.

The NHS has been busier than ever, treating more patients to higher standards. It has had to work very hard to control its costs. It has also worked very hard to control MRSA by, for example, the clean~~your~~hands campaign and the Matron's Charter with signs of improvement by the year end.

There have also been new policies to introduce and issues to tackle. These have included implementing the European Working Time Directive for junior doctors and new staff contracts.

People throughout all parts of the service have done extremely well to make improvements in so many areas despite this very demanding set of issues.

The future

This is still a service in transition with a great deal more to do. We are only five years into the ten-year *NHS plan*. The main emphasis in the early years has been on building capacity – more staff and facilities – and making targeted improvements. Emphasis from now on will be on improving quality in all its aspects and on securing value for money for the public.

This report shows how in the last year we have begun putting in place the levers which will at the same time drive improvements in both quality and value for money.

More choice for patients, more tailored services, new service providers, new arrangements for spreading good practice, new financial incentives and new ways of assessing performance will all help drive improvement.

For the first time ever the NHS will begin to apply the same approaches to health promotion and protection. All the evidence suggests that by supporting people to improve their health we will improve both quality and the cost to the whole system.

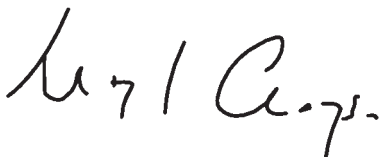
These are very big changes. I know that we will face tough decisions and have some periods of real difficulty as we drive to improve quality and value for money. I also know that as we do so, it will be very important that NHS organisations and their partners – from the not-for-profit, private and public sectors – continue to work well together in the spirit of our shared goals and values.

Our first and driving goal is to improve the health and well being of the people of this country in a way that ensures equity of access to care and support for all its citizens.

Celebration

We must be very clear sighted about the problems of today and the challenges of tomorrow. I believe that we should also celebrate what has been achieved and congratulate everyone involved. This report shows that we have come a very long way from a time of extraordinarily long waiting lists, chaotic A&E departments and very poor outcomes in some of our services.

Every week I try to visit different parts of the country to meet the people delivering the services and to discuss their experiences, concerns and hopes. I am constantly impressed by the passion, skills and determination I encounter. Increasingly, I am seeing good examples of local innovation and leadership. It is this passion, these skills and determination that have created these achievements.



Sir Nigel Crisp
13 May 2005

2. Key points for the year

Sustained improvement since 2000

Faster, more convenient services

- almost 98% of people attending A&E services were seen and treated or admitted within 4 hours
- long waits are down:
 - no-one waits more than three months for coronary artery bypass grafts or for cataract surgery
 - only 30,000 people are waiting more than 13 weeks for outpatient consultations: a fall of 363,000 since 2000
 - only 41,000 people are waiting more than 6 months for inpatient admission: a fall of 224,000 since 2000
- the inpatient waiting list is at its lowest point ever with 822,000 waiting: a fall of 84,000 in the year and 491,000 from its peak
- delayed discharges have fallen 16% over the year: a 63% reduction since June 2001
- 1.4 million more people used A&E, Walk-in Centres and minor injuries services during the year
- NHS Direct use continues to grow with NHS Direct online and the new interactive NHS Direct TV channel

More personal care and better patient experience

- more choice for patients – everyone has choice at six months. In some specialties there is choice at the point of referral
- action to deliver race equality
- continued high levels of patient satisfaction
- NHS Live projects to involve patients in better services

Action on health promotion and protection

- publication of *Choosing Health*, leading the way for a new drive on health
- continued falls in premature mortality from cancer, coronary heart disease and suicide
- increases in the numbers of people stopping smoking

Quality, innovation and reform

- publication of national standards applicable throughout the NHS
- a new Quality and Outcomes Framework in primary care leading to improvements in monitoring and managing patients
- concerted action on MRSA, beginning to have impact by year end
- continuing innovation with the publication of *10 High Impact Changes*: the service redesigns which are proven to work
- reform of the whole system: with NHS Foundation Trusts and new service providers from the independent sector

Value for money

- reduction in overheads and costs
- the spread of best practice, streamlining services
- contributing to the health and prosperity of the nation with better health, investment in regeneration areas and major contributions to research and British industry.

3. The changing NHS – quality, innovation and reform

Since 2000, the NHS has concentrated on building up capacity and making improvements in targeted areas. It now has a foundation of success from which to tackle quality in all its aspects.

This chapter sets out:

- how the NHS is planning to secure both quality and value for money
- the way in which innovation – with the redesign of services and jobs – is being spread throughout the NHS
- reforms to the whole way in which the NHS works.

Since 2000, the NHS has targeted and made improvements in specific areas – there is faster and more convenient access to services, premature deaths from the big killers of cancer and coronary heart disease are falling, the death rate from suicide is at its lowest recorded figure, new services have been created and there are big increases in staff numbers, equipment and facilities.

The NHS can now build on this successful foundation to improve quality in all its aspects and to make sure that the new investment in the NHS delivers value for money for the public.

This new approach, set out in *Creating a Patient-led NHS*¹, describes the range of levers in the system which, taken together, will drive both quality and value for money. The main points are:

- a patient-led system where patients increasingly have choice over services and treatments, supported by improved information
- independent assessment against the *Standards for Better Health* by the Healthcare Commission
- new financial incentives – payment by results – which mean that services which attract patients and are able to provide treatment at or less than the national tariff will thrive in the new system
- greater autonomy for NHS organisations to make decisions and take accountability
- the introduction of new suppliers from the private and not-for-profit sectors which offer patients more choice, introduce new ideas and practices and increase competition
- continued development and support for clinical and corporate governance
- the creation of the NHS Institute for Learning, Skills and Innovation which will continually search for world best practice, publish its results and promote innovation and the spread of good practice.

1 Department of Health, *Creating a Patient-led NHS – Delivering the NHS Improvement Plan (March 2005)*
www.dh.gov.uk/assetRoot/04/10/65/07/04106507.pdf

3.1 Improving quality

This section describes three of the main quality issues dealt with during the course of the year – establishment of standards, tackling MRSA and the new GP contract. Others, such as improvements in access, are described elsewhere.

A framework of standards

*Standards for Better Health*² was published in summer 2004. It sets out the core standards that all NHS organisations in England should be achieving now and the developmental standards that they should be aiming to achieve.

The Healthcare Commission will assess all NHS organisations in England against these standards. From 2006/07, subject to further legislation, the Commission plans to assess independent healthcare organisations by reference to the same standards, ensuring that patients receive the same high quality care no matter where they are treated.

The standards

- **Safety** – patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients
- **Clinical and cost effectiveness** – patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes
- **Governance** – Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the healthcare organisation
- **Patient focus** – healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being
- **Accessible and responsive care** – patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway
- **Care environment and amenities** – care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function; provide as much privacy as possible; are well maintained; and are cleaned to optimise health outcomes for patients
- **Public health** – programmes and service are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population serviced and reduce health inequalities between different population groups and areas.

2 Department of Health, *Standards for Better Health* (July 2004)
www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf

Tackling MRSA

Tackling methicillin resistant *Staphylococcus aureus* (MRSA) and other healthcare associated infections (HCAIs) is a major priority for the NHS. As there is no one simple solution to this problem, a wide ranging action plan to address both infection control and hospital cleanliness is being implemented. Not all infections are preventable but a challenging new target to halve MRSA bacteraemia by March 2008 has been set; achieving this will require sustained effort over the next three years. However, the NHS has made a promising start and the first six months of data for 2004/05 showed a six per cent drop in bacteraemias compared with the same period in the previous year³.

Other recent actions include:

- establishing a rapid review panel to assess claims made for products with the potential to reduce HCAIs
- launch of the national hand hygiene campaign in acute trusts
- issuing a call for HCAI research proposals
- publication of the Matron's Charter
- publication of revised guidance on cleaning, including new higher national standards and a model cleaning contract to ensure contracts are driven by quality and not only price.

The campaign against HCAIs will continue and develop further in the coming year. For example, a new rapid test for MRSA is being piloted to establish if these techniques can help improve patient management and the value of a Hygiene Bill is being considered.

Guy's and St Thomas' is a large specialist acute NHS Foundation Trust admitting patients from a wide area. The Trust delivers a range of complex and intensive treatments where there is a high risk of HCAI. It had one of the highest incidences of MRSA bacteraemia among all acute Trusts in 2003. At the beginning of 2004 an Infection Control Working Group was set up to improve the level of achievement of best practice in infection control.

It was found that MRSA was usually introduced into the hospital by patient carriers and then transmitted by hand by healthcare staff, with environmental and air transmission also playing some part in transfer. MRSA often entered the bloodstream through intravenous lines inserted during treatment. Co-ordinated action had, therefore, to be taken over a number of fronts, including:

- identification, screening and decontamination of patients at risk of carriage before admission where possible
- identification, screening and decontamination of carriers or infected patients after admission
- decontamination of staff hands after every patient contact
- cleaning the environment and maintaining high standards of hospital hygiene
- implementing a vascular catheter care programme.

Following sustained action on all these fronts, Guy's and St Thomas' saw reduced numbers of MRSA bacteraemias in each successive quarter of 2004. In the last quarter of 2004, the number recorded was less than half that arising in the same three months in 2003.

3 www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4085951&chk=HBt2QD

The new GP contract – introducing the Quality Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced in April 2004 and means that GP practices are, for the first time ever, rewarded for the quality of their work and not just their list size. The framework is a tool for driving up the quality of services offered by family practices. It is the first time in the world that an evidence-based system has been introduced on this scale to reward excellent clinical practice. In particular, it rewards practices that deliver high-quality care and prevention in ten of the most common long-term illnesses.

The areas covered by the Quality and Outcomes Framework

Heart disease	Cancer
Diabetes	Stroke
Hypertension	Lung disease
Epilepsy	Hypothyroidism
Mental illness	Asthma

In each area, practices are expected to carry out regular surveillance, scrutiny and monitoring of patients to best practice guidelines and take action as necessary. Initially expectations were that practices would achieve about 75 per cent of the QOF points available. Full information on practices' achievement against the QOF will not be available until the summer, but early indications are that, on average, practices have achieved over 90 per cent. This means, for example, that over 2,500,000 people with asthma and more than 1,500,000 people with diabetes are now treated according to high quality evidence-based protocols.

3.2 Innovation

A huge amount of innovation in services and job redesign is underway, supported by changes to staff contracts and infrastructure.

10 High Impact Changes

In September 2004, the Modernisation Agency published *10 High Impact Changes for Service Improvement and Delivery*⁴. This document has been welcomed throughout the NHS; it identifies, distils and sets out key principles from NHS best practice in improvement.

These high impact changes were identified by the Modernisation Agency through its work with thousands of local clinical teams. Each of the ten changes has already been implemented by some NHS organisations, and they have proven to provide significant, measurable improvements in the way they deliver care. Many local NHS organisations and communities are adopting the changes as part of a community-wide whole-system partnership, focusing on those aspects of the changes that fit with the local context and local priorities.

NHS Institute for Learning, Skills and Innovation

Over the past few years many new initiatives – often supported by the Modernisation Agency – have helped the NHS transform services for patients and improved patients' experiences. Over time the NHS itself will be able to take on more of the Modernisation Agency's work in spreading good

⁴ Modernisation Agency, *10 High Impact Changes for Service Improvement and Delivery – A guide for NHS leaders* (September 2004)
www.content.modern.nhs.uk/NR/rdonlyres/6E0D282A-4896-46DF-B8C7-068AA5EA1121/654/HIC_for_web.pdf

practice and the Agency is being wound down. There is, however, still a central role to play. The NHS Institute for Learning, Skills and Innovation will be established by July 2005 and will support the NHS and its workforce in accelerating the delivery of world-class health and healthcare for patients and public by encouraging innovation and developing capability at the front line.

NHS Connecting for Health

NHS Connecting for Health – the national programme for IT – is delivering systems to revolutionise the way that the NHS delivers care. Following a period of rapid procurement and systems development, new systems are now being piloted and implemented in all areas of the country:

- Choose and Book allows patients to book their hospital appointment, directly from their GP's surgery, at a time and location that suits them. Choose and Book first went live in July 2004 and is now being rolled out across the country
- Electronic Transfer of Prescriptions (ETP) sends prescriptions directly from the GP practice to the patient's choice of pharmacy, saving time, improving safety and widening patient choice. An ETP pilot site went live in February 2005, with more implementations planned during 2005
- the Quality Management and Analysis System (QMAS) supports the Quality and Outcomes Framework element of the new General Medical Services Contract for GPs and went live across the country in 2004
- in October 2004 a centrally managed, secure, clinical email and directory service called Contact was launched to provide the NHS with a specifically developed system which meets the British Medical Association's requirements for secure clinical email
- key to providing an electronic NHS Care Record for every patient, securely accessible by healthcare professionals at any NHS location in England, is the creation of a core data storage and messaging system, known as the Spine. The Spine will store personal characteristics of patients, such as demographic information, and, as further systems are implemented, will grow over time to include summarised clinical information which may be important for the patient's future treatment and care, such as allergies, visits to A&E and adverse reactions to drugs. The initial phase of Spine implementation started in July 2004 to support Choose and Book
- the new applications are underpinned by a new broadband infrastructure for the NHS, known as the New National Network (N3)
- Picture Archiving and Communications Systems (PACS) capture, store, distribute and display static or moving digital images such as electronic X-rays or scans, bringing benefits to both patients and clinicians. PACS enables clinicians and care teams working together to view common information and so speed up diagnosis, supporting both better care planning and quicker discharge from hospital. Implementing PACS not only reduces procurement costs but will also allow images to be sent and viewed at NHS locations across the country. The first PACS installations went live in Spring 2005.

New staff contracts

New staff contracts that recognise and reward development of skills and improvement in quality and value for money are being introduced across the NHS.

Agenda for Change, covering most skill groups, is being rolled out nationally with the aim of completion within a year. At the end of April 21 per cent of staff had assimilated to Agenda for Change.

The new General Medical Services contract has introduced the Quality and Outcomes Framework discussed earlier. It is backed up by a very large increase in investment for primary care services. This has been guaranteed to rise by 36 per cent in England for the three-year period ending 2005/06.

The new contract for consultants was implemented in 2004. It is designed to value and reward those who do most for the NHS, to modernise and improve working lives, and to support service redesign and improvement.

3.3 Reform of the system

Alongside innovation, the whole NHS system is being reformed.

NHS Foundation Trusts

NHS Foundation Trusts (NHSFTs) are at the cutting edge of the commitment to devolution and a patient-led NHS. In line with the programme of reforms set out in the *NHS Plan*, NHSFTs have far greater local ownership and involvement of patients, the public and staff to innovate and develop services tailored to the needs of their local communities. NHSFTs remain part of the NHS and subject to NHS standards, performance ratings and systems of inspection.

Our aim is that by 2008, all NHS acute Trusts in England will be given the opportunity to apply to become NHSFTs. Six more NHS Trusts were awarded foundation status by Monitor (the Independent Regulator of NHS Foundation Trusts) on 1 April 2005, bringing the total to 31 NHSFTs in operation today. A further 32 Trusts have made detailed applications.

Independent assessment of healthcare providers

The Healthcare Commission has created a new approach to assessing and reporting on the performance of healthcare organisations, following a wide-ranging consultation. The new system, or annual health check, came into force on 1 April 2005 and will look at a much broader range of issues. It aims to reduce regulatory burdens while giving the public a more accurate picture of performance. It will give an annual overall performance rating on a four-point scale, ranging from excellent to weak.

Organisations will be assessed against existing commitments, new national targets, use of resources, performance against the *Standards for Better Health* and, from 2006/07, their local targets. In addition, improvement reviews will assess performance in meeting developmental standards by reference to particular domains. The first results of this new system of assessment will be published in September 2006.

Use of a range of different suppliers

The NHS is now using more services from the voluntary and independent sector. There has been an increase in independent sector Walk-in Centres and seven of these are being developed specifically to meet the needs of commuters. Four will be in London (Victoria, King's Cross, Canary Wharf and Liverpool Street), with one each in Newcastle, Manchester and Leeds.

The Independent Sector Treatment Centre (ISTC) Programme aims to reduce waiting times by introducing additional clinical capacity. It will increase the choice of service providers available to patients. ISTCs are a key driver in cutting waiting times in areas such as ophthalmology and orthopaedics where traditionally there have been bottlenecks in provision.

There are currently five fully operational ISTCs, including a national ophthalmology chain (consisting of two mobile ophthalmology units delivering services from Cumbria to the South Coast) and Kidderminster NHS Treatment Centre, which opened in February 2005 and will offer 1,800 orthopaedic procedures annually over five years. The January report on treatment centres stated that there have been over 16,000 NHS patients treated in ISTCs since September 2003⁵. In total, there are expected to be 34 ISTCs, carrying out up to 250,000 procedures annually. The majority will commence service in 2005 with the remainder delivering in early 2006. In addition, the procurement of £1 billion worth of diagnostic procedures, to include PET, CT and MRI scans, is currently being tendered.

⁵ Department of Health, *Treatment Centres: Delivering Faster, Quality Care and Choice for NHS Patients (January 2005)*
www.dh.gov.uk/assetRoot/04/10/05/24/04100524.pdf

4. The changing NHS – faster, more convenient services

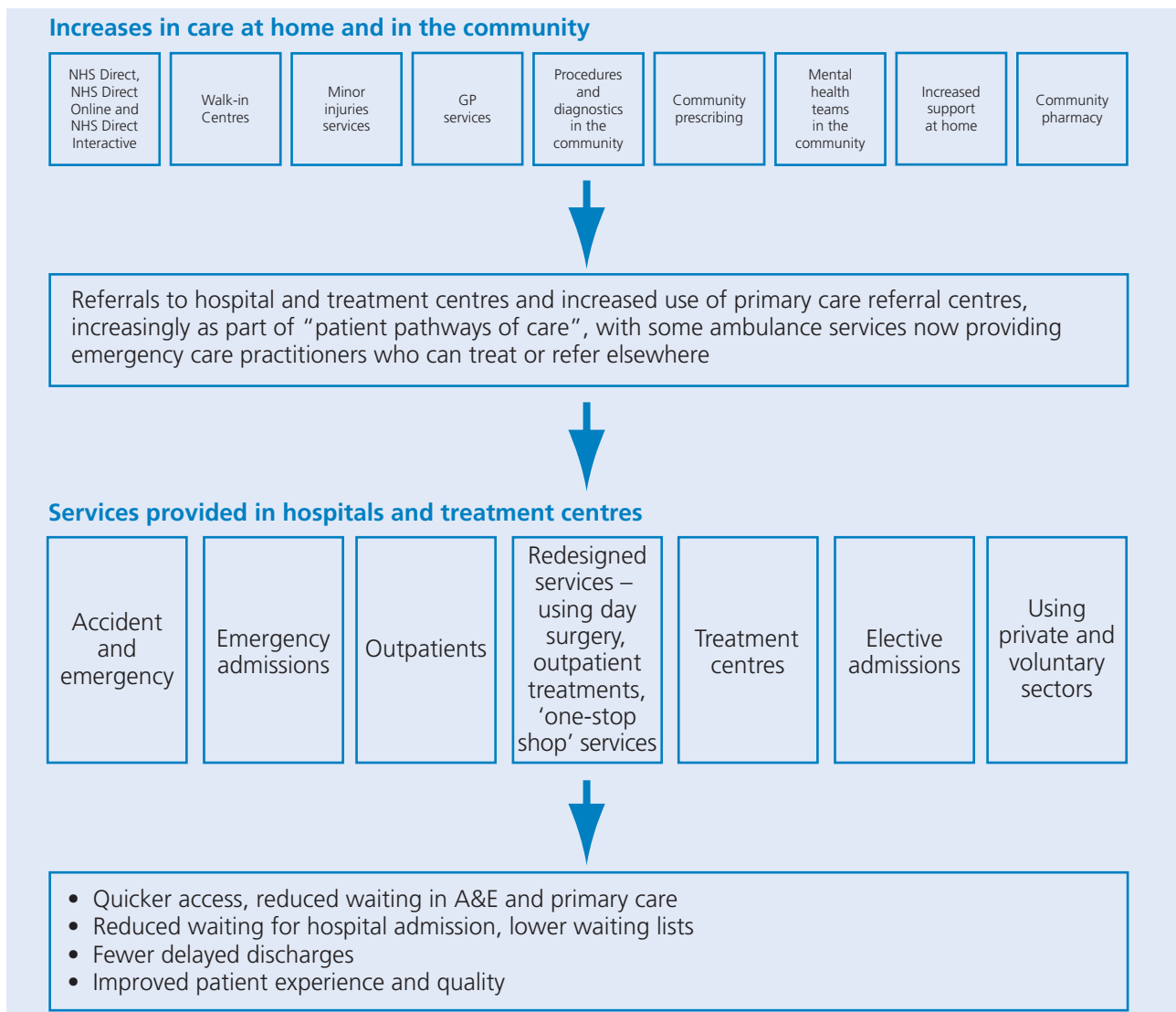
The NHS is changing very fast to become much more patient- and user-led, with faster and more convenient access to higher quality services.

- there is now a far wider range of services available, with specific attention given to people with long term conditions, those with mental health problems, older people and children and young people
- there are dramatic falls in waiting times and waiting lists
- more people are using services as they become faster and more convenient
- there is widespread innovation, supported by good partnership working in the NHS, with social care and beyond.

4.1 Services closer to home and in a wider range of settings

The range of services is growing, as illustrated by the chart below.

Chart A: The changing NHS: local treatment, faster services, more choice and flexibility, improving quality



Changes to the NHS are giving patients both more accessible healthcare and a greater range of treatment options. While general practice remains the primary contact point, patients can also access services such as NHS Direct, NHS Walk-in Centres (NHS WICs), and minor injuries services. Taken together, these new services are being used about 20 million times a year.

NHS Direct is expanding its range of services. This service offers health advice and can also direct patients to other healthcare services if they need further help. Use of this service is increasing, with a rise in visits to NHS Direct Online of more than two and a half million to over nine million during 2004/05. Meanwhile, calls to NHS Direct have remained at over six million. In addition, the range of media by which NHS Direct is accessible has expanded, with the launch of NHS Direct Interactive, a digital television service, in December 2004.

NHS WICs offer patients advice and treatment from early in the morning to late at night, without the need for an appointment. There are now 64 NHS WICs and a further 25 centres are being developed. These include seven centres which are being procured from the independent sector specifically to meet the needs of commuters. The first WICs opened in 2000. Since opening in 2000, WICs have seen over six million people and each now sees an average 108 patients a day.

A further 2,124,000 people were seen in 2004/05 in minor injuries services. These provide open access minor injury and in some cases minor illness care. They provide a GP- or nurse-led service, often working in liaison with major A&Es, particularly in rural locations. Together with the rapidly expanding WIC sector, these services are expected to form a core part of the new urgent care framework being developed.

More services delivered through pharmacies

Recent developments in pharmacy services have meant that community pharmacists can now offer more services, advice and help. The new Community Pharmacy Contractual Framework came into effect on 1 April 2005 and will allow pharmacists to:

- provide repeat dispensing – patients will be able to get their medicines supplied in instalments from their pharmacy, without having to go back to their GP every time they need a new prescription
- offer advice to improve public health on subjects such as healthy eating, stopping smoking and regular exercise
- dispose of unwanted medicines
- provide medicine use reviews for those with long term conditions.

The strategy *Choosing Health Through Pharmacy*⁶, published on 1 April 2005, further describes the key role pharmacists can play in improving and promoting better health.

6 Department of Health, *Choosing Health Through Pharmacy, A programme for pharmaceutical public health 2005-2015* (April 2005)
www.dh.gov.uk/assetRoot/04/10/74/96/04107496.pdf

Pharmacy-based needle exchange scheme

East Elmbridge and Mid Surrey and East Surrey PCTs' needle exchange scheme is available in 28 community pharmacies. In 2004, some 73,000 syringes (and many more needles) were supplied. More than 325 clients regularly used the service, an increase of 20% over the last five years. The average return rate of used equipment was 70%, and reached 82% during the final quarter of the year. There have been no new cases of HIV recorded locally among injecting drug users for nine years.

The scheme undertakes a wide range of campaigns and projects, often linked with other services, aimed at improving health and well-being for example: overdose prevention, good nutrition, and prevention of initiation into injecting. Special attention is given to raising awareness of hepatitis infection. Pharmacists participating in the scheme receive regular training and support.

Primary care

GPs surgeries remain the first and most regular point of contact with the NHS for most people. The introduction of the new contract from April 2004 led to both the new approach to quality described in the last chapter and changes to out-of-hours services.

Since 1995, GPs have had the right to opt out of out-of-hours services but remained responsible for ensuring that the service was provided. From April 2004 PCTs took over this responsibility and have subsequently started to introduce new services that bring together GP out-of-hours services with NHS Direct, ambulance services and other providers. While there have inevitably been some initial problems in some areas, the new services are also bringing benefits as described by this example.

High level of patient satisfaction with nurse-led out-of-hours service in Cheshire

Patients wanting medical attention out-of-hours (OOHs) are now put through to expert nurses employed by the PCT. Doctors still make home visits but these have reduced. The PCT has reported a high level of patient satisfaction.

OOHs care is provided by a range of professionals, including practice, district and hospital nurses, nurse clinicians and nurse practitioners, as well as emergency care practitioners. Nurses offer telephone advice, three nurse-led clinics, arrange home visits or refer patients to hospital. More than 2,700 people are coming through the service each month and the majority of calls have been closed by nurses.

The National Clinical Director for Primary Care, Dr David Colin-Thome, produced a report in April 2004⁷ that shows that NHS primary care is continuing to expand and provide a wider range of services to patients. Practitioners working in primary care are also very often those who initiate the innovations and developments in community services described in this chapter.

Support for people with long term conditions

Services are being extended for the seventeen and a half million people in the UK who have a long term health condition. Many of these people, particularly those who are older or who have more than one condition, frequently find themselves being admitted to hospital as an emergency. Such

⁷ Department of Health, *A responsive and high-quality local NHS: The primary care progress report 2004* (April 2004) www.dh.gov.uk/assetRoot/04/07/93/97/04079397.pdf

admissions are distressing and could often be avoided, or their stay in hospital reduced, if they had better, more proactive care in the community.

The Department has published a great deal of guidance on this during the year⁸ based on research and best practice in the UK and abroad.

Self-care is often an important part of the arrangements for supporting people with long term conditions. Research shows that supporting self-care can improve health outcomes and increase patient satisfaction; it can empower patients to take more control over their lives. Here too, new publications⁹ are designed to help spread good practice.

Expert patients in Greenwich

People with a long term condition in Greenwich are gaining the skills and confidence they need to manage their own health. A series of courses run by volunteer tutors, who are formally trained, assessed and accredited by staff on the Expert Patient Programme and who themselves have a long term condition, aims to build self-confidence and encourage patients to be partners in their own healthcare.

Each week participants make their own action plan which could cover anything from exercise or diet to social and family life or just trying something different. They feedback on their plans the following week and, if they met an obstacle, the group offers suggestions to 'problem-solve'.

Health and social care organisations are already beginning to adopt new approaches to support people with long term conditions and are appointing community matrons. Community matrons are highly skilled nurses who use their training and experience to improve the health outcomes of those people whose clinical needs are high.

Community matrons help avoid unnecessary admissions

The Luton Treatment Centre has ten highly skilled community matrons, from a variety of nursing backgrounds. Their purpose is to proactively support patients in the community so they can avoid unnecessary hospital admissions or, if they are admitted, can be discharged home more quickly.

The matrons are able to build up a good rapport with their patients and can constantly monitor their care, increasing the frequency of visits according to their current state of health. They can be contacted by patients as soon as they experience a deterioration in their health, which prevents the person waiting until they are so poorly that they need to be admitted in an emergency. The matrons also have access to an extended nurse prescriber's course enabling them, in collaboration with GPs, to make beneficial adjustments to a patient's medication.

Patient feedback has been positive, and they say they feel more secure having a single point of contact. GPs are also seeing the benefits, not least of which is a significant reduction in the number of GP call-outs to patients who are high-intensity users of the health service.

8 Department of Health, *Supporting People with Long Term Conditions. An NHS and Social Care Model to support local innovation and integration* (January 2005).

www.dh.gov.uk/assetRoot/04/09/98/68/04099868.pdf

Department of Health, *National Service Framework for Long-term Conditions* (March 2005)

www.dh.gov.uk/assetRoot/04/10/53/69/04105369.pdf

9 Department of Health, *Self Care – A Real Choice: Self Care Support – A Practical Option* (January 2005)

www.dh.gov.uk/assetRoot/04/10/17/02/04101702.pdf

Department of Health, *Self care support: A compendium of practical examples across the whole system of health and social care* (February 2005)

www.dh.gov.uk/assetRoot/04/10/43/90/04104390.pdf

Community mental health services

The provision of mental health services in the community is being strengthened. As at last September, there were around 198 crisis resolution, 255 assertive outreach and 82 early intervention teams established in England. Around 14,900 people are now being seen by assertive outreach teams and around 70,000 people benefited from crisis resolution services in 2004/05.

Support for older people

The *National Service Framework for Older People*¹⁰, published in 2001, set the goal of helping more people stay in control of their own lives by ensuring 30 per cent of people receiving care from social services did so at home.

That target has now been met, two years ahead of schedule. Increasing levels of home care is not only improving the lives of older people but reducing pressures on acute hospital and residential care services. Since 1999, intensive home care provision has risen by 27 per cent. 662,000 older people (aged 65 and over) were being helped to live at home in March 2004. This is frequently being achieved through new and innovative approaches.

The HomeBridge project 'stepping stone'

A new project to provide recuperative care and rehabilitation for older people in Ashford is a 'stepping stone' between hospital and home, or between residential care and living independently in the community.

The HomeBridge project operates out of a purpose-built unit of seven bungalows at the Farrow Court sheltered housing complex. Residents, who can stay for up to six weeks, receive focused support and recuperative care aimed at helping them return to their own home.

Since opening in May 2004, 46 clients have been through the service which offers support from a scheme manager and support worker, community nurses, occupational therapists, physiotherapists and rehabilitation workers, with a meals-on-wheels service and additional domiciliary care service also available if needed.

These innovative approaches are supported by national programmes.

The Healthy Communities Collaborative (HCC)

The HCC, run by the National Primary Care Development Team, is working to reduce falls among the over 65s and strengthen communities by encouraging health and social care professionals to work together with older people. The Gateshead HCC team, and its sister sites in Easington in County Durham and Northampton, have recorded a 32% drop in falls over the past year.

In November 2004 Professor Ian Philp, the National Clinical Director for Older People, published a report that highlights progress since 2001 under the National Service Framework for Older People and sets out a vision for the future¹¹.

10 Department of Health, *National Service Framework for Older People* (May 2001)
www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf

11 Department of Health, *Better Health in Old Age* (November 2004)
www.dh.gov.uk/assetRoot/04/09/32/15/04093215.pdf

Children and young people

The past year saw the joint publication by the Department of Health and the Department for Education and Skills of the *National Service Framework for Children, Young People and Maternity Services*¹². The National Service Framework champions the principle that services should be designed and delivered around the needs of service users, by empowering children and their families through full involvement in choices about their care. Key developments since the publication of the framework have been:

- the announcement of a British National Formulary for Children to be published later this year
- the establishment of a performance management system for Child and Adolescent Mental Health Services
- the appointment of Professor Al Aynsley-Green (formerly the National Clinical Director for Children) as the first Children's Commissioner
- the extension of the Expert Patient Programme to children and families
- the early development of managed children's networks in each SHA
- the development and testing of new and extended roles to support the protection of children around the time of birth, by late 2005
- the introduction of an accelerated development programme for maternity support workers who will provide parenting and public health support to vulnerable families and improve continuity of care between antenatal and early infancy services.

Social care

Many of the developments in community services depend on good local working relationships between NHS organisations and local authorities' social services departments. Earlier this year, proposals were published on the future direction of social care for adults. The Green Paper, *Independence, Well-being and Choice*¹³, sets out proposals to:

- offer more control, more choice and high-quality support for those who use care services
- harness the capacity of the whole community, so that everyone has access to the full range of universal services and an opportunity to play a full part in society
- improve the skills and status of the workforce to deliver the vision.

The key proposals in the Green Paper include:

- wider use of direct payments and the piloting of individual budgets to stimulate the development of modern services delivered in the way people want
- greater focus on preventative services to allow for early targeted interventions
- a strong strategic and leadership role for local government, working in partnership with other agencies, particularly the NHS, to ensure a wide range of effective and well-targeted provision, which meets the needs of our diverse communities

12 Department of Health, Department for Education and Skills, *National Service Framework for Children, Young People and Maternity Services* (September 2004)

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT_ID=4089111&chk=U8Ecln

13 Department of Health, *Independence, well-being and choice: our vision for the future of social care for adults in England* (March 2005)

www.dh.gov.uk/assetRoot/04/10/64/78/04106478.pdf

- encouraging the development of new models of service delivery and harnessing technology to deliver the right outcomes for adult social care.

Table A: Increased activity in primary and community care

Patient access	In 1999/2000	In 2004/05	Increase during 2004/05	Increase since NHS plan ¹
Calls to NHS Direct ²	1,650,000	6,586,000	181,000 (2.8%)	4,936,000 (299%)
Visits to NHS Direct Online	0	9,285,000	2,743,000 (41.9%)	9,285,000
Patient visits to Walk-in Centres	0	2,068,000	486,000 (30.7%)	2,068,000
Prescribing				
Number of prescriptions	541 million ³	686 million ⁴	36.4 million ⁵ (5.6%)	145 million (27%)
Cost of drugs prescribed	5,547 million ³	8,080 million ⁴	570 million ⁵ (7.6%)	2,532 million (46%)
Mental health				
Assertive outreach (number of teams)	130 ⁶	255 ⁷	4 ⁸ (1.6%)	125 ⁹ (96%)
Crisis resolution (number of teams)	0	198 ⁷	61 ⁸ (44.5%)	198
Early intervention (number of services)	0	82 ⁷	43 ⁸ (110.3%)	82
Social Care				
Number of contact hours of home care provided ¹⁰	2,684,000 ¹²	3,113,000 ¹³	130,000 ¹⁴ (4.4%)	429,000 (16%)
Number of households receiving intensive ¹¹ home care ¹⁰	68,700 ¹²	87,100 ¹³	5,700 ¹⁴ (7.0%)	18,400 (27%)
Referrals to consultants				
Number of GP referrals made to outpatients	9,061,000 ¹⁵	9,527,000 ¹⁶	4,000 ¹⁶ (0.0%)	465,000 ¹⁶ (5.1%)

- 1 Change since the NHS Plan takes as a baseline the nearest annual figure to July 2000, compared to the latest annual position
- 2 The 2003/04 figure was incorrectly reported as 6,411,000 in the December 2004 Report. The correct figure is 6,405,000.
- 3 Figures are on a year to June 2000 basis
- 4 Figures are on a January to December basis (ie calendar year 2004)
- 5 Increase from calendar year 2003 to calendar year 2004
- 6 Figure collected in autumn 2000
- 7 Figures collected in autumn 2004
- 8 Increase between autumn 2003 and autumn 2004
- 9 Increase between autumn 2000 and autumn 2004
- 10 Data is collected annually in September each year
- 11 Defined as more than 10 contact hours and 6 or more visits during the week
- 12 September 1999 figure
- 13 September 2003 figure as September 2004 figure not available at time of publication
- 14 Increase from September 2002 to September 2003
- 15 Figure adjusted to allow direct comparison with 2004/05
- 16 Figures are subject to possible revision when final outturn data is received

4.2 Faster services, reduced waiting

Patients have faster access to care and treatment in primary care, A&E, as outpatients and as inpatients and there are fewer delayed discharges. There is more to do, for example in diagnostics. However, these achievements are remarkable, particularly when compared with the position at the time the *NHS Plan* was published.

Urgent and emergency care

Perhaps the most impressive achievement has been the increase in people seen and treated or admitted in A&E within four hours. In the last quarter of 2004/05 97 per cent of people were seen in four hours and the position has continued to improve, with latest monthly management information showing a figure of 98.1 per cent for April 2005. This has been achieved by the hard work, innovation and dedication of thousands of people throughout the NHS and in its partner organisations.

This achievement is particularly impressive given the very large increase in first A&E attendances, up 679,000 in major A&E departments and 1,399,000 overall. This has been accompanied by a significant increase in emergency admissions of 200,000 (4.7% per cent).

Ambulance services too have performed very well, maintaining the standard of reaching 75% of life-threatening emergencies (category A calls) within eight minutes.

Underpinning these services has been greater access to primary care with over 99 per cent of the population able to see a primary care professional in 24 hours and a GP within 48 hours.

Graph A: Percentage of patients spending four hours or less in A&E

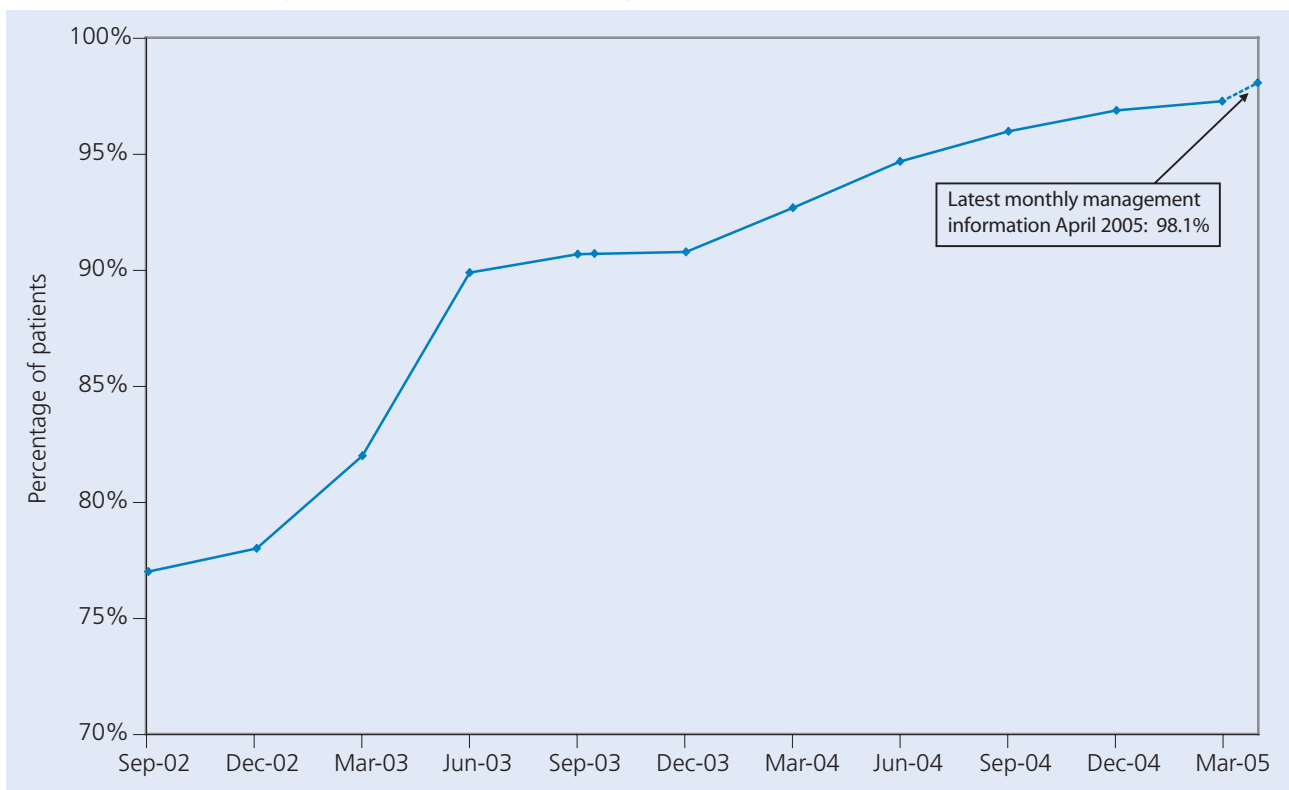


Table B: There is continuing growth in emergency activity

	In 1999/2000	In 2004/05	Increase during 2004/05	Increase since NHS plan ¹
First A&E attendances (Including Walk-in Centres and minor injury services)	13,167,000 ²	16,712,000	1,399,000 (9.1%)	3,545,000 (27%)
Ambulance emergency journeys	2,850,000	3,354,000 ³	176,000 ⁴ (5.5%)	504,000 ⁵ (18%)
Emergency incidents attended	3,429,000	4,268,000 ³	282,000 ⁴ (7.1%)	839,000 ⁵ (24%)

- 1 Change since the NHS Plan takes as a baseline the last end March figure before July 2000 (ie the 1999/2000 figure), compared to the latest annual position
- 2 There were no Walk-in Centres in 1999/2000
- 3 Most recent data is for 2003/04
- 4 Increase from 2002/03 to 2003/04
- 5 Increase from 1999/2000 to 2003/04

Graph B: Percentage of patients with access to a GP within 48 hours, or to a primary care professional (PCP) within 24 hours

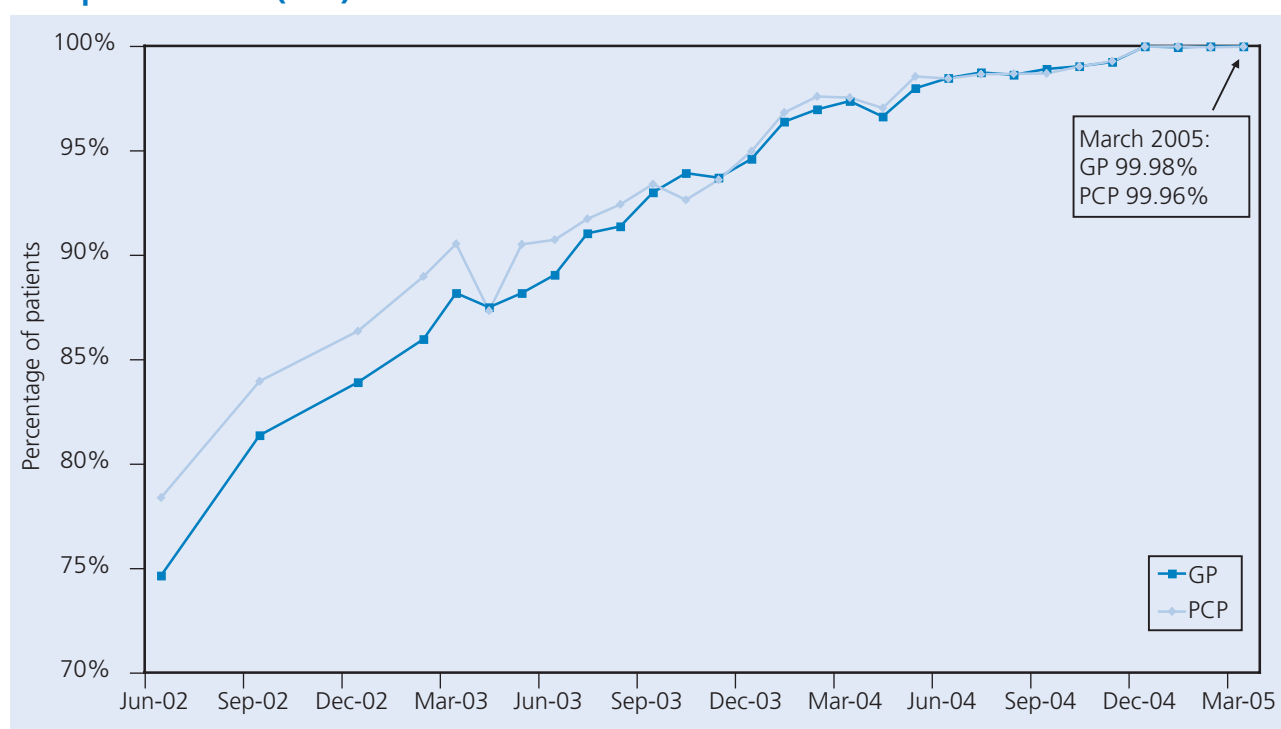


Table C: GP and primary care professional appointment availability

	March 2002	March 2005	Increase over last 12 months ¹	Increase since March 2002 ¹
GP within 2 days	74.64% ²	99.98% ³	2.62%	25.34%
Primary care professional within 1 day ⁴	71.70% ⁵	99.96% ³	2.44%	28.26%

- 1 Percentage point change based on data as at the time of reporting. Changes to definitions are not taken into account
- 2 Percentage of practices
- 3 From April 2004, access to a GP/primary care professional at a local NHS Walk-In Centre may count towards the 24/48 hour primary care access target, but only for practices that have an agreement with an NHS Walk-In Centre, which offers GP/primary care professional services, that includes referring and/or diverting practice patients. Only these figures include this change
- 4 These figures are calculated using the definition of primary care professional adopted in 2002/03 that allows a GP to be included as a primary care professional, where an appointment was available with a GP within the primary care professional timeframe
- 5 Estimate. The actual figure for March 2002 for primary care professional was 59.24%, however this does not use the amended definition explained in note 4. On the basis of the average difference the amendment has made to results throughout 2002/03, the estimated figure for March 2002 would be 71.70% as shown in the table

Faster access is understandably changing the way the public use services. A&E departments, Walk-in Centres and minor injury services are all seeing big increases in activity. NHS plans for the future will need to take account of these trends. Part of these plans will need to be better integration of services as shown in this example:

Kent Ambulance Trust's unscheduled care desk

Patients who phone 999 with emergency needs receive an ambulance from Kent Ambulance Trust. Non-urgent (category C) patients are transferred to an unscheduled care desk where an emergency care practitioner or paramedic can assess the caller's needs and provide them with the most appropriate local service to meet their needs. This could include a GP appointment, either in or out of hours, rapid response nursing, or 24-hour emergency mental health team, among other options. In addition to better supporting patients, this has also improved the dialogue between local clinicians and helped develop more treatment choices for patients. Data for the period May 2004 to February 2005 shows that 5,609 patients were dealt with by the desk. Of these, 39% accepted an alternative to A&E at the time of the call. Before the introduction of the desk, around 90% of patients were taken to A&E. Further work is underway to research full end outcomes for the patients transferred to the desk.

Reduced hospital waiting

Waiting times for an outpatient consultation have fallen very fast. The number of people waiting more than 13 weeks has fallen by 363,000 since March 2000 to 30,468 at the end of March 2005.

Graph C: Patients waiting over 13 weeks for an outpatient appointment

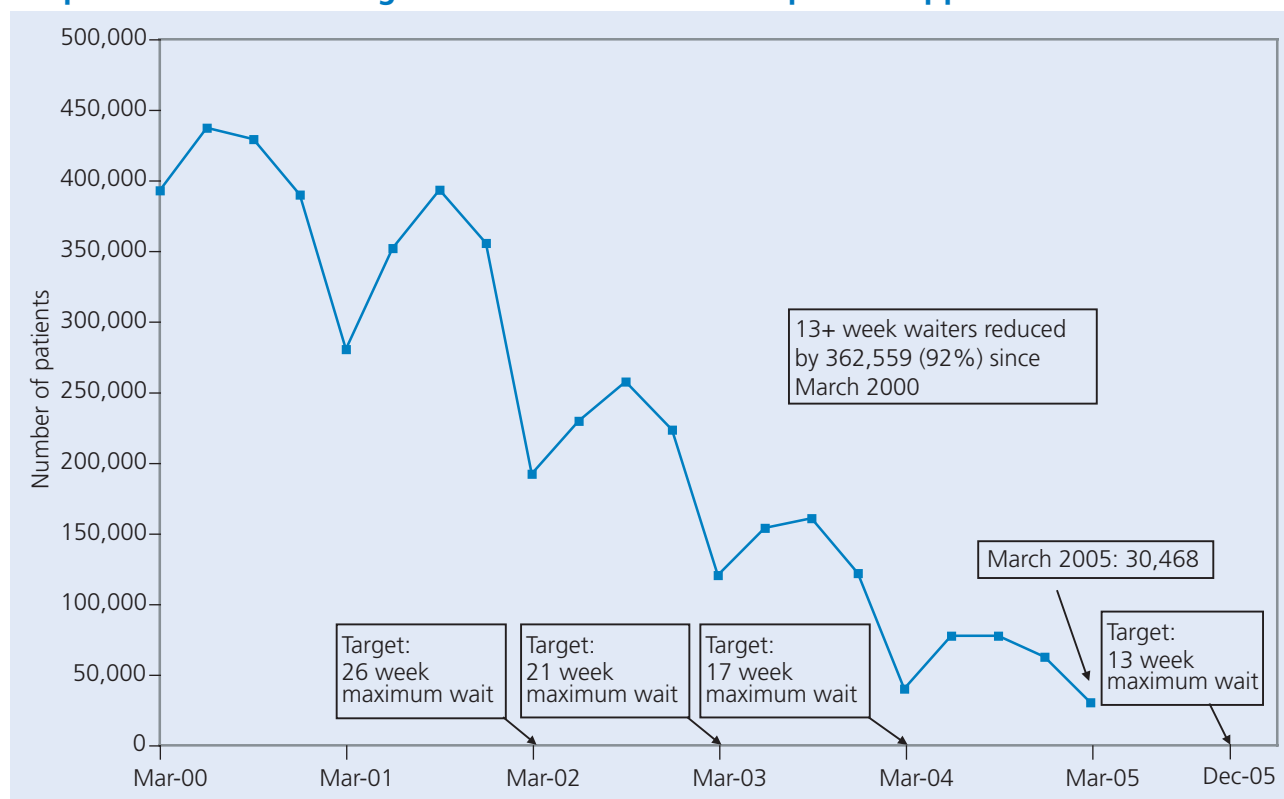


Table D: Outpatient access

	March 2000	March 2005	Reduction in last 12 months	Reduction since NHS plan ¹
Number of people who had been waiting over 17 weeks ²	n/a ³	148 ⁴	230	n/a
Number of people who had been waiting over 13 weeks ²	393,027	30,468	9,861	362,559

- 1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (ie the March 2000 figure), compared to end March 2005 position
- 2 Figures are cumulative. For example, there were 30,468 patients waiting more than 13 weeks in March 2005, of which 148 were waiting more than 17 weeks
- 3 The number waiting over 17 weeks were not collected until April 2002
- 4 Of the 148 patients who had been waiting over 17 weeks, 37 were waiting for an appointment at English Trusts and 111 were waiting for an appointment at Welsh hospitals

Waiting times for inpatient treatment have also fallen very fast, with only 40,800 waiting more than six months at 31 March. The target is that no patients will wait more than six months by 31 December.

In two major areas, cardiac revascularisations and cataract surgery, the maximum waiting time is now three months.

Graph D: Patients waiting over six months for inpatient admission

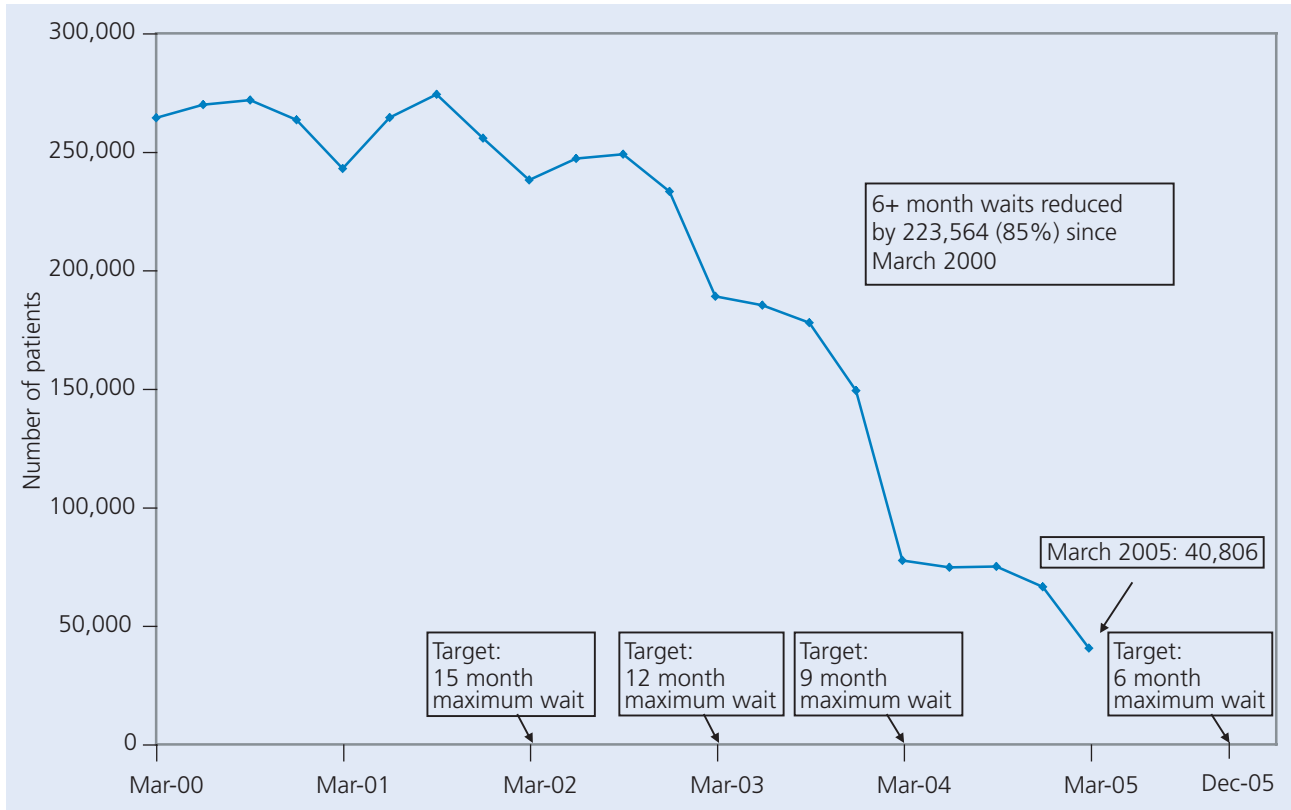


Table E: Inpatient access

	March 2000	March 2005	Reduction in last 12 months	Reduction since <i>NHS plan</i> ¹
Number of people who had been waiting over 9 months ²	126,388	41 ³	182	126,347
Number of people who had been waiting over 6 months ²	264,370	40,806	39,320	223,564

- 1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (ie the March 2000 figure), compared to end March 2005 position
- 2 Figures are cumulative. For example, there were 264,370 patients waiting more than six months in March 2000, of which 126,388 were waiting more than nine months
- 3 Of the 41 patients who were waiting over nine months, 35 were waiting for admission to English Trusts and 6 were waiting for admission to Welsh hospitals

At the same time, the inpatient waiting list continues to fall, dropping 84,100 in the year and by 215,400 since publication of the *NHS Plan*.

Graph E: Inpatient waiting list

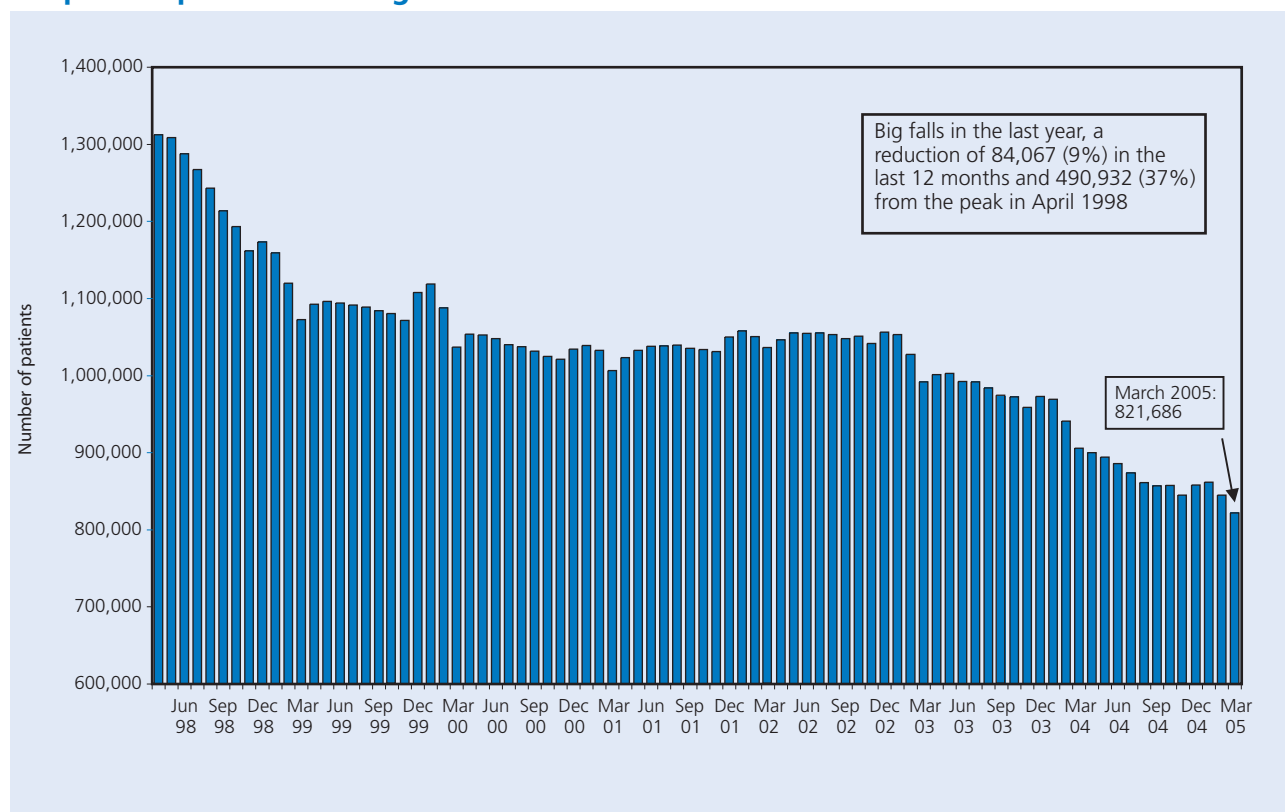


Table F: Total number of patients waiting for admission to hospital

	March 2000	March 2005	Reduction in last 12 months	Reduction since NHS plan ¹
Total waiting list	1,037,066	821,686	84,067	215,380

1 Change since the NHS Plan takes as a baseline the last end March figure before July 2000 (ie the March 2000 figure), compared to end March 2005 position

Reducing delayed discharge

Unnecessary waiting for discharge from hospital after treatment is continuing to decrease. Levels of delayed discharges have fallen considerably from 2,821 in March 2004 to 2,359 in March 2005.

Graph F: Number of patients of all ages occupying an acute hospital bed with delayed discharge

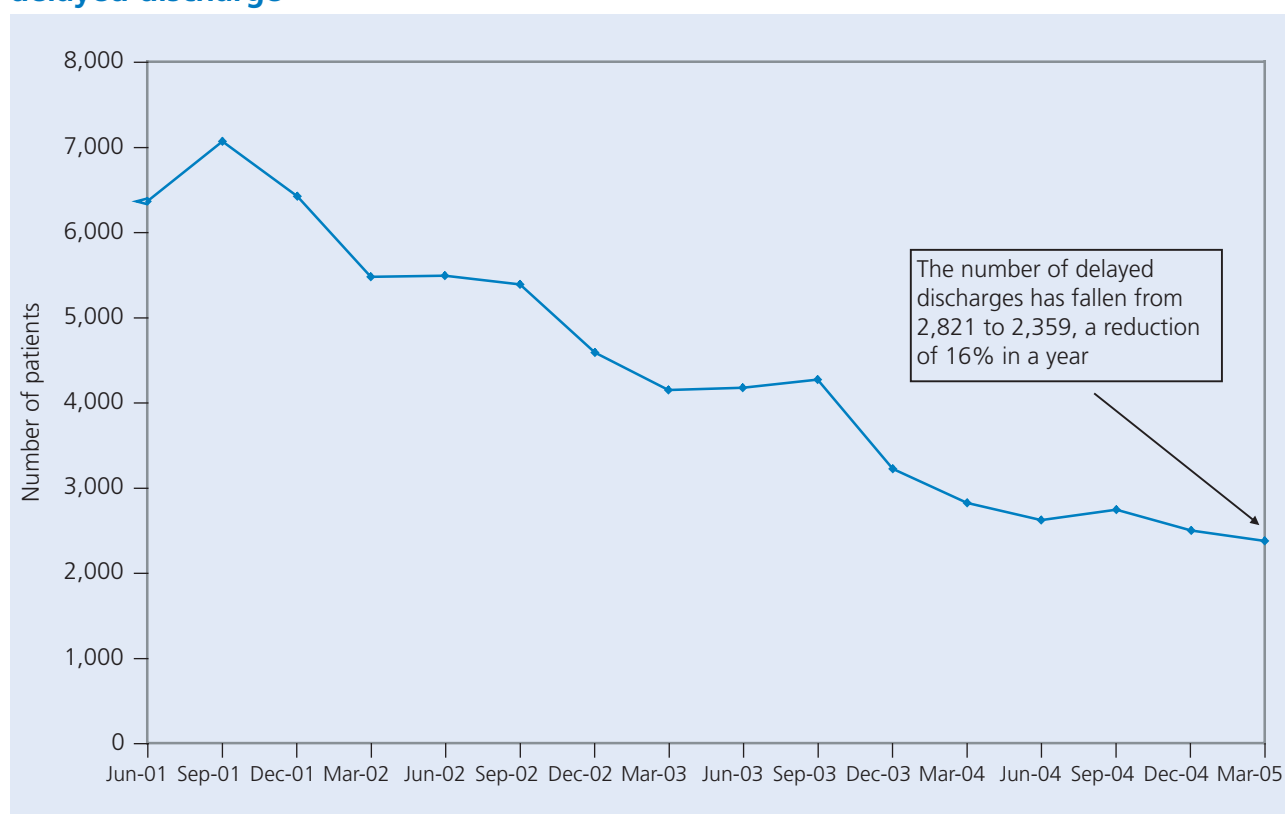


Table G: There is a continuing reduction in delayed discharges

	March 2000	March 2005	Reduction in last 12 months	Reduction since NHS plan ¹
Number of patients of all ages occupying an acute hospital bed with delayed discharge	n/a ²	2,359	462 (16%)	n/a
Number of patients over 75 occupying an acute hospital bed with delayed discharge	5,431	1,804	327 (15%)	3,627 (67%)

- 1 Change since the NHS Plan takes as a baseline the last end March figure before July 2000 (ie the March 2000 figure), compared to end March 2005 position
- 2 Data was not collected in March 2000

Table H: Outpatient activity

	In 1999/2000	In 2004/05	Increase during 2004/05	Increase since NHS plan ¹
Number of first outpatient attendances with a consultant	12,136,000	13,522,000 ²	223,000 ³ (1.7%)	1,386,000 (11%)
Number of GP referrals made to outpatients	9,061,000 ⁴	9,527,000 ⁵	4,000 ⁵ (0.0%)	465,000 ⁵ (5.1%)

- 1 Change since the NHS Plan takes as a baseline the last end March figure before July 2000 (ie the 1999/2000 figure), compared to the latest Annual position (ie calendar year 2004)
- 2 Figures are for calendar year because Quarter 4 figures are not yet available
- 3 Increase from calendar year 2003 to calendar year 2004
- 4 Figure adjusted to allow direct comparison with 2004/05
- 5 Figure is subject to possible revision when final outturn data are received

Table I: There is continuing growth in treatments in different settings

	In 1999/2000	Forecast increase in 2004/05 ¹	Increase since <i>NHS plan</i> ²
Elective hospital admissions (FFCEs) ³	4,891,000 ⁴	1,000 (0.0%)	555,000 (11.3%)
Procedures in outpatients	n/a	14,000 to 64,000 (0.7% to 3.1%)	n/a
Procedures in primary care	n/a	16,000 to 66,000 (3.0% to 12.4%)	n/a
Total procedures	n/a	32,000 to 132,000 (0.4% to 1.6%)	n/a

1 Figures are subject to possible revision when final outturn data is received

2 Change since the *NHS Plan* takes as a baseline the nearest annual figure to July 2000 (ie 1999/2000), compared to the latest annual position (the forecast for 2004/05)

3 All NHS funded patients including those treated in both NHS and independent hospitals

4 Figures have been adjusted to allow direct comparison with 2004/05

The future

Analysis of hospital activity levels shows that we are beginning to see new trends developing:

- there are very big increases in the use of the new community-based services such as Walk-in Centres and NHS Direct
- there is no growth in GP referrals to hospital, suggesting that more services are being provided locally
- hospital emergency services have increased significantly, while planned services have seen little growth even though hospital waiting times are falling fast.

There are several important areas, such as diagnostics, where we do not yet have adequate information – although local figures suggest that there have been big increases in activity in many areas, such as MRI scans and parts of pathology. We also know that diagnostic waiting times are often too long.

These trends need further analysis but overall they show the importance of:

- continuing to develop convenient, local community-based services
- integrating all the urgent and emergency services into functioning networks
- focusing much more on diagnostics, reducing waiting times to ensure that the NHS as a whole hits the 2008 target of a maximum 18 weeks from going to the GP to starting inpatient treatment through all the intermediate outpatient and diagnostic steps.

5. The changing NHS – becoming patient led

The NHS is improving with more capacity and targeted improvements in particular services. As it improves it can turn its attention to wider issues of quality, particularly patient experience.

This chapter sets out how the NHS is:

- promoting choice
- listening to patients
- responding innovatively to patient involvement through NHS Live
- promoting equality and tackling discrimination.

The NHS has had a very large increase in capacity and, as the last chapter shows, made big improvements in the availability and convenience of services. Its challenge in the future is to move from being a service that simply does things *to* or *for* people to one which works *with* them in supporting them to make decisions about their health and about the services they will use.

This approach was set out in *Creating a Patient-led NHS*¹⁴ published in March. This chapter reviews some of the main developments in the year.

5.1 Choice

Nationally, the NHS is giving patients needing planned hospital care more choice of provider for their treatment. Following successful pilot schemes, the national implementation of choice at six months began in April 2004 and was extended to all patients and specialties by the end of August. By the end of March 2005, almost 49,000 patients had already accepted an offer of choice and had been treated more quickly by an alternative provider.

By the end of this calendar year, all patients needing elective care will be offered the choice of four to five providers at the point of referral by their GP and the opportunity to book their hospital appointment at a time of their convenience. Choice at referral will mean that some ten million patients a year will be able to choose the hospital for their treatment which best meets their individual needs and preferences. The new service, Choose and Book, which is being implemented throughout 2005, will enable the majority of patients to choose their hospital and book their appointments electronically either from the GP's surgery or later from home or work by contacting a telephone helpline or through the internet.

Ultimately, by 2008, patients needing planned hospital care will be able to choose to be treated by any healthcare provider in the country which meets NHS standards at NHS prices. As a transitional step to free choice, from April 2006 patients will be able to choose from the four or five local providers commissioned by their PCTs, together with all NHS Foundation Trusts and nationally procured Independent Sector Treatment Centres. All other independent sector providers may also apply to be on the list of choices for patients, if they are able to operate to NHS standards and at NHS tariff.

¹⁴ Department of Health, *Creating a Patient-led NHS* (March 2005)
www.dh.gov.uk/assetRoot/04/10/65/07/04106507.pdf

Choice in cataract surgery

PCTs in West Surrey have implemented choice at the point of referral, direct from optometry practices, in line with the January deadline. Patients are able to choose from four providers including three local NHS trusts plus a mobile treatment centre operated by Netcare UK.

The local health community based its care pathway on the nationally recommended model. However, additional eye measurements are being performed by optometrists to allow even quicker assessment of patients on arrival at their eye clinic.

Refining the whole process this far was only possible due to the excellent level of support received from optometrists and consultants across Surrey. As a result of people working hard to make the project succeed, patient care has really been improved. West Surrey have already incorporated the lessons learned from cataract choice into their plans for Choose and Book.

5.2 Listening to patients

Listening to the views of patients is essential for understanding the experience, priorities and needs of patients. Trusts and PCTs have access to many different sources of public and patient feedback, all of which can be used to inform local action aimed at improving the patient experience and developing a patient-led NHS.

The national patient survey programme, which is administered by the Healthcare Commission (HC), is one such source of "customer intelligence". All NHS Trusts and PCTs take part in a rolling programme of surveys, and each survey is based on a standardised questionnaire and methodology. This means that the surveys provide a robust snapshot of relative performance from the patients' point of view. The results of each survey also form part of the assessment of NHS service providers by the HC.

Since 2001, around one million patients have taken part in the national patient survey, and have given their views about local services across a range of healthcare settings. During 2004/05, the HC carried out four national surveys asking patients across England about their experiences of emergency departments, outpatients, mental health and primary care services.

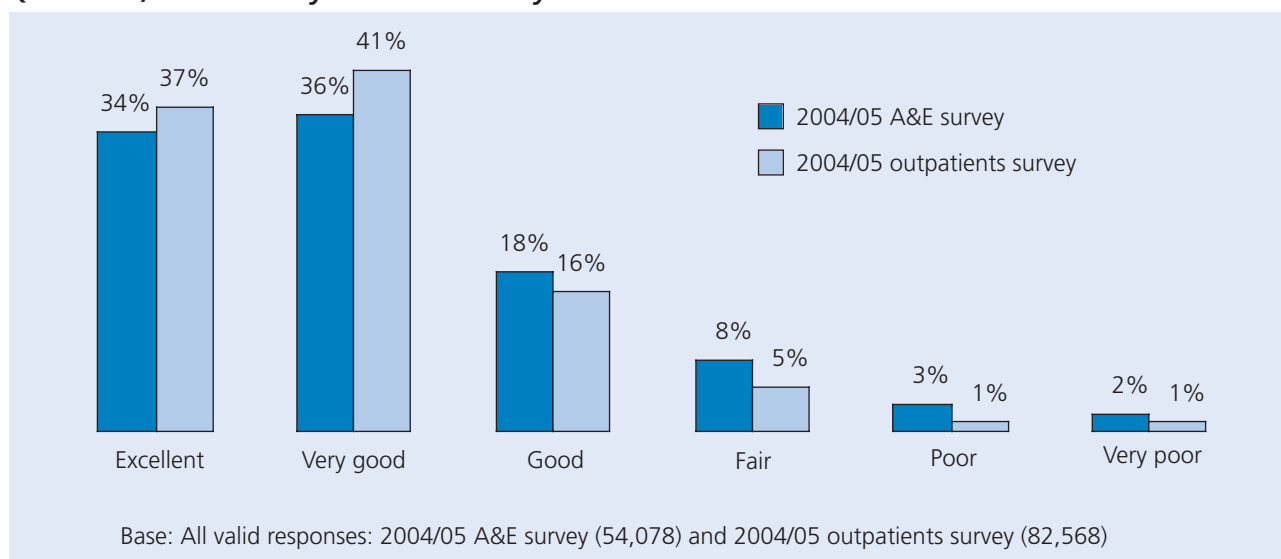
Findings from the first two of the surveys, in emergency departments and outpatients, were published by the HC in February¹⁵. Results showed that nationally around seven in ten or more recent users rate the quality of care they received as *excellent* or *very good*, with a further one in six rating their care as *good*. A similarly high proportion are also positive about most of the different aspects of care and treatment covered in both surveys.

Results for the 2004/05 primary care and mental health service surveys will be published in the summer of 2005.

15 www.healthcarecommission.org.uk/NationalFindings/Surveys/PatientSurveys/fs/en?CONTENT_ID=4000117&chk=XPJRIh

Graph G: Quality of care

Q: Overall, how would you rate the care you received?



NHS Live

NHS Live has emerged as an important enabler of change during the last year. Conceived as a programme to support local projects that focus on improving the quality of the patient experience, it has now shown its potential as a valuable national learning community.

We have 300 local projects underway which are on track to deliver positive outcomes for patients and users. A number of these projects have benefited from having a private sector ‘learning partner’ – someone from one of eight corporate sponsor companies – who works with them to input fresh ideas and helps the local team to think differently about delivering more innovative, ambitious outcomes. All project leaders can access support in their SHA as well as make new connections across the NHS and social care network.

As the programme moves into its second year, we see the opportunity to use NHS Live to help accelerate the delivery of our strategic priorities. The fact that NHS Live promotes and supports ‘bottom up’ change and the sharing of good practice across networks makes it a useful vehicle to drive forward the culture change required to create a patient-led NHS.

Examples of some of the NHS Live projects are given here:

Sunderland Urgent Care Team

Sunderland Teaching Primary Care Trust's Urgent Care Team was set up through an NHS Live project to provide an alternative model of care for patients who require acute care. The multi-disciplinary team is nurse-led, operates city-wide 24 hours a day, seven days a week and provides acute care in patients' homes.

City Hospitals Sunderland NHS Foundation Trust had twice the national average of acute admissions to hospital with 98,000 attendances in A&E. Some early patient involvement work explored why this was the case. Reasons included confidence in the care provided and previous good experience. However, the major reason stated was that there was no alternative model of care other than hospital admission.

The team comprises highly skilled practitioners who operate at an advanced clinical level to assess and treat acutely ill patients in their home. The team provides quality timely care to patients, with a response time of 30 minutes from receiving the call to attending the patient's home. The team now sees 250 new patients a month and this is increasing month on month.

The team initially focused on patients with chronic obstructive pulmonary disease and chest infection, who had the highest admission rate to the acute hospital and highest readmission rate. It now sees an expanded range of patients requiring acute care.

Patients have responded positively to the service, with all stating that they feel in control of their care for the first time in their illness. In addition, patients felt they had one-to-one care and said being cared for at home was a better experience.

What you need to know about me

Canterbury and Coastal NHS Primary Care Trust set up a team comprising a mixture of staff, patient and user representatives and patient advisory and liaison representatives. They devised the 'What you need to know about me' patient project. The focus of this was to:

- involve patients and carers, asking them about their experiences of a cross-section of NHS services within the community setting
- find out what users of the service really think and look at ways of involving them in planning changes
- learn from non-medical people
- work as a multidisciplinary team
- recognise the contribution of the NHS staff and encourage them to become much more patient-focused and consider the diverse needs of individuals and involve them in their own care.

The project took a year to complete. Four services were targeted: community hospitals, health visiting, occupational therapy and podiatry. These were representative of the work of the PCT and gave a cross-section of different age groups.

The questionnaire was qualitative and people were interviewed personally. They were asked if they felt as though they were treated as an individual and their specific needs met by the service in question.

The results were encouraging. People were extremely complimentary about the services they received, the staff attitude and overall care given. The things that required changing are being addressed as follows:

- alteration in appointment systems to be more flexible
- arrangements made for safe facilities for mums seeing the health visitors when they have other children to care for
- greater information about services and access to electronic information on specific conditions
- continuity of care was an issue, in that people would like to see the same practitioner. This is not always possible, therefore awareness sessions for staff are to be implemented emphasising the importance of reiterating and evaluating relevant episodes of care.

Health Insight Unit

The Department of Health has set up a Health Insight Unit. Its goal is to provide in-depth insight into public and patient needs, attitudes and behaviours, in terms of health and the usage of the healthcare and social care systems. This will enable strategy to be based on a deeper understanding of needs and stimulate initiatives to deliver more personalised services, while improving the quality of services overall. Over time, through monitoring trends and forecasting, it will inform long-term health strategies and improve investment efficiency.

5.3 Promoting equality and tackling discrimination

The founding value of the NHS was that it should be available to everyone regardless of who they are and their ability to pay.

Over the last year, a great deal of attention has been paid particularly to issues of race equality. The NHS Chief Executive set out a ten-point Leadership Plan in February 2004.

Race Equality Action Plan

Action	Responsibility
1. Health services and outcomes	
Strategic direction: Through the forthcoming planning guidance, embed race equality into future Local Delivery Plans to enable more personalised care, reduced chronic disease and health inequalities, increased capacity and community regeneration	DH and all NHS leaders with national and local partners
Align incentives: Build race equality into the new standard and target local performance management systems and into the new setting regime, into inspection model	DH and all NHS leaders with national and local partners
Development: Provide practical support to help NHS organisations make service improvements for people from ethnic minorities	NHS Top Team and NHS Modernisation Agency
Communications: Encourage fresh approaches to communications to engage people from ethnic minorities more effectively in improving outcomes	All NHS organisations and DH
Partnerships: Work with other national and local agencies to promote the health and well-being of people from ethnic minority communities	DH and all NHS leaders in concert with national, regional and local partners

Action	Responsibility
2. Developing People	
Mentoring: Senior leaders to show their commitment by offering personal mentorship to a member of staff from an ethnic minority	All senior leaders in DH and NHS
Leadership action: Senior leaders to include a personal 'stretch' target on race equality in their 2004/05 objectives	NHS Chairs and CEs; DH Board members
Expand training, development and career opportunities: Enhance training for all staff in race equality issues. Develop more entry points for people from ethnic minorities to join the NHS and take up training. Improve access for black and minority ethnic staff to the full range of development programmes, support networks and professional training. Encourage appropriately qualified leaders from ethnic minorities in health and other sectors to consider and apply for executive positions	Local WDCs and HR networks, NHS Leadership Centre, NHSU and other training providers
Systematic tracking: Build systematic processes for tracking the career progression of staff from ethnic minorities including local and national versions of the NHS Leaders scheme	All senior leaders and NHS Leadership Centre
Celebrate achievements: Acknowledge the contributions of all staff in leaders tackling race inequalities and promote opportunities for staff from ethnic minorities to celebrate their contribution to the NHS	DH and all NHS

The plan was backed up by an independent panel led by Trevor Phillips of the Commission for Racial Equality to review progress and report back to the Chief Executive's Conference of NHS leaders. It is also supported by the appointment of an Equality and Human Rights Director for the NHS and the Department of Health.

Increasingly, equality of access and equality of health outcomes will become an important issue for the NHS as discussed in the next chapter.

Delivering equality in mental health

January saw the publication of *Delivering Race Equality in Mental Health Care* (DRE)¹⁶, an action plan for achieving equality and tackling discrimination in mental health services in England for all people of black and minority ethnic (BME) status. The programme is based on delivering more appropriate and responsive services, improved community engagement and better monitoring and dissemination of information.

DRE itself is just one component of a wider programme of action bringing about equality in health and social care. It will support the implementation of the ten-point race equality action plan in the NHS, and will also help NHS trusts to fulfil their obligations under the Race Relations (Amendment) Act 2000.

¹⁶ Department of Health, *Delivering race equality in mental health care: An action plan for reform inside and outside services* (January 2005)
www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf

Learning disability

Learning disability is another area of potential discrimination. A learning disability White Paper¹⁷ was published in 2001. A recent report¹⁸ by the Valuing People National Director, Rob Greig, gives details of the progress made since then and recommends priorities for action for the next five years. It demonstrates that:

- people are being listened to more
- person-centred planning, done properly, makes a difference in people's lives
- the Supporting People programme has helped many more people live independently
- organisations are working together better at a local level.

17 Department of Health, *Valuing people: A strategy for learning disability for the 21st century* (March 2001)
www.archive.official-documents.co.uk/document/cm50/5086/5086.pdf

18 Department of Health, *Valuing people: The story so far... A New Strategy for Learning Disability for the 21st Century* (March 2005)
www.dh.gov.uk/assetRoot/04/10/70/59/04107059.pdf

6. The changing NHS – health promotion and protection

As services improve, more attention can be paid to health promotion and protection.

This chapter describes:

- the government-wide approach to *Choosing Health*
- improvements in smoking cessation and immunisation
- the continuing improvements in mortality rates for cancer, coronary heart disease and suicide.

6.1 Choosing Health

As services improve and prevention and earlier interventions begin to reduce demand for some kinds of healthcare, the NHS has been able to turn more attention to promoting health and well-being.

Last year saw two highly significant landmarks in setting out the future direction for the NHS and how it will serve the population of the country: the *NHS Improvement Plan*¹⁹ and the Public Health White Paper *Choosing Health*²⁰. In March 2005 these were followed up with the publication of *Delivering Choosing Health*²¹, which explains how these plans will be put into practice. Together, these provide the blueprint for the development of the NHS over the next four years and an important shift towards improving health.

Delivering Choosing Health states that national and local action will focus on 45 ‘big wins’ – key interventions that evidence and expert advice suggest will make the greatest impact on health in the shortest period of time. These cover the main priorities for action within *Choosing Health*:

- tackling obesity
- reducing the numbers of people who smoke
- reducing harm and encouraging sensible drinking
- improving sexual health
- improving mental health and well-being
- reducing health inequalities.

Supporting strategies aimed at:

- promoting personal health
- developing the workforce
- building research and development
- using information and intelligence.

19 Department of Health, *The NHS Improvement Plan: Putting people at the heart of public services* (June 2004) www.dh.gov.uk/assetRoot/04/08/45/22/04084522.pdf.

20 Department of Health, *Choosing health: making healthy choices easier – Executive Summary* (November 2004) www.dh.gov.uk/assetRoot/04/09/47/51/04094751.pdf

21 Department of Health, *Delivering Choosing health: making healthy choices easier* (November 2004) www.dh.gov.uk/assetRoot/04/10/57/13/04105713.pdf

And action across government on:

- helping children and young people to lead healthy lives
- promoting healthy and active life among older people.

Delivering Choosing Health is backed up by two new action plans. *Choosing Activity: a physical activity action plan*²² brings together all the commitments in *Choosing Health*, as well as other action across government, which will contribute to increasing levels of physical activity. This includes school physical education and sport, local action to encourage activity through sport, transport plans, the use of green spaces and NHS advice to individuals on increasing activity by using pedometers.

*Choosing a Better Diet: a food and health action plan*²³ describes how diet and nutrition commitments in the White Paper will be met, including action on advertising and promotion of foods to children, simplified food labelling, obesity education and prevention, and nutritional standards in schools, hospitals and the workplace.

Two examples of the approach to improving the health of the public are reducing smoking and improving immunisation.

Reduction in the number of smokers

The NHS Stop Smoking Services continue to expand to help ever more smokers to quit. The number of successful quits increased by 63 per cent in 2004.

Table J: More people are stopping smoking

	In 2000/01 ¹	In 2004 ²	Increase during 2004 ³	Increase since NHS plan ⁴
Number of people who had successfully stopped smoking at 4 week follow-up	64,600	259,300 ⁵	100,200 63%	194,700 301%

1 Earliest year for which figures available for England

2 Figure is for calendar year 2004 because quarter 4 figures for 2004/05 are not yet available

3 Increase from calendar year 2003 to calendar year 2004

4 Change since the NHS Plan takes as a baseline the first available financial year figure (ie the 2000/01 figure) compared to the latest calendar year figure (ie 2004)

5 April to December 2004 figures are provisional

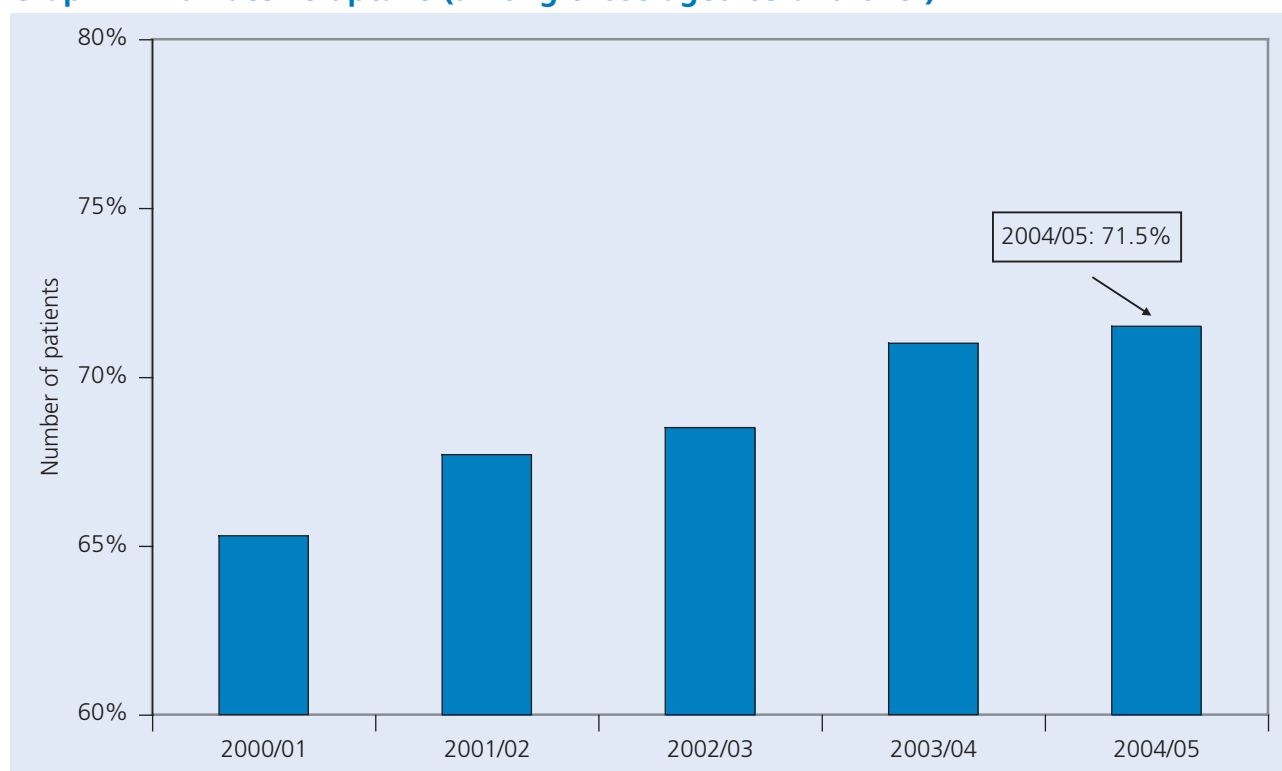
Plans for the future of NHS support to help smokers quit were set out in *Choosing Health*. A key challenge for the NHS will be to make all enclosed public places and workplaces in the NHS completely smoke free. Further reductions in the number of smokers will further decrease the incidence of the two biggest killer diseases – cancer and coronary heart disease.

Immunisation

As part of the winter plan, the NHS vaccinated a record percentage of older people against flu this year.

22 Department of Health, *Choosing Activity: a physical activity action plan* (March 2005)
www.dh.gov.uk/assetRoot/04/10/57/10/04105710.pdf

23 Department of Health, *Choosing a Better Diet: a food and health action plan* (March 2005)
www.dh.gov.uk/assetRoot/04/10/57/09/04105709.pdf

Graph H: Flu vaccine uptake (among those aged 65 and over)

6.2 Reducing mortality and morbidity

Cancer

The NHS is delivering improved cancer services, more quickly, to more people than ever before. Over the last six years, the cancer mortality rate for people under 75 has fallen by over 12 per cent. This equates to the saving of around 33,000 lives. Britain's men have had the world's sharpest fall in premature deaths from lung cancer and in the past decade British women have had the world's biggest decrease in deaths from breast cancer. A national bowel cancer screening programme, one of the first of its kind in Europe, will be rolled out from next year. This should result in a 15 per cent reduction in deaths in the screened group.

Significant progress has been made towards the aims set out in the *NHS Cancer Plan*. Latest figures show that:

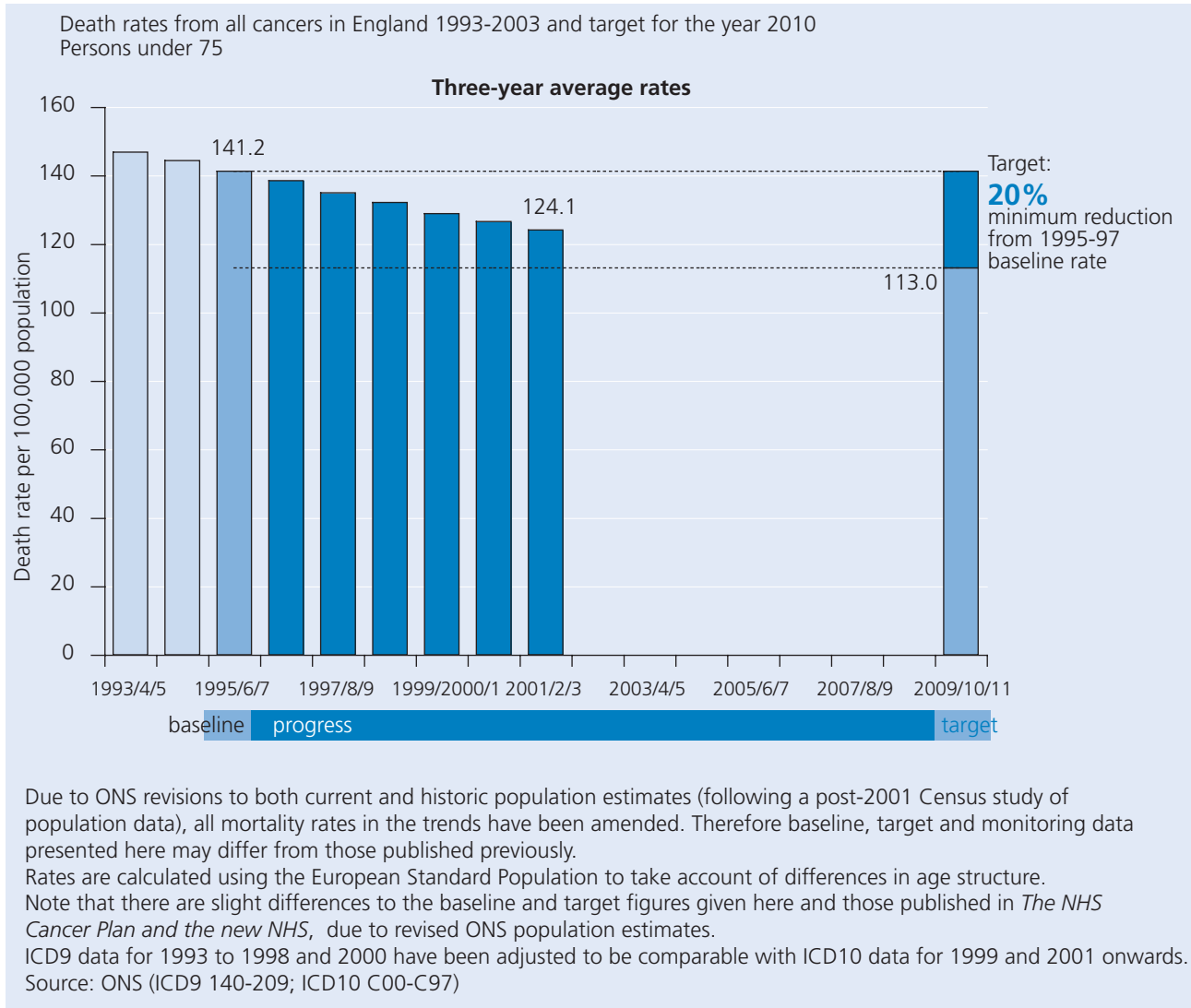
- over 99 per cent of people with suspected cancer are seen by a specialist within two weeks of being referred by their GP; over 97 per cent of women with breast cancer are receiving their first treatment within one month of diagnosis²⁴
- since April 2001, over 250,000 more women have been invited for screening due to the expansion of the breast screening service to women aged 65 to 70²⁵
- there has been a 38 per cent increase in cancer consultants since 1997 and a 55 per cent increase in consultants in other specialties who spend a significant amount of their time caring for cancer patients²⁶
- since April 2000, over 1,100 pieces of new modern equipment have been delivered to diagnose and treat cancer.

24 www.performance.doh.gov.uk/cancerwaits/

25 Department of Health, *The NHS cancer plan and the new NHS: Providing a patient-centred service* (October 2004) www.dh.gov.uk/assetRoot/04/09/25/37/04092537.pdf

26 Source: Department of Health Medical and Dental Workforce

Graph I: Cancer mortality target



Taking a 'whole system' approach

The Whittington NHS Trust colorectal clinic has reduced non-urgent waits for investigations and results from 15 weeks to 8 weeks, with all urgent referrals being met within the *NHS Cancer Plan* commitments.

A whole-system approach was taken to mapping and improving the patient pathway by the whole colorectal team. The following ideas were tested and implemented:

- the clinical nurse specialist undertook an extended role and a protocol-driven nurse-led clinic has been established
- the nurse-led rectal bleeding clinic routinely sees patients under 40 with bright red bleeding
- three nurse endoscopists provide a nurse-led flexible sigmoidoscopy and biopsy clinic for urgent referrals
- a consultant is available to offer support and advice if a patient requests it.

Coronary heart disease

The NHS is continuing to deliver major improvements in the treatment of coronary heart disease:

- premature deaths from heart disease, stroke and related diseases have fallen from 141 deaths per 100,000 people in 1995/96/97 to 103 per 100,000 people in 2001/02/03, a 27.1 per cent fall²⁷
- the decline in premature deaths from these diseases is also having an impact on health inequalities. Over the past seven years, the absolute gap in mortality rates between the fifth of areas with the worst health and deprivation indicators ('the Spearhead Group') and the country as a whole has narrowed by 22 per cent. We are currently on track to meet the target of a 40 per cent reduction in the gap by 2010²⁸
- as part of the government-funded School Fruit and Vegetable Scheme, almost two million four to six year olds in over 16,000 schools throughout England are receiving a free piece of fruit or vegetable every school day²⁹
- around 2.3 million people are currently receiving statins (cholesterol-lowering drugs), potentially saving thousands of lives every year, as well as reducing the number of heart attacks³⁰
- there have been radical reductions in the length of time patients wait for treatment. Only a few years ago it was not uncommon for patients to wait over two years for surgery. Now, no one waits over three months³¹ and heart patients are being offered a choice of hospital for their treatment at time of diagnosis
- 681 defibrillators have been installed in busy public places, such as stations and airports. So far these have saved the lives of 58 people. A further 2,300 defibrillators were recently allocated to ambulance services and are in the process of being installed³².

27 Source: National Centre for Health Outcomes Development, <http://nww.nchod.nhs.uk/>

28 Source: National Centre for Health Outcomes Development, <http://nww.nchod.nhs.uk/>

29 Source: Department of Health School Fruit and Vegetable Scheme

30 www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/CoronaryHeartDisease/CoronaryArticle/fs/en?CONTENT_ID=4097422&chk=gB%2BXku

31 Source: Department of Health's Monthly Monitoring Returns

32 www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/CoronaryHeartDisease/CoronaryPromotionProject/fs/en

Wallasey Heart Centre

The centre was set up to tackle the unmet needs of the local population. It is a primary-care-based partnership involving the NHS; the Council; Wirral HeartBeat (a local cardiac charity); Wirral Multicultural Centre; Irish Community Care Merseyside; and Wirral Fire Service.

The centre provides:

- a specialist GP in cardiology performing regular patient assessments, with same-day advice/management service for GPs and practice nurses
- a twice weekly cardiac rehabilitation service for up to 10 post-myocardial infarction and post heart-bypass surgery or angioplasty patients
- lifestyle & weight management service for those at risk of CHD
- a specialist nurse-led heart failure clinic
- a community echocardiography service
- testing to exclude or confirm suspected heart failure.

Wallasey Heart Centre has had over 5000 referrals since it opened in October 2000. Less than 10% are referred on to secondary care. User and carer appreciation is enormous. Lifestyle & Weight Management has proven very effective: 79% lost weight and 55% lowered their blood pressure over and above the effects of medication.

In Wallasey Village the CHD death rate for the over 75s has dropped to almost half the UK average; in deprived Seacombe it now rivals the rates in affluent west Wirral. High-risk ethnic groups are engaged through Wirral Multicultural Centre and Irish Community Care Merseyside. Post-rehabilitation users can now continue exercising through an innovative link between Wirral Heartbeat and Wallasey Fire Service.

Wallasey Heart Centre is now also addressing the psychological impact of chronic disease by assessing heart failure patients with a locally validated computerised mental health assessment tool.

Table K: There have been big improvements in treatment for coronary heart disease

	In 1999/2000	In 2004/05	Change over last 12 months	Change since <i>NHS Plan</i> ¹
CHD Revascularisations ²	46,000	65,900 ³	5,590 ⁴ (9.3%)	19,900 (43%)
Lipid regulating drug prescription items ⁵	9.0 million ⁶	29.4 million ⁷	6.7 million (30%)	20.4 million (227%)
Time to thrombolysis (% treated within 60 minutes of call)	24% ⁸	55% ⁹	7% ¹⁰	31% ¹⁰
Number of patients waiting over 3 months for a heart operation (revascularisation)	5,660 ¹¹	0 ¹²	-2,824	-5,660 ¹³

1 Change since the *NHS Plan* takes as a baseline the last annual figure before July 2000 (ie the 1999/2000 figure), compared to the latest annual position (usually March 2005)

2 Figures include non-English residents and private patients treated in NHS hospitals

3 2003/04 figure as this is the latest available data

4 Increase from 2002/03 to 2003/04

5 Lipid regulating drugs refers to section 2.12 of the British National Formulary. These drugs, of which more than 90% are statins, regulate the concentration of cholesterol

6 Year to June

7 Data is for calendar year 2004 (ie January to December 2004) as this is the latest available data

8 Only 39 (out of 216) hospitals in England were collecting this data in 1999/2000

9 Percentage is the aggregated national average for the whole of 2004/05 and excludes Welsh hospitals

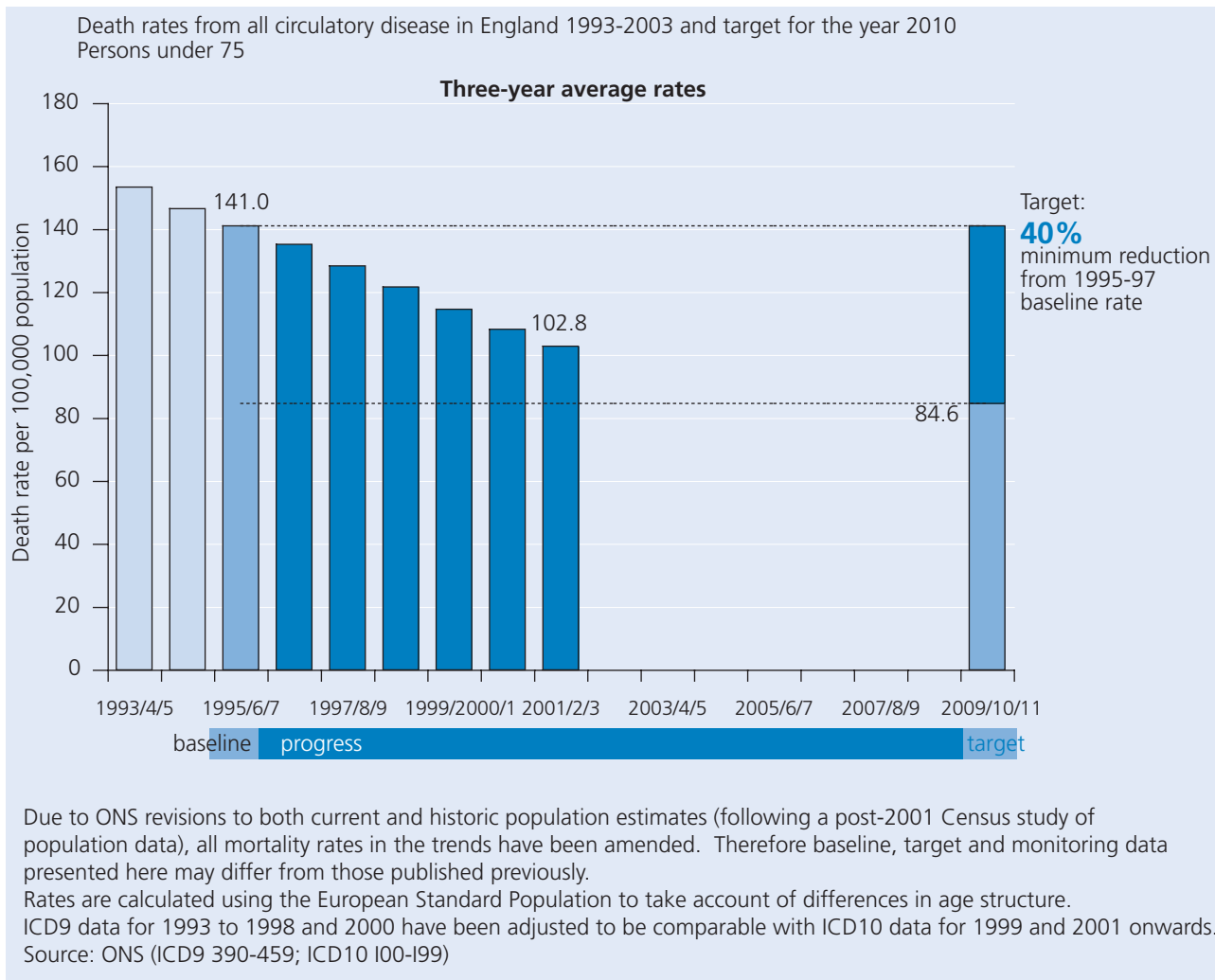
10 Percentage point change

11 April 2002 figure as data collection did not start until this date

12 March 2005 figure

13 This compares the April 2002 figure to the March 2005 figure

Graph J: Circulatory disease mortality target



Mental health and well-being

The first National Service Framework for Mental Health was produced in 1999. Last December, the National Director for Mental Health, Professor Louis Appleby, published his five-year report on the progress of its implementation³³. His review reflects the huge amount of activity that has taken place in mental health services in the past five years and the benefits of this activity for service users and their carers.

Mental health services have recently seen large increases in spending and staff numbers and greatly increased use of modern treatments. These improvements were made possible by an expanding mental health workforce. Compared with 1999, we now have an additional 747 consultants, 8,341 psychiatric nurses, 2,479 clinical psychologists, and 527 psychotherapists working in the NHS.

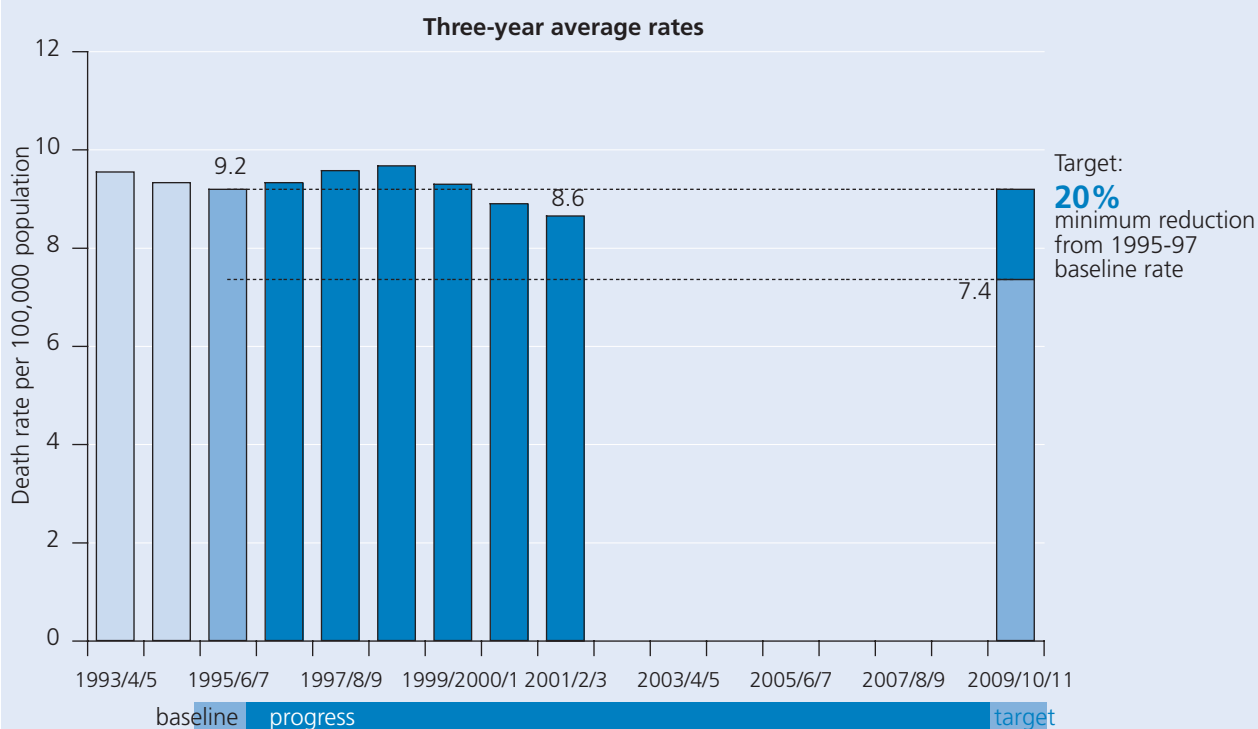
Perhaps most importantly, the rate of death from suicide has been steadily falling for the past five years – it is now at its lowest recorded figure. The overall death rate from suicide in the most recent period (2001-03) has fallen to 8.6 deaths per 100,000 population in England. This marks a reduction of six per cent from the baseline rate in 1995-97 of 9.2 deaths per 100,000. If the trend of the last five years were to continue, we would meet our target to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010.

33 Department of Health, *The national service framework for mental health – five years on* (December 2004) www.dh.gov.uk/assetRoot/04/09/91/22/04099122.pdf

Graph K: Mental health target

Death rates from intentional self-harm and injury of undetermined intent excluding 'verdict pending' in England 1993-2003 and target for the year 2010

All persons



Due to ONS revisions to both current and historic population estimates (following a post-2001 Census study of population data), all mortality rates in the trends have been amended. Therefore baseline, target and monitoring data presented here may differ from those published previously.

Rates are calculated using the European Standard Population to take account of differences in age structure.

ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards. Source: ONS (ICD9 E950-E959, plus E980, excluding E88.8 (inquest adjourned); ICD10 X60-X84, Y10-Y34 excl. Y33.9 (verdict pending))

As detailed in Professor Appleby's report, a new work programme in the National Institute for Mental Health in England (NIMHE) is now exploring ways of expanding the availability of talking treatments, building on the large increase in the number of staff who can deliver psychological therapies. Also highlighted in his report is a new programme to modernise inpatient care by eradicating all unsuitable wards through increased capital investment. The NHS has already started this work with the allocation of an additional £30 million to mental health trusts with the greatest needs.

Milton Court mental health rehabilitation unit

This unit in Doncaster offers an alternative to hospital admission for people in mental health crises. Milton Court offers a wide range of therapeutic initiatives, all underpinned with the tenets of the social inclusion and recovery philosophy. For example, the trust is working in conjunction with Doncaster College, which provides service users with a tailored numeracy course to suit their individual needs. It has set up a charitable stall in Doncaster market, which service users manage. Goods for sale on the stall are donated and proceeds put back into Milton Court.

7. The changing NHS – value for money

The NHS is receiving very large increases in public funding. Services are undoubtedly improving but it is very important that the money is well used, securing value for money as well as quality.

This chapter:

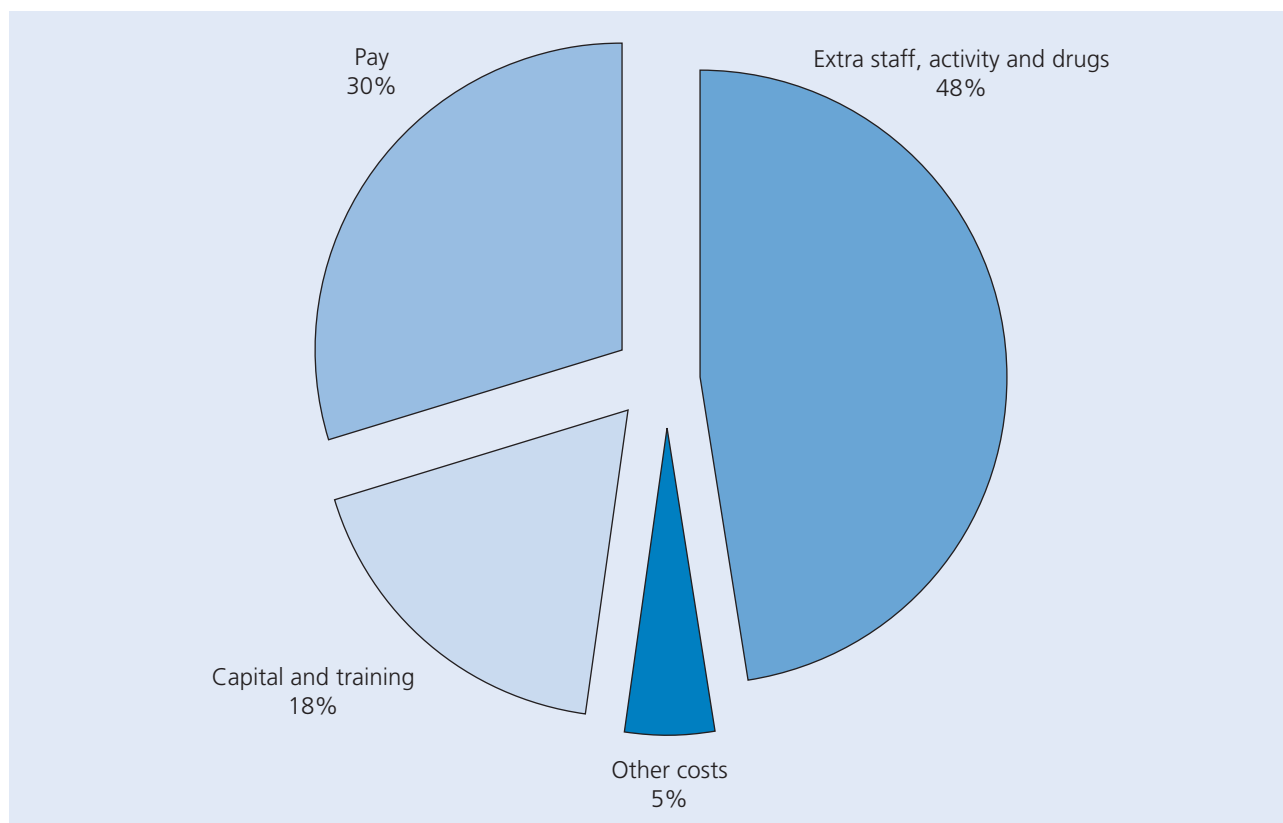
- outlines how the extra funding is being spent
- describes value for money in terms of:
 - the reduction of overheads and costs
 - productivity measured in terms of activity and quality
 - the introduction of best practice and job and service redesign
 - contribution to the health and prosperity of the country.

7.1 NHS expenditure

Total NHS expenditure in 2004/05 rose by £6.7 billion, of which £5.8 billion was increased revenue expenditure and £0.9 billion increased capital expenditure.

The following chart shows broadly how the extra funding has been used. It is followed by a brief summary of investment in staff and beds showing how capacity has expanded.

Chart B: High-level breakdown of the additional £6.7 billion NHS expenditure in 2004/05



This extra funding has been used to:

- **improve access to, and quality of, services through extra staff, activity and drugs** – £3.2 billion of the increase has been used to employ additional staff, increase prescribing and purchase more goods and services. Approximately £1.4 billion was spent on additional staff and £0.8 billion on increased prescribing. The balance was used to purchase more goods and services
- **invest for the future through capital and training** – to achieve world-class service standards, the NHS needs to invest in people and infrastructure. Investment in training, research and capital increased during the year by £1.15 billion. This helped to deliver the opening of six new hospitals and there has also been a four per cent increase in medical school intake
- **ensure that pay levels are sufficient to attract and retain staff** – around £2 billion has been invested in pay and this is having a direct impact on staff numbers. The number of staff employed has increased significantly, with 8,050 extra doctors and 11,160 extra nurses, midwives and health visitors
- **meet unavoidable cost pressures** – such as inflation on goods and services.

More staff

Since publication of the *NHS Plan*, growth in the total NHS workforce has increased by an average of 3.9 per cent every year. The 2004 annual workforce census³⁴ again showed that staff numbers had increased over the previous year's figures, with:

- over 1.3 million people employed in the NHS. This represents an increase of 48,160 since September 2003 and a growth of 233,710 since 1999
- 84 per cent of NHS staff (1.1 million) have a direct role in patient care and 16 per cent support the infrastructure; included within the latter are managers, who make up 2.8 per cent of total NHS staff
- 397,520 qualified nursing, midwifery and health visiting staff (including practice nurses), 67,880 more than in 1999
- 30,650 consultants, 7,330 more than in 1999
- 31,520 GPs (excluding retainers, registrars and locums), 3,060 more than in 1999
- 58,960 qualified allied health professionals, 11,040 more than in 1999.

³⁴ Department of Health, NHS workforce census for England at 30 September 2004 (March 2005)
www.dh.gov.uk/PublicationsAndStatistics/Statistics/StatisticalWorkAreas/StatisticalWorkforce/fs/en

Table L: Increase in frontline staff

	Sept 1999	Sept 2004	Increase over last 12 months at Sept 2004	Increase since NHS plan ¹
Frontline staff	926,200	1,119,600	36,480 (3.4%)	193,400 (21%)
<i>of which:</i>				
All doctors (excluding retainers)	94,000	117,000	8,050 (7.4%)	23,100 (25%)
Total qualified nursing, midwifery (including practice nurses) and health visiting staff	329,600	397,500	11,160 (2.9%)	67,900 (21%)
Qualified allied health professionals	47,900	59,000	3,010 (5.4%)	11,000 (23%)

1 Change since the NHS Plan takes as a baseline the last annual figure before July 2000 (ie the September 1999 figure), compared to the latest annual position (ie the September 2004 figure), as data is taken from the annual workforce census of 30 September each year

We are also investing for the future by increasing the numbers of medical school and training places for the workforce of the future.

Table M: Numbers of training places for doctors and nurses

	In 1999/2000	In 2004/05	Increase over last 12 months	Increase since NHS plan ¹
Medical school intake	3,972	6,326	244 (4.0%)	2,354 (59%)
Nursing and midwifery training commissions	18,707	24,284 ²	1,328 ³ (5.8%)	5,577 ⁴ (30%)

1 Change since the NHS Plan takes as a baseline the last annual figure before July 2000 (ie the 1999/2000 figure), compared to the end March 2005 position (ie the 2004/05 figure)

2 2003/04 figure as this is the latest available data

3 Increase from 2002/03 to 2003/04

4 Increase from 1999/2000 to 2003/04

More beds

As the NHS changes more services are provided outside hospitals and bed numbers become a poor measure of capacity. However, bed numbers are still expanding as shown in table N. There were 3,213 critical care beds in January 2005, compared with 2,362 in January 2000 – a 36 per cent increase. This is an increase of 70 critical care beds since January 2004, when there were 3,143 beds. The number includes 1,426 high-dependency beds – an increase of 77 per cent since 2000.

Table N: There are more beds available than in previous years

	In 1999/2000	In 2004/05	Increase over last 12 months	Increase since <i>NHS plan</i> ¹
Total number of general and acute beds	135,080	137,277 ²	598 ³ (0.4%)	2,197 (1.6%)
Total number of intermediate care beds	4,242	8,928	231 (2.7%)	4,686 (110%)
Total number of open and staffed critical care beds	2,362 ⁴	3,213 ⁵	70 ⁶ (2.2%)	851 ⁷ (36%)

1 Change since NHS Plan takes as a baseline the last annual figure before July 2000 (ie 1999/2000), compared to the latest annual position

2 This is the 2003/04 figure as this is the latest available data

3 Growth from 2002/03 to 2003/04

4 Figure as at January 2000, as target measured from this point

5 Figure as at January 2005

6 Increase at January 2005 compared to January 2004

7 Increase at January 2005 compared to January 2000

7.2 Delivering value for money

The public rightly want to know that the enormous investment in the NHS is delivering value for money. Given the range of activities and scope of the NHS, there is no easy and straightforward answer to this question.

In the first few years after the *NHS Plan* was published a significant part of the new funding was used to catch up on poor standards, making good some of the damage of the past and to invest in new capital facilities and the recruitment and training of staff. Much of this would not have immediate effect. Now that capacity is much nearer what is needed, it is becoming increasingly important to search constantly for value as well as quality.

This section describes this in four areas:

- reducing overheads
- more efficient delivery of activity and outcomes
- the introduction of best practice, service redesign and new working practices
- contribution to the health and prosperity of the country.

Reducing overheads

Although management overheads are low by comparison with private healthcare, we aim to further reduce these and maximise the proportion of our resources that go directly to front line delivery. To support this we have a three part strategy:

- **reduce the cost of policy, funding and regulation of the system.** In 2004-05:
 - we completed a 38 per cent reduction in Departmental (head office) staff down to 2,245
 - the Secretary of State for Health announced the completion of a review of the Department of Health's Arm's Length Bodies (ALBs) and confirmed a reduction in the number of ALBs from 38 to 20, a saving of £500m in ALB expenditure by 2007/08, and a 25 per cent reduction in posts in the same period
 - following on from this review, it was recently announced that the Healthcare Commission and the Commission for Social Care Inspection are to form a single

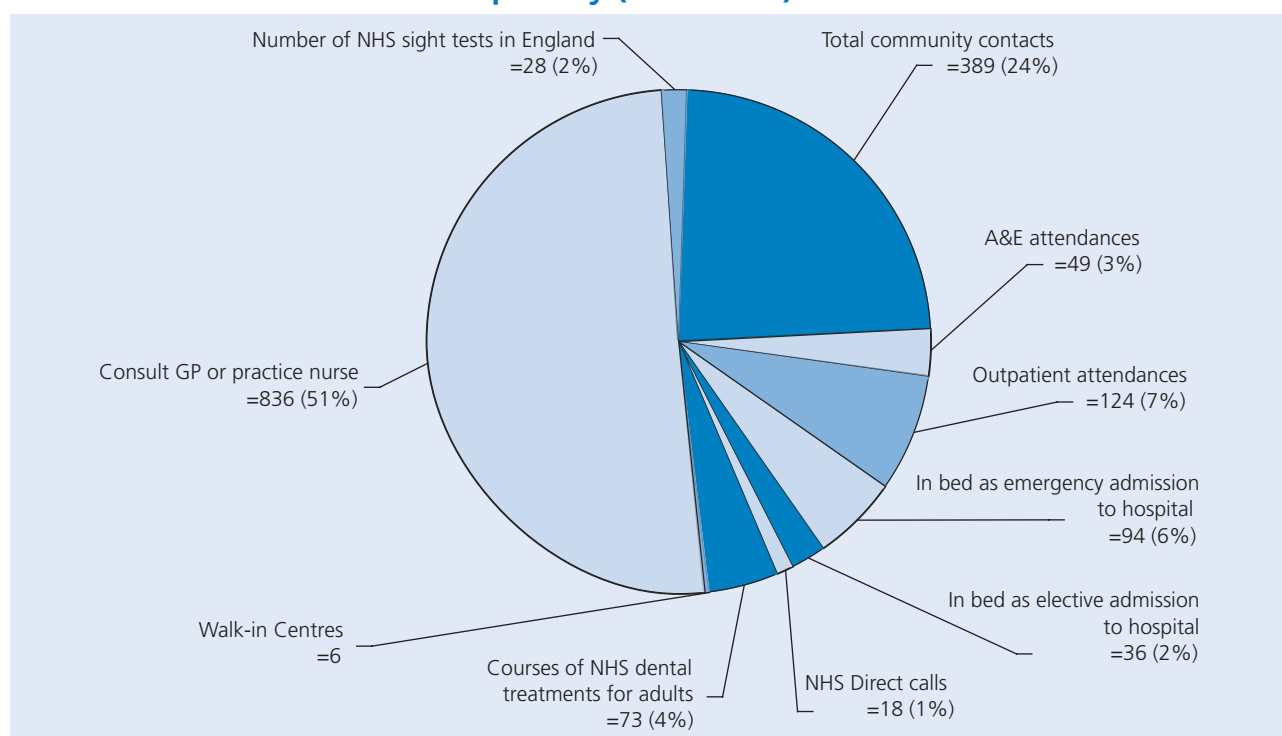
organisation by 2008. This will help to reduce the burden that regulation can place on the frontline.

- **improve procurement efficiency.** In 2004-05
 - we agreed a seven per cent price reduction for branded prescription medicines, which came into force on 1 January this year and will enable the NHS to save at least £300 million per annum
 - new long-term arrangements for reimbursement of generic medicines were introduced in April. These new arrangements will further promote a transparent and competitive market for NHS generic medicines whilst generating annual savings of some £300 million
 - we achieved annual savings of around £160 million on renegotiation of national procurement contracts
 - eleven enterprise wide software agreements were signed for the NHS, including with Microsoft and Oracle, through the national programme for IT.
- **reduce the cost of corporate services such as finance and human resources.**
 - NHS Shared Business Services came into being on 1 April this year. This is a joint venture between the Department of Health and the private sector firm Xansa, and is the first of its kind. It will offer NHS organisations the benefits of guaranteed cost savings, reduced capital expenditure and high quality services, saving more than £220 million of NHS money over the next ten years.

More efficient delivery of activity and outcomes

As a greater proportion of resources is released into the delivery of front line services, we need to ensure that we improve efficiency across the full range of our business – taking into account not just activity counts but also quality and outcomes.

The difficulty in measuring productivity is illustrated by the following chart which shows some of the many different types of NHS activity.

Chart C: Contacts with the NHS per day (thousands)

Some commentators mistakenly try to measure productivity by relating hospital admissions to funding increases – thereby equating eight per cent of activity with 100 per cent of costs. This is particularly inappropriate at a time when the NHS is trying to do as much treatment as possible outside hospital. Even more importantly it is investing – in drugs, for example – to reduce the need for treatment in the first place.

The Department of Health is developing, with independent academic help, a measure of productivity which covers 1900 categories of NHS activity, which between them cover about 75 per cent of NHS expenditure. This new measure will also take account of quality in terms both of outcomes and service. We expect to publish further details in the summer.

Our interim measure, which adjusts for expenditure on quality that does not lead directly to increased activity, suggests an increase in output during 2003/04 (latest available figures) of around 4.5 per cent and an increase in cost efficiency of some two per cent. This figure does not, of course, take into account improvements in outcomes or the quality of service provided in, for example, reducing waiting.

Best practice, service redesign and new working practices

This report is full of examples of best practice and service redesign. The Modernisation Agency's *10 High Impact Changes* describes the ten interventions which have been tested throughout the NHS and have the most impact on quality and efficacy.

For the future, the introduction of new IT systems and new staff contracts will help improve both quality and value for money with a significant increase of in 'productive time' ie face-to-face time between professionals and patients.

Contribution to the health and prosperity of the country

This contribution is broadly in three areas:

- **improved mortality and quality of life creating a healthier and more productive workforce.**

Derek Wanless' report *Securing Good Health for the Whole Population*³⁵ outlined the benefits for us all if we succeed in achieving a society more fully engaged in health. The prize includes longer, healthier lives, fewer working days lost, and reductions in the pressure on health services in the future. This can only be achieved by people making informed decisions about their health. *Choosing Health* recognises that the government cannot make the choices for people, but it can support people by making healthy choices easier, for example, more support for the 69 per cent of smokers who want to quit, and investment in better primary care to make more services available in the community.

- **investment in some of the more disadvantaged areas of the country aiding regeneration.**

We are in the middle of the biggest hospital building programme in the NHS, with much of this capital investment targeted to the most economically deprived areas of the country; 40 of our new hospital schemes are being developed in the 50 most deprived local authority districts in the country.

- **promotion of research and development through the links with universities and, for example, investment in research and development.**

Clinical research is central to the health and wealth of the UK. The research generates evidence on which to base interventions and services to promote good health and to prevent and treat disease. Research also develops wealth by improving the health of the population and by stimulating industrial investment and growth. The government, therefore, aims to establish the UK as a world leader in clinical research and the NHS is central to this ambition. In 2004 the Chancellor of the Exchequer announced an additional £100 million per annum to the NHS research and development budget to support clinical research.

Much of this new funding will support the work of the newly established UK Clinical Research Collaboration (UKCRC). This partnership between government, charities, industry, NHS, academic medicine and patients is making rapid progress to build up the NHS and academic research infrastructure, strengthen clinical academic careers, develop incentives for research in the NHS, streamline regulation and governance, and co-ordinate research funding. Patients will benefit from early access to the latest medical advances, and the strengthened NHS research infrastructure will attract further investment in the UK by global pharmaceutical companies.

At present, although we can identify costs and benefits for individual activities in these three areas, we have not got a comprehensive measure of value added across these areas.

35 Wanless, D (2004) *Securing Good Health for the Whole Population: Final Report*. London: HM Treasury/Department of Health.



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