Chief Executive's Report to the NHS

December 2004

Department of Health

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1. Preface from the Chief Executive

Staff in the NHS have performed magnificently this year. 2004 has been a very good year of sustained progress for the NHS. Whilst there is much further to go, we can clearly see the dividends from investing in the NHS:

- further improvements in access to services, with a 12% reduction in waiting lists – 35% down from their peak six and a half years ago
- continued falls in premature deaths from cancer, heart disease and suicide
- thousands more people using services, with many delivered in new, more convenient ways such as Walk-in Centres, NHS Direct and Treatment Centres
- delayed discharges from hospitals down by a third in the year
- a record number of people quitting smoking.

As services improve and capacity grows, we are offering patients more choice and personal attention. The *NHS Improvement Plan*, published in June, sets out our intention to build on our success over the next three years, offering improvements for all patients whether they need hospital treatment or care for long term conditions. We know there are areas where we can do better – rebuilding confidence in the NHS – and have ambitious plans to do so.

These successes in service delivery have given us the space to make advances in health improvement and promotion. *Choosing Health*, published last month, sets out clear plans to work in partnership locally and across Government to help people live healthier lives. The NHS is becoming a true health service, not just a service for the sick, injured and vulnerable.

Radical reform – to put the patient in the driving seat

We are changing the whole way the NHS works to ensure that everything we do fits around the individual needs of our patients and public – patients do not have to fit around the NHS. This year we have introduced the first NHS Foundation Trusts as local organisations to address local needs. We have introduced a wider range of providers to bring in new ideas and create flexibility. We have developed new employment contracts, enabling us to have more staff, working differently and to reward continued learning and the delivery of quality services.

Two independent inspectorates have been established this year– the Healthcare Commission and the Commission for Social Care Inspection – which will review the whole range of services, drive up standards and enable patients to be assured of the quality of the care they receive.

Looking to the future, we are also investing heavily in information technology to enable the NHS to deliver faster, safer and more convenient care.

These changes are underpinned by a continuing commitment to the basic values of the NHS – the intention to provide services, equally, to everyone regardless of their circumstances and their ability to pay.

A track record of success

We now have a four-year track record of success. This has come through the hard work of staff, supported by clear direction, planned investment, innovation and learning from best practice in this country and abroad. However, no matter how sound the strategy, there will always be new challenges, unexpected obstacles and sometimes setbacks. We will continue to tackle these, quickly and vigorously, wherever they occur.

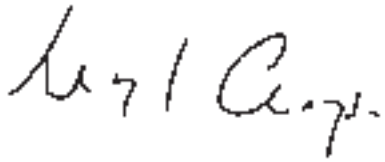
We are taking firm action on reducing hospital acquired infections, with modern matrons, modern cleaning techniques and improved cleaning contracts. We are developing new contracts with dentists and have provided additional funding to develop dentistry.

Like any well run organisation we must continually strive to improve efficiency and value for money. I am particularly aware that an organisation the size of the NHS can be bureaucratic both for patients and staff. We are therefore concentrating our resources at the frontline – 84% of staff deliver frontline patient services, with 13% maintaining the infrastructure, whilst 3% are managers. We have reduced the size of the Department of Health by one third. We are reducing the number of national requirements and targets and their associated paperwork, and plans are underway to reshape the bodies and agencies that support health and social care, reducing the number by almost half, with savings of £0.5billion.

However, the sheer scale of the NHS is also an asset and we are using it to make big savings in purchasing pharmaceuticals, IT and Treatment Centres. We have also recently announced plans to use our purchasing power to secure further independent diagnostic services. The trick is for us to combine our corporate muscle with localised services and personalised care.

This report shows an NHS that is succeeding. Success, now and in the future, depends on the hard work and dedication of hundreds of thousands of people in the NHS, Local Authorities, partner organisations and the Department of Health. I know that these successes are hard won and that the people delivering the services – and those leading the changes – have to contend with many pressures during the year, managing their resources carefully and seeking improvements in every aspect of care.

I am privileged to meet patients and staff every week and see how services are being delivered and improved in every part of the country. I am constantly impressed by the skills and the passion that people bring to their work. These people make all the difference, we all owe them our thanks.



Sir Nigel Crisp
3 December 2004

This report will be accompanied by a statistical supplement and an Autumn Performance Report.

2. Key points for the year

Four years of sustained improvement

Faster and more convenient services

- waiting times for services are reducing however you access services – in A&E, primary care and treatment in hospital
- the size of the waiting list has also fallen by 12% in 12 months (35% or 455,000 down from its peak)
- 18 more Walk-in Centres, now serving over 1.5 million patients a year, NHS Direct and online services are now used 13 million times a year and 5 more NHS-run Treatment Centres opened
- delayed discharges have reduced by over a third in the year

A new focus on health promotion and health improvement

- through *Choosing Health*, the programme for helping people choose healthy lifestyles and look after their health
- with continued falls in premature deaths from cancer and heart disease, and suicide rates at the lowest level on record
- the largest ever number of people giving up smoking - 205,000, an increase of almost 50%

Greater patient satisfaction

- ambulance services rated as excellent, very good or good by 98% of users
- improvements in the satisfaction ratings of hospital inpatients

Radical reforms to put patients firmly in the driving seat

- the introduction of Foundation Trusts and use of new service providers to promote creativity and local action
- new staff contracts to increase flexibility and support change
- national standards and independent inspection

Responding to patients and public concerns

- with robust action and leadership on cleaning, MRSA and dentistry

Greater efficiency

- reducing overheads and national requirements on targets and paperwork
- improving purchasing of drugs, IT and corporate services, saving more than £400 million a year
- developing IT programmes to support safety, quality and efficiency

Thanks to the efforts of staff

- these improvements have been made in a demanding year through the hard work, skills and passion of hundreds of thousands of staff in the NHS and its partner organisations

3. The changing NHS – local treatment, faster services, more choice and flexibility, improving quality

The NHS is changing very fast to become much more patient and user centred with faster and more convenient access to higher quality services. This chapter describes:

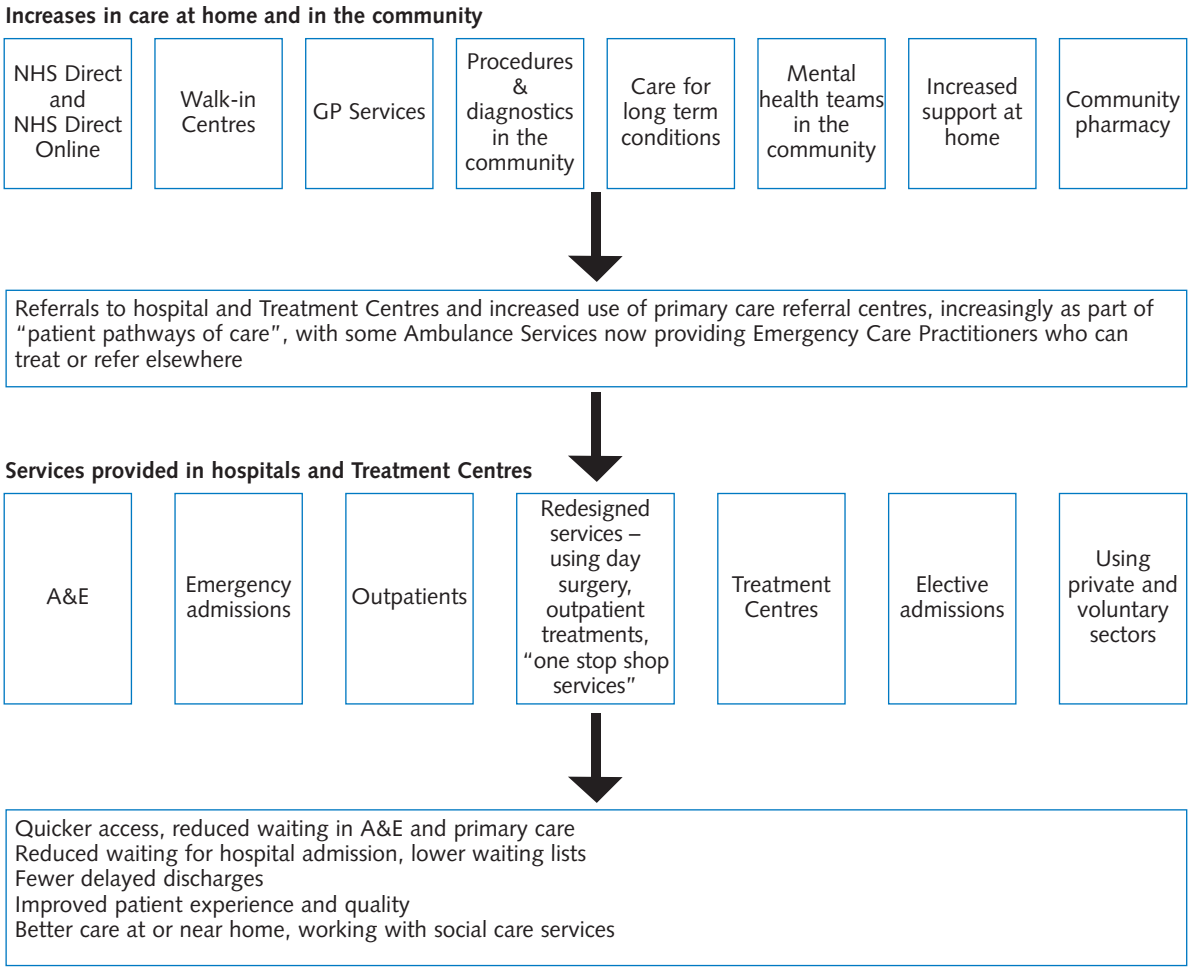
- the increasing range of services available locally
- faster access to see a GP, in A&E, in hospital and fewer delayed discharges
- improving care for older people
- the work to improve the patient experience and patient satisfaction
- many local examples of the way services and staff roles are changing to provide improvements.

The NHS is changing very fast with a wider range of services now available making it easier for people at home, locally or from their workplace to get advice, support and treatment.

Traditionally we have looked for help via our GP or our hospital A&E. There are now many more choices available. There are also changes in hospital services with greater use of outpatients, different groups of staff, different locations to go to and even some different service providers.

All of this is designed to provide more personal, more local and higher quality services. The following chart shows how the NHS is changing.

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



3.1 New and expanding services in the community

NHS Direct and NHS Direct Online now provide the first contact with the NHS for about 13 million people a year. The big increase this year is in the use of the online service with 1.2 million more hits than last year. Both services can provide individuals with advice, but can also direct people on to the right place for further help. Increasingly NHS Direct is integrating its services with ambulance services, GP out of hours services and others to provide patients with a fully integrated and seamless service.

SEADOC, on the South East coast, is a GP-led service, providing face-to-face consultations from the Conquest Hospital. It is clinically integrated with NHS Direct, which provides call handling and clinical assessment for patients out of hours. Patients seeking medical help when practices are closed ring NHS Direct, and are triaged on the phone. Those requiring medical attention can receive a face-to-face consultation, either at a primary care centre or in the patient's home.

An example of how services are now available to people close to their home or workplace, is the growth in NHS Walk-in Centres. At these Centres, patients can get advice and treatment without needing a prior appointment. There are now 61 NHS Walk-in Centres open, with a further 21 in development. An average Walk-in Centre sees 40,000 patients a year. They are fast becoming an established feature of local NHS services.

Oldham's first Walk-in Centre complements the essential services provided by GPs and the A&E department at the Royal Oldham Hospital. Patients can drop in without having to make an appointment and the GPs and nurses at the Centre are able to treat a wide variety of minor injuries, ailments and illnesses. As the Centre is open from 7am until 10.30pm, patients need not rearrange work or other commitments.

Our existing Walk-in Centres will be supplemented by commuter services in Leeds, London, Manchester and Newcastle, to be opened in 2005.

Where extended services in primary care are well established, it is evident that they not only help patients, but can also help to manage demand on other parts of the system. Local NHS organisations have found that innovative referral models, such as in Greater Manchester, can be particularly effective at taking a whole system view and helping to reduce the flow into secondary care of patients who could be treated more appropriately and quickly elsewhere. In some cases this could mean, for example, that a patient is seen by a Practitioner with a Special Interest in primary care, rather than needing to be referred to a hospital consultant.

There are presently 56 schemes active in **Greater Manchester**, with 27 more planned. These will take approximately 42,000 referrals from GPs that would previously have been directly referred – and in some cases, inappropriately referred – to hospital services in a full year. After the GP refers a patient, that referral will then be triaged by a relevant health professional, such as a GP with a special interest or an allied health professional, who will decide on the most appropriate service for onward referral, or will provide the patient with a treatment protocol for care under their GP. Analysis of the first schemes show that they are reducing the time that patients wait for treatment from months to a matter of weeks and that they are often a less expensive way to provide care.

Offering a wider range of services in primary care is important for the NHS to extend patient choice, especially as such services are often more convenient, closer to home and less daunting than traditional hospital care.

Ipswich Hospital NHS Trust has initiated a chemotherapy outreach programme so that cancer patients throughout East Suffolk can have chemotherapy in GP surgeries and even in their own homes. The Trust started the programme after surveying patients about their preferences and discovering that they really wanted to have their chemotherapy provided closer to home. This pioneering service is proving to be hugely beneficial for people who no longer have to make tiring journeys into hospital for treatment.

We estimate that there are over 300 million contacts with primary care staff over the course of a year: with GPs, practice nurses, or other professionals. Table A quantifies some of the activity that goes on in the community. Increased, high quality prescribing helps to keep people out of hospital. Good social care helps people to stay in their own homes and out of hospital. This is a very clear example of where the NHS relies on the good work of its partner organisations, particularly Local Authorities.

The **Witham, Braintree and Halstead Care Trust** was established on 1st October 2002. It is responsible for the local health services for everyone living in the district. It is also responsible for health and social care services for older people. This means that there is one organisation providing the services that older people used to receive from local NHS organisations, Essex County Council and Braintree District Council.

A few examples of the types of services that the Care Trust is responsible for delivering are GP services, Community Hospital and Nursing Services, Physiotherapy Services and local District General Hospital Services. It also makes sure that older people living in the area can receive assessment and care management, home care support, sheltered housing, or residential care.

Table A: Increased activity in community and primary care

Patient access	**In 1999/2000**	**In 2003/04**	**Increase over last 12 months at Sept 2004**	**Increase since *NHS Plan*[1]**
Calls to NHS Direct	1,650,000	6,411,000	-33,800 (-1.1%)	4,761,000 (289%)
Visits to NHS Direct Online	n/a	6,542,000	1,236,000 (45%)	n/a
Patient visits to Walk-in Centres	n/a	1,582,000	176,000[2] (22%)	n/a
Prescribing medicines	**Year to June 2000**	**Year to June 2004**	**Increase over last 12 months at Sept 2004**	**Increase since *NHS Plan*[1]**
Number of prescriptions	541 million	668 million	37.7 million (5.9%)	128 million (24%)
Cost of drugs prescribed	£5,547 million	£7,811 million	£604 million (8.2%)	£2,263 million (41%)
Social care	**Sept 1999**	**Sept 2003**	**Increase over last 12 months at Sept 2003**	**Increase since *NHS Plan*[1]**
Number of contact hours of home care provided	2,684,000	3,113,000	130,000 (4.4%)	429,000 (16%)
Number of households receiving intensive[3] home care	68,700	87,100[4]	5,700 (7.0%)	18,400 (27%)

1 Change since the *NHS Plan* takes as a baseline the nearest annual figure to July 2000, compared to the latest annual position (usually 2004)
2 Figures collated from monthly returns and include some estimates for missing returns. Estimates unavailable for two sites at September 2004. Increase not adjusted for the growth in number of Centres between years
3 Defined as more than 10 contact hours and 6 or more visits during the week
4 Figure published in May 2004 edition of the report was provisional and has now been finalised

3.2 Transforming emergency care

Emergency care too is changing very fast and shows how the NHS is improving. In his recent report, Professor Sir George Alberti, the National Director for Emergency Care, found that performance has been revolutionised in England since the publication of the *NHS Plan*. He cited a range of independent sources, including the National Audit Office, to show the clear improvements that have been made.[1] Some of these include:

- By October, 96.4% of people were spending less than four hours in A&E from the time they arrived to the time they were admitted, transferred or discharged
- More doctors are working in emergency care, and there are expanded roles for nurses, paramedics, allied health professionals and Emergency Care Practitioners (ECPs)
- The ambulance service now reaches more patients more quickly than ever before, with over 75% of life threatening emergencies (category A calls) attended within eight minutes
- There are improved patient experiences, with 85% of patients rating A&E, and 98% rating ambulance services, as either 'excellent', 'very good' or 'good'.[2]

This high level of performance is all the more notable because it has been achieved at a time of continuing high demand in emergency care. The number of attendances has grown partly because services such as Minor Injury Units and Walk-in Centres have made emergency care more accessible. Increased attendances also partly represent performance-induced demand. Patients are now more inclined to go to A&E as their first port of call, as they can expect to be treated by appropriate professionals, to high clinical standards and, importantly, they can expect to be treated far more quickly than in the past.

We have also seen increased demand for ambulance services. In the last year, there has been a 5.5% increase in emergency ambulance journeys. Similarly to A&E, the ambulance service has managed to deliver faster access to patients in the face of greater demand. The service now reaches more patients more quickly than ever before.

1 Professor Sir George Alberti (Department of Health), *Transforming Emergency Care in England*, (October 2004), http://www.dh.gov.uk/assetRoot/04/09/17/81/04091781.pdf. National Audit Office, *Improving Emergency Care in England*, (October 2004), http://www.nao.org.uk/publications/nao_reports/03-04/03041075.pdf

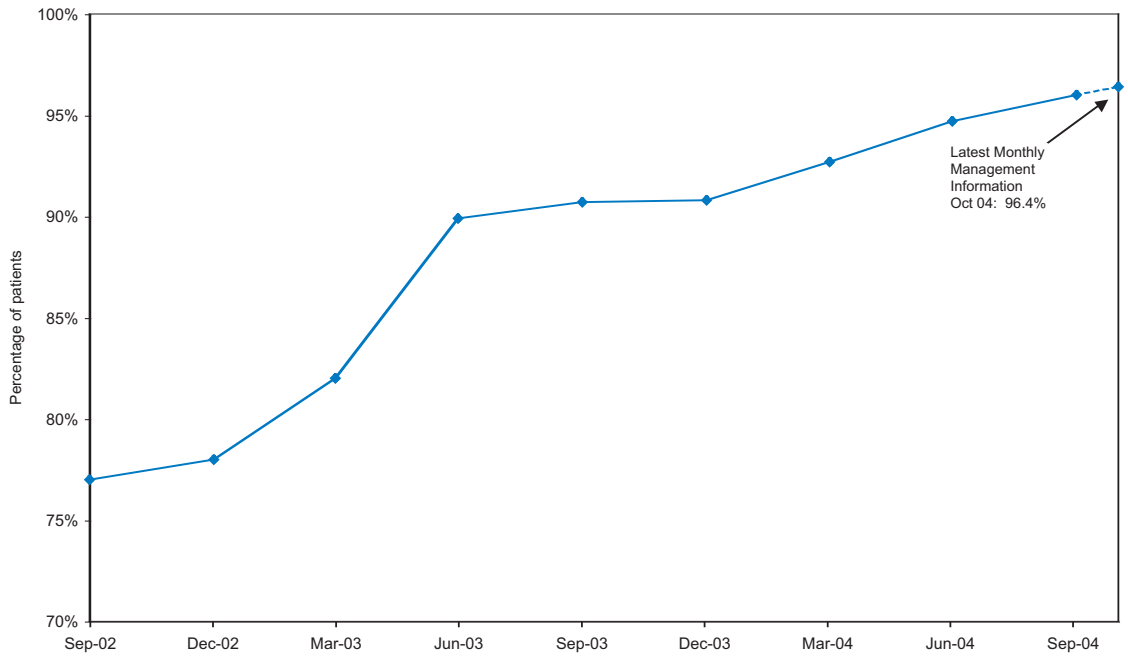
2 Based on most recent patient survey results: for ambulance services, carried out by the Healthcare Commission in 2003/04; and for A&E departments, carried out by the Commission for Health Improvement in 2002/03.

Table B: There is continuing growth in emergency activity

	In 1999/2000	In 2003/04	Increase over last 12 months at Sept 2004	Increase since *NHS Plan*[1]
New A&E attendances	13,167,000[2]	15,313,000	617,000 (7.9%)	2,146,000 (16%)
Total emergency admissions	3,887,000[3]	4,274,000[4]	121,000 (5.9%)	387,000 (10%)
Ambulance emergency journeys	2,850,000	3,354,000	176,000[5] (5.5%)[5]	504,000 (18%)

1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (i.e. the 1999/2000 figure), compared to end March 2004 position (i.e. the 2003/04 figure)
2 Figure does not include Walk-in Centres or Minor Injury Units
3 The figure published in the May 2004 edition of the report has now been rebased to enable like for like comparisons
4 Figure published in May 2004 edition of the report was provisional and has now been finalised
5 Increase over the last 12 months at March 2004

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



The number of doctors working in emergency care has increased and there have also been significant developments in skill mix. A key innovation in the workforce is the role of the Emergency Care Practitioner, who can support GPs, out of hours services, ambulance services and A&Es. They are often able to see and treat patients without the need for onward referral to other professionals, so that patients are treated more quickly and pressure can be relieved on local emergency care services.

Staff at **Airedale NHS Trust** have achieved high performance in their A&E department by redesigning staff roles around patient needs. All senior nurses in A&E are trained as Emergency Nurse Practitioners so they can see and treat patients, and avoid unnecessary waiting to see a doctor. The Trust has worked with Huddersfield University to develop an academic training programme for these new roles, and the training package is now being adopted by other Trusts. The Trust and the local PCT are also re-thinking where services are offered, so that patients who attend A&E out of hours with primary care problems can be treated on the same site by primary care professionals.

The transformation in A&E is being matched by changes in how ambulance services look after their patients. The example below shows an expanded scheme that includes Emergency Care Practitioners.

Essex Ambulance Service NHS Trust has radically reformed the way it delivers unscheduled care, utilising a multi-disciplinary approach, including Emergency Care Practitioners (ECPs) and GPs. ECPs can see, treat and discharge patients where appropriate, or refer direct to the most appropriate primary care service or acute speciality. The out of hours service uses GPs to provide care in primary care centres, to give telephone advice to patients accessing out of hours and to provide clinical leadership to ECPs carrying out home visits.

The progress that the NHS has made in emergency care, and the current performance, are outstanding by international standards. Parliament's Public Accounts Committee, recently congratulated the NHS for the good progress made in emergency care.[3]

3.3 Faster and better access to diagnosis and treatment

The NHS has increased its capacity so that it can carry out more activity. Increases in the number of elective procedures, in primary care, outpatients and inpatient settings, are crucial to the ability of the NHS to offer choice and to deliver fast treatment for patients. Increasing capacity is not just about spending more money; it is also about service redesign, as demonstrated in Nottingham.

Nottingham City Hospital NHS Trust found that discharges peaked at the end of the day rather than being spread evenly. The Trust ran a small 'Plan, Do, Study, Act' cycle, during which four wards were encouraged to discharge medically fit patients by midday. As a result, hundreds of patients were able to go home earlier in the day and discharges became more evenly distributed. This, in turn, has led to more efficient use of bed capacity as more elective patients can come in on the same day as others are discharged. There were also fewer cancelled operations as a result of this service redesign.

The extra capacity supplied by Treatment Centres is important to the ability of the NHS to increase elective activity. This is tackling bottlenecks in procedures and diagnostic tests that can cause delays in the patient's journey.

3 http://www.publications.parliament.uk/pa/cm200304/cmselect/cmpubacc/uc1233-i/uc123302.htm

Treatment Centres

Treatment Centres are streamlined units that provide pre-booked surgery and diagnostic tests for patients. As they provide care outside the emergency setting, they minimise the risk of cancelled operations due to emergency pressures. There are 28 NHS-run Treatment Centres now open, spread across England, and a further 18 in development. They draw on international expertise, develop leading edge practice and aim to embed the learning in other parts of the NHS.

When designing a new Treatment Centre for the local population, clinicians from **Hinchingbrooke Health Care NHS Trust** visited the United States to learn from innovative practice there. The versatile design of the Trust's new Treatment Centre caters for clear patient flows. There is an "airport style" patient check-in where all booking and scheduling is completed electronically. Patients then go either to a circular "fast track", if they are having minor operations, or a separate stream if they need to stay longer and require general anaesthesia. When their procedure has been completed, patients recover in a "cabin", which is a single room fronted with patio-type doors, allowing a high degree of privacy whilst staff can still observe patients at all times.

King's College Hospital NHS Trust currently delivers over 70% of its elective surgical procedures as day cases in its Treatment Centre. The Trust is on target to hit at least 75% of total elective procedures as day cases by March 2005. The Centre has reduced pressure on inpatient beds by bringing down the normal length of stay from a number of days to a number of hours. Patients have been highly satisfied with having their procedures undertaken in the Treatment Centre, as they can return home on the same day.

Independent sector capacity

In addition to the Treatment Centres run by the NHS, we are increasingly using independent sector (IS) capacity to carry out elective activity, speed up treatment and to help deliver greater choice for NHS patients. The Department of Health awarded contracts to run the new Independent Sector Treatment Centres (ISTCs) on the basis that bidders provide high clinical standards, fast access, additional staff to the NHS workforce and offer good value for money to NHS commissioners.

There are now two mobile ISTCs, one fixed site at Daventry and interim services at three further sites. The mobile units are concentrating on cataracts and are each performing an average of 39 cataract removals per day. The efficient and streamlined patient flow and the specialised nature of the units mean that they achieve a high degree of productivity.

In addition to the main ISTC activity, a further contract with two IS providers was awarded in May 2004 to focus mainly on orthopaedic procedures. All of this extra capacity has meant that over 17,000 NHS patients have been treated in IS run facilities in the last year.

We expect that IS capacity will play an increasing role in delivering NHS treatment. 34 IS schemes are expected in total, with many opening during 2005.

More treatments in different settings

The NHS continues to modernise and deliver activity in new settings. Existing data reporting does not fully capture this evolving, more varied pattern of provision. Further work is in hand to better record the full range of activity in these modernised settings. But the information available does show a growth in treatments in different settings.

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

	In 2003/04	Forecast increase in 2004/05	Forecast growth in 2004/05
Elective hospital admissions (FFCEs)[1]	5,448,000	169,000	3.1%
Procedures in outpatients	2,048,000	35,000 to 72,000	1.7% to 3.5%
Procedures in primary care	532,000	20,000 to 53,000	3.7% to 10%
Total	8,029,000	223,000 to 294,000	2.8% to 3.7%

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

The new referral models being introduced across the NHS are having an interesting impact on GP referrals to hospital. In some places, referrals to outpatients are increasing, whilst in others they are reducing. New referral models can be particularly effective at reducing inappropriate referrals. Even though GP referrals have been higher in the first half of this year than last year, hospital activity has increased so there is no negative impact on waiting times.

Table D: Outpatient activity

	In 1999/2000	In 2003/04	Increase over last 12 months at Sept 2004	Increase since *NHS Plan*[1]
Number of new outpatient attendances with a consultant	12,136,000	13,431,000	42,500 (0.6%)	1,295,000 (11%)
Number of GP referrals made to outpatients	8,961,000	9,417,000	80,400 (1.7%)	456,000 (5.1%)

1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (i.e. the 1999/2000 figure), compared to end March 2004 position (i.e. the 2003/04 figure)

Greater choice

Nationally, we are rolling out choice in secondary care by giving patients who need elective procedures a choice of provider, starting with those patients who will wait longest for their treatment. Since 2002, a series of pilots have been running across the country, giving patients who will wait longer than six months for elective care the choice of an alternative provider for faster treatment. For example, the London Patient Choice Project has been offering choice at six months across 32 PCTs since October 2002. It has proved popular across all age and socio-economic groups and has led to faster treatment and improved patient experiences.

Since the end of August 2004, choice at six months has been extended to all patients across all specialities. Between April and October 2004, 125,800 eligible patients were offered choice at six months, with 24,300 taking up an offer to be treated more quickly by an alternative provider.

To facilitate the "Choice at six months" initiative **Eastern Hull PCT** and three neighbouring PCTs have employed a team of five patient care advisors. They provide impartial support and information to patients to help them make informed decisions about their care. The advisors also support patients in booking appointments and accessing transport and interpreting services. The care advisors have increased the uptake of choice and the level of information and support provided to patients in an area of high social deprivation.

Faster access to primary care

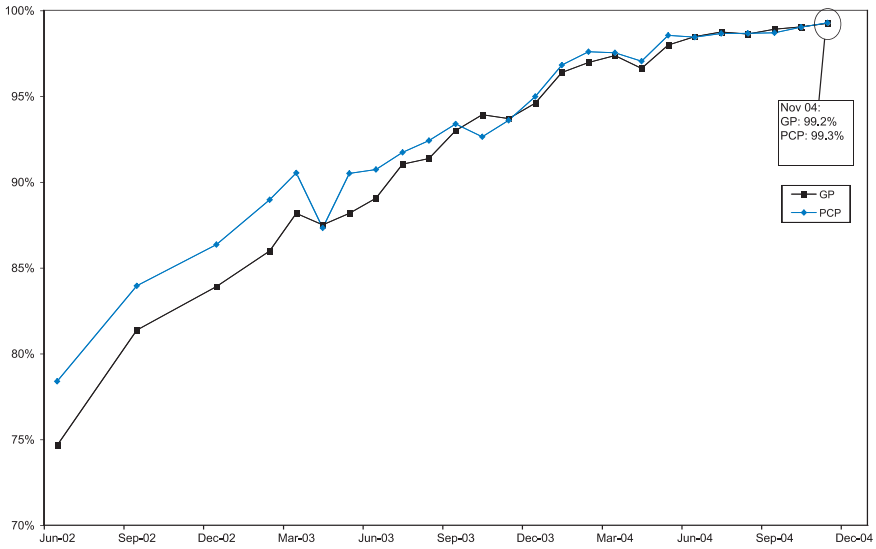
In primary care, as elsewhere, it is very important to ensure that patients get fast access to help. Recent improvements in primary care access have continued over the last six months. The table and chart below show that over 99% of patients are now able to see a GP within two working days or a primary care professional within one working day, if they wish.

Table E: GP and primary care professional appointment availability

	March 2002	Nov 2003	Nov 2004	Increase over last 12 months at Nov 2004	Increase from Mar 2002 to Nov 2004
GP within two days	74.6%[1]	93.7%	99.2%[2]	5.5%[3]	24.6%[3]
Primary care professional within one day[4]	71.7%[1,5]	93.6%	99.3%[2]	5.7%[3]	27.6%[3]

1 Percentage of practices
2 From April 2004, access to a GP 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 services, that includes referring and/or diverting practice patients. Only these figures include this change
3 Percentage point 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 PCP was 59.2%, 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 71.7% as shown

Graph B: Percentage of patients with access to a GP within 48 hours, or a Primary Care Professional (PCP) within 24 hours



In some cases, we know that practices have simply stopped having booked appointments in order to meet this target. This is not the aim. We are working with practices to ensure that patients have fast access to a GP and can book a later appointment with them, if they so wish.

A practice in the West Midlands was operating a restricted booking system which only allowed patients to book on the day that they rang. After hearing a National Primary Care Development Team presentation on Advanced Access, one of the GPs recognised that the practice's appointment system was not flexible enough to offer patients choice. The practice measured their demand and capacity for appointments and also re-trained receptionists on the new way of working. After initially only allowing pre-booking to working patients, and those who had difficulty with transport, the practice was able to open up its appointment system to any patient requesting a pre-booked appointment.

There are now many imaginative ways in which local organisations are linking in their traditional primary care services with out of hours, and other new services, to make improvements for patients. An example is shown below.

Medway PCT has set up an in hours urgent primary care service (same day treatment). This complements the out of hours GP service and offers practices a combination of urgent, same day appointments to assist with the achievement of primary care access targets as laid down in the *NHS Plan*, as well as full cover service during the afternoon to free up time for administration and practice training.

The service was funded using primary care development monies. Access to the service is free and open to all practices, with appointments available throughout the day. A limit of five calls per 1000 registered population has been applied to the full cover afternoon service to ensure equity, but practices wishing to exceed this limit have the option of paying for increased use. The service enables the PCT to offer flexible support for practices experiencing unexpected problems, such as sickness absence, and to provide uniformity in clinical training by supporting a PCT-wide programme of educational afternoons.

Faster access for outpatient consultations

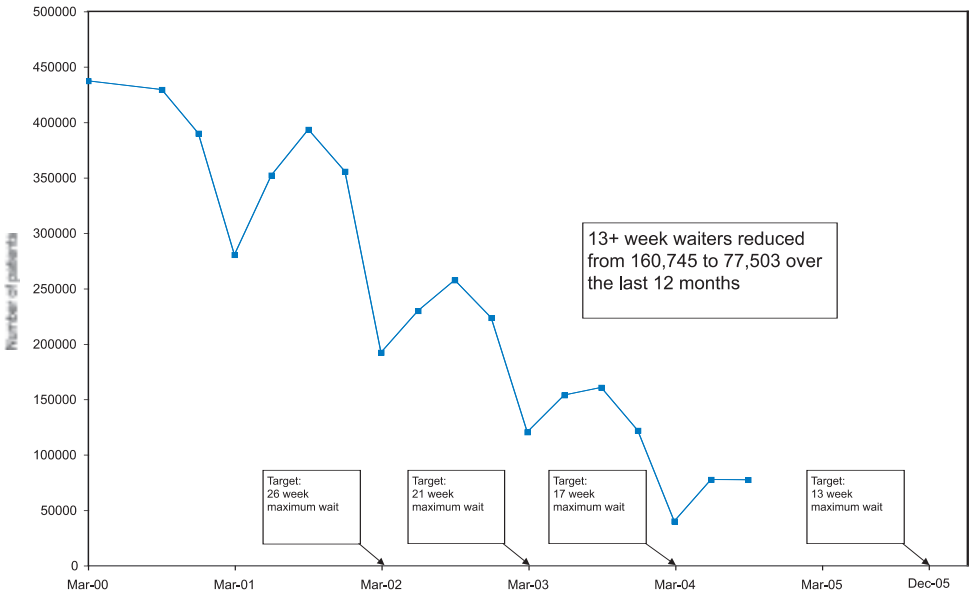
We are now seeing faster access across the whole patient pathway. The year to March 2004 was particularly impressive in speeding up access. The NHS is now well on target to deliver a maximum three month wait target for outpatients in December 2005 and a maximum six month wait for inpatients.

Table F: Outpatient access at the end of September 2004

	March 2000	Sept 2003	Sept 2004	Reduction in last 12 months at Sept 2004	Reduction since *NHS Plan*[1]
Number of people who had been waiting over 17 weeks	n/a[2]	34,170	148 (31)[3]	34,022	n/a[2]
Number of people who had been waiting over 13 weeks	393,027	160,745	77,503	83,242	315,524

1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (i.e. the March 2000 figure), compared to end September 2004 position
2 The number waiting over 17 weeks was not collected until 2002
3 Of the 148 patients who had been waiting over 17 weeks, 31 were waiting for an appointment at English Trusts and 117 were waiting for an appointment at Welsh hospitals

Graph C: 13+ week outpatient waiters, March 2000 – September 2004



The examples below from Cambridgeshire show how some Trusts are streamlining the services they provide in outpatients.

Peterborough Hospitals NHS Trust has redesigned the way it provides cataract services to streamline the assessment process and minimise the number of times patients need to attend outpatients. Cataract patients referred through its direct access service now need to visit the hospital only twice, when they would formerly have had to attend up to eight times. This has dramatically reduced the patient journey from first assessment to surgery to only six weeks. The direct access service also delivers a high standard of care, with 98.7% of patients achieving a visual acuity of 6/12 or better, excelling against Royal College of Opthalmology guidelines.

Addenbrooke's dermatology clinic has taken an innovative approach to cut down on the number of outpatient appointments that are missed, which has led to clinic time being used more efficiently. When new patients are referred, they are asked if they would like to join a text messaging service which will remind them of their appointment via their mobile phone. Patients receive a text message reminder a few days before the appointment, which gives the date and time, but does not include details of the clinic to protect confidentiality. Before the service was introduced, 8% of new patient appointments were missed. The text messaging scheme, combined with another scheme where new patients can phone and book an appointment time to suit them, has reduced the rate of missed new appointments by half, whilst costing virtually nothing to run.

Faster access for inpatient treatment

The tables and charts below show the progress that has been made in speeding up inpatient treatment over the last six months and since the *NHS Plan*. In March 2000, over 126,000 patients waited longer than nine months for inpatient treatment, with some waiting as long as 18 months. Now, hardly any patients wait longer than nine months.

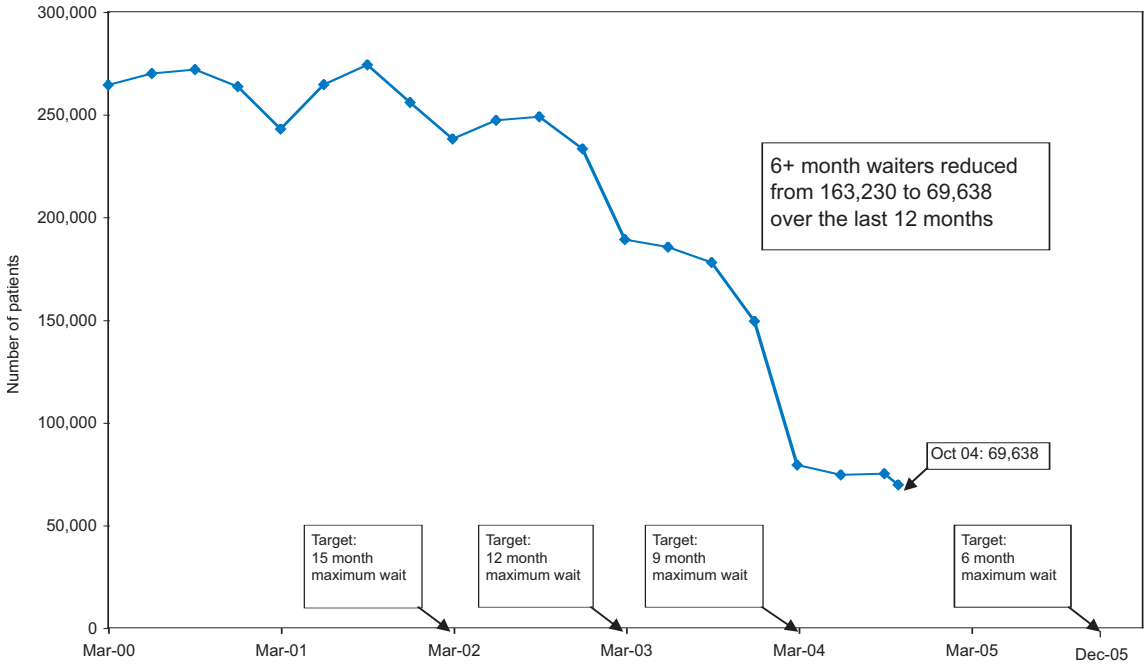
In the last 12 months, there has been a reduction of 93,600 in the number of patients waiting over six months for inpatient treatment, although much of that reduction was achieved towards the end of the last financial year.

Table G: Inpatient access at the end of October 2004

	March 2000	Oct 2003	Oct 2004	Reduction in last 12 months at Oct 2004	Reduction since *NHS Plan*[1]
Number of people who had been waiting over nine months[2]	126,388	38,954	57 (48)[3]	38,897	126,331
Number of people who had been waiting over six months[2]	264,370	163,230	69,638	93,592	194,732

1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (i.e. the March 2000 figure), compared to end October 2004 position
2 Figures are cumulative. For example, there were 264,370 patients waiting more than six months in March 2000, of which 126,388 patients were waiting more than nine months
3 Of the 57 patients who were waiting over nine months, 48 were waiting for admission to English Trusts and nine were waiting for admission to Welsh hospitals

Graph D: 6+ month inpatient waiters, March 2000 – October 2004



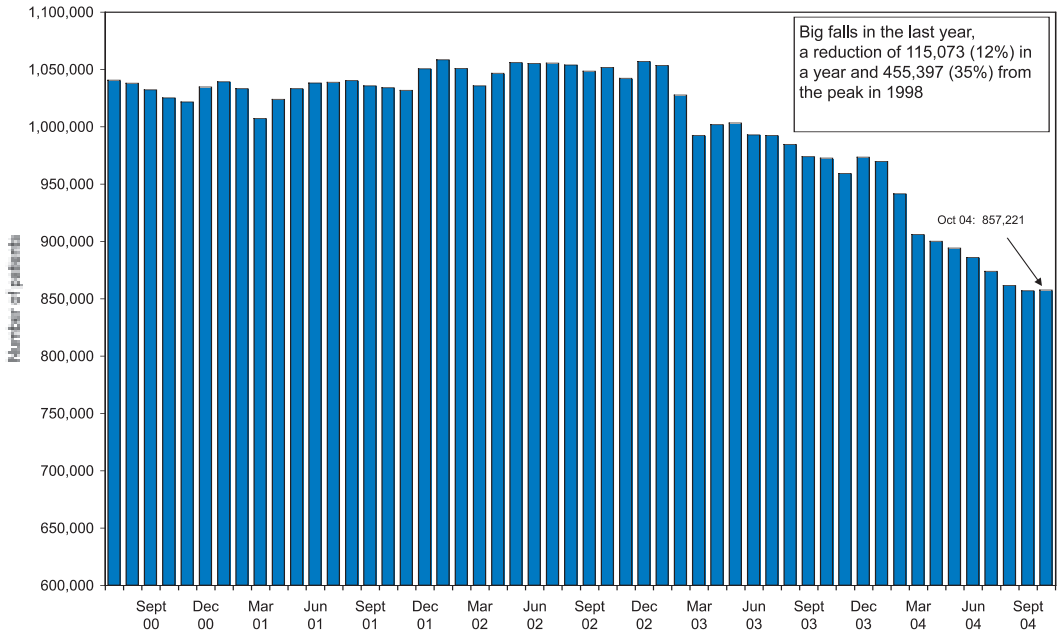
The total inpatient waiting list has reduced by 115,000 in the last 12 months. The peak of the inpatient waiting list was 1,313,000 in April 1998: since then it has fallen by 35% to 857,000 in October 2004. We have seen a small rise in October, of 621 from September, and can expect some further rises over the winter, but the downward trend is now very firmly established.

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

	March 2000	Oct 2003	Oct 2004	Reduction in last 12 months at Oct 2004	Reduction since *NHS Plan*[1]
Total waiting list	1,037,066	972,294	857,221	115,073	179,845

1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (i.e. the March 2000 figure), compared to end October 2004 position

Graph E: Inpatient waiting list, July 2000 to present



Discharge from hospital

Unnecessary waiting for discharge from hospital after treatment is also being reduced. The introduction of financial reimbursement for delayed discharges has proven to be an important development in forging partnership working between health and social care services. This joint working leads to improved discharge planning for patients.

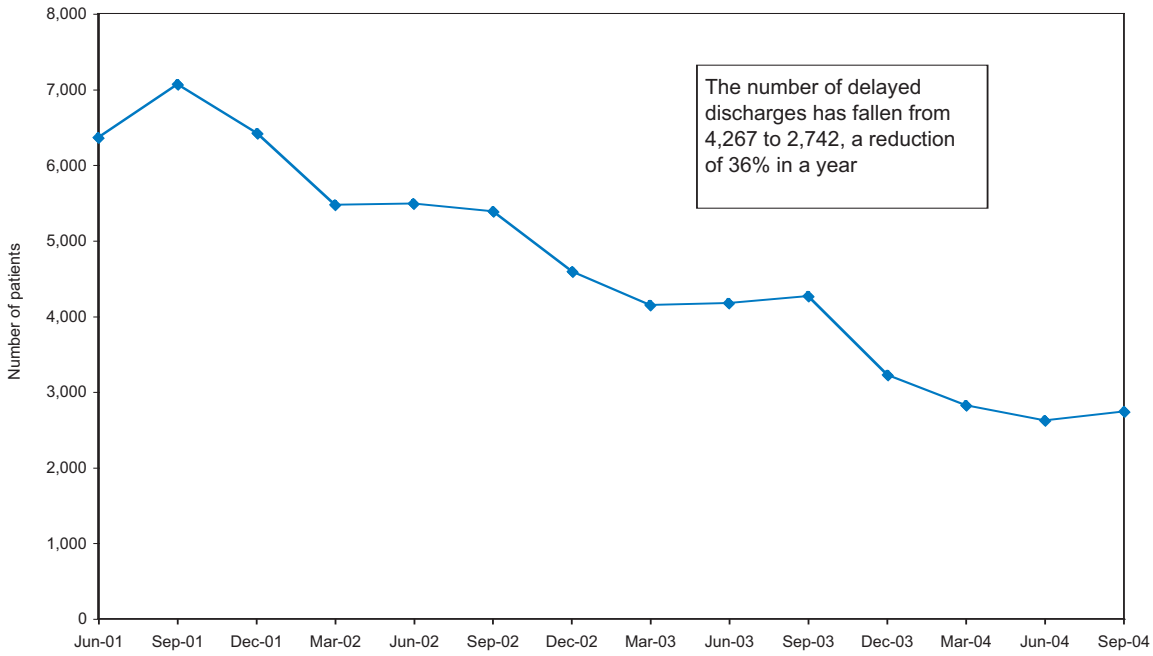
Despite a slight increase in the second quarter of this year, levels of delayed discharges have fallen considerably from 4,267 in September 2003 (the start of the shadow period for financial reimbursement) to 2,742 by September 2004. The progress made on delayed discharges since the *NHS Plan* now represents a saving of over one million inpatient bed days a year. The long term reduction is shown in the table and graph below.

Table I: There is a continuing reduction in delayed discharges

	March 2000	Sept 2003	Sept 2004	Reduction in last 12 months at Sept 2004	Reduction since *NHS Plan*[1]
Number of patients of all ages occupying an acute hospital bed with delayed discharge	n/a	4,267	2,742	1,525 (36%)	n/a
Number of patients over 75 occupying an acute hospital bed with delayed discharge	5,431	2,988	2,002	986 (33%)	3,429 (63%)

1 Change since the *NHS Plan* takes as a baseline the last end March figure before July 2000 (i.e. the March 2000 figure), compared to end September 2004 position

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



Western Sussex PCT has a primary intermediate care service to prevent patients being inappropriately admitted to hospital and to facilitate early discharge when admission is necessary. Intensive care at home is provided by a team of nurses, occupational therapists and physiotherapists. Patients can be discharged as soon as they are clinically fit in the knowledge that they will receive ongoing monitoring and intermediate care in their own home. This not only offers patients greater choice over where they would like to receive their care, but has significant systemic savings in terms of freeing up acute beds and increasing capacity.

3.4 Spreading improvement more widely – older people's care, mental health and children's services

Very good early progress has been made in improving access to services and in cancer and coronary heart disease. Improvement is now being spread more widely into other priorities, as the extra investment, modernisation of services and reform takes hold.

Older people's health

Offering supportive services in the community can help older people to live independently in their own homes. A recent report from Professor Ian Philp, the National Director for Older People's Health, found that older people in England are now healthier, more active and live longer than ever before.[4] Some of the progress in services for older people includes:

- Now, only 4.4% of all over 75s in an acute bed are experiencing a delayed discharge compared to 12% in September 2001
- Last year, 42,900 people aged over sixty had given up smoking at the four-week follow up stage, compared to 12,900 in 2000/01

4 Professor Ian Philp (Department of Health), Better Health in Old Age, (November 2004), http://www.dh.gov.uk/assetRoot/04/09/32/15/04093215.pdf

- The number of households receiving intensive home care has increased by 18,400 in the last four years
- Intermediate care services, which bridge the gap between hospital and the home, provided convalescence for more than 331,000 people in 2004 – 80% of whom were older people – compared with 132,000 in 1999

In **Sunderland**, the local PCT, Social Services Department, City Hospital and Mental Health Trust are working together to run a 52-bed intermediate care centre. The centre provides rehabilitation for patients, many of whom are older people, who are medically stable, but have illnesses such as stroke, trauma or dementia. Patients undertake personalised rehabilitation aimed at supporting them to return to their own homes rather than care homes. The intermediate care service is freeing up inpatient bed days at the City Hospital for other patients to be admitted. Of the people who have been cared for at the centre, 73% are continuing to live at home six months after they have been discharged.

Promoting mental health and well being

Professor Louis Appleby, the National Clinical Director for Mental Health, will be publishing a full report on progress in mental health services soon. There have been significant steps to expand the mental health workforce. Between September 1999 and June 2004, the number of consultant psychiatrists rose by 24%, while between September 1999 and September 2003, numbers of mental health nurses rose by 15% and clinical psychologists by 48%. There has also been a large increase in the number of staff who can deliver psychological therapies; psychologists and primary care mental health workers.

Service reform will increasingly move to primary care and the broader community. Mental health services are now providing more personalised care; using preventative services, self-care, and treatment in the community. Significant steps have been taken to build capacity in both health and social care services by creating new mental health teams, often community-based, and introducing new ways of working. 13,000 people are now seen by assertive outreach and up to 60,000 people seen by crisis resolution teams every year.

The following table shows the increase in community based mental health teams.

Table J: Community mental health services

	Autumn 2000	Spring 2003	Spring 2004	Increase over last 12 months at Spring 2004	Increase since *NHS Plan*[1]
Assertive outreach (number of teams)	130	219	271	52 (24%)	141 (108%)
Crisis resolution (number of teams)	n/a	102	179	77 (75%)	127[2] (244%)[2]
Early intervention (number of services)	n/a	36	41	5 (14%)	25[2] (156%)[2]

1 Change since the *NHS Plan* takes as a baseline the nearest annual figure to July 2000 (i.e. Autumn 2000) compared to the latest annual position (i.e. Spring 2004)
2 Increase between Autumn 2001 and Spring 2004

The National Institute for Mental Health in England (NIMHE) is leading the implementation of a comprehensive action plan for working across twenty Government departments, agencies and other organisations at national level. The aims are to deliver improvements in the full range of services that matter to adults with mental health problems, tackle the stigma and discrimination associated with mental illness and reduce the social exclusion of those with a mental illness. Work will also be taken forward specifically to improve mental healthcare for ethnic minorities. The forthcoming publication of 'Delivering Race Equality' will launch a period of change in how we root out discrimination and provide mental healthcare for our diverse society.

Birmingham and Solihull Mental Health Trust has established a team of mental health support workers to provide rehabilitation in the community. The intensive support for patients in crisis that the team provides can help to prevent avoidable admission to hospital, and also helps more older people to live independently at home through additional home care. One of the team's most valuable interventions has been prompting and monitoring compliance with prescribed medication, which has helped to prevent numerous avoidable admissions to psychiatric assessment wards.

South Staffordshire Healthcare Trust and **Cannock Chase PCT** have been working with local partners on a mental health self-help scheme. The scheme enables GPs and primary care staff to prescribe self-help books covering issues such as depression, anxiety, bulimia, obsessive compulsive problems, social phobia, panic, anger, stress, low self esteem and the aftermath of sexual abuse. Where a self-help approach is appropriate for patients, they can avoid unnecessary referral to secondary care. Patients are given follow-up phone calls by a primary care mental health worker to monitor their progress.

Children's health

One of the ways in which we are raising standards of quality and safety across the NHS is through the implementation of the rolling programme of National Service Frameworks (NSFs). On 15 September 2004, we launched the NSF for children, young people and maternity services. This NSF is the biggest ever national initiative to improve health and social care for children.

The NSF also supports the extension of choice throughout the NHS, for example

- for mothers as to where and how they deliver their babies
- for families as to where they go for emergency care when their child is ill
- for young people, as to the gender of the healthcare professional they see and what form their medicines should be in.

The NSF was published jointly with the Department for Education and Skills in recognition of the need for it to be delivered in partnership by the NHS with Local Authorities and others. The NSF is an integral part of the cross-Government programme of 'Change for Children' which is working to bring services together in pursuit of five outcomes for children, young people and families. The outcomes, which were developed with children and young people, include 'be healthy' and 'stay safe', and the NHS, in delivering the NSF and other policies to

improve the health of children (for example, those set out in *Choosing Health*) will have a key role in making Change for Children happen.

3.5 Clinical governance and patient safety

A key goal of the NHS is to ensure that patients receive high quality, safe care, not just sometimes, but every time they encounter NHS services.

The NHS has been in the forefront internationally in addressing how quality and patient safety can be made real throughout a complex health service.

The Government has set out a range of standards which will shape the direction of healthcare in the future.[5] Firmly oriented towards quality of care, they cover seven domains: safety, clinical and cost effectiveness, governance, patient focus, accessible and responsible care, care environment and amenities and public health. The Healthcare Commission has published the proposed criteria through which these standards will be assessed in their consultation document, *Assessment for Improvement*,[6] published on 29 November 2004.

The National Patient Safety Agency (NPSA) is leading a programme to learn lessons from the things that go wrong in healthcare and to reduce risks for future patients. This is one of the first such initiatives in the world. A reporting and learning system is being introduced throughout the NHS with all adverse events and near misses being identified, logged, analysed and the findings acted upon.

A programme of clinical governance has been promoted through all NHS organisations in the country so that Boards and clinical teams have the knowledge and skills to make quality assurance, quality improvement and safety a core part of their everyday activities and routines (not merely an add-on extra).

3.6 Improving patient experience and patient satisfaction

As services expand, the NHS can concentrate more and more on providing personal and flexible care for everyone. Improving patient experience of care and patient satisfaction are now at the core of NHS activity. This embraces listening to patients and their advocates, understanding their needs better, responding to them increasingly as "customers" as well as patients.

There are now patient forums in every PCT, NHS Trust and NHS Foundation Trust in England. The forums have grown to a combined membership of nearly 5,000 people, whose role is to monitor and review their local health services and strengthen the accountability of those services to their local community. Just one of the ways in which the forums are making a difference is that around 600 of their members have volunteered to take part in cleanliness inspections to help raise standards of cleanliness and increase infection control in hospitals.

5 Department of Health, *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08*, (July 2004), http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf

6 Healthcare Commission, *Assessment for Improvement*, (November 2004), http://consultation.healthcarecommission.org.uk/site/index.php?view=assessment&sub=view_pdf

We need to continue to listen to the views of patients, whether expressed through forums, surveys, or other means, and to respond to their needs when designing and delivering services, as they have done in Lincolnshire.

The Modern Matrons at **United Lincolnshire Hospitals NHS Trust** wanted to improve the experiences of people with learning disabilities and their carers. They met with service users to gather their views on how to improve the acute services they received. They came up with four recommendations:

- to educate staff about learning disability, involving presentations from service users
- to make information more understandable and accessible
- to produce a video on common procedures undertaken in A&E, which would help to explain the environment and equipment used
- to make menus simpler and more appetising

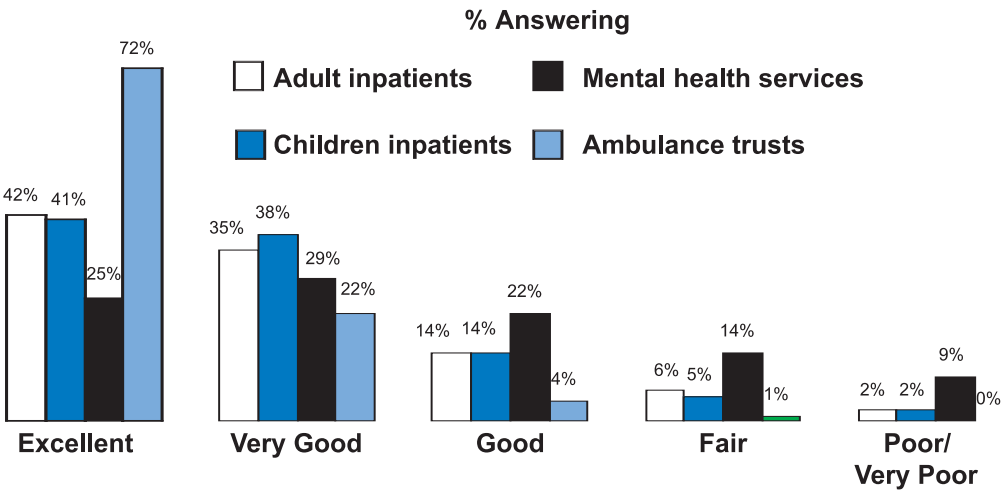
It has brought real benefits that the Modern Matrons have changed services based on what patients and service users really want.

Patients continue to report positive experiences of the NHS through the independent Healthcare Commission's annual survey programme. Results of five surveys were published this summer: new surveys for ambulance trusts, mental health, and children and young people; and repeat surveys for adult inpatients and primary care. Overall ratings of care are consistently high.

- Among adult inpatients, the number rating the service as 'excellent' has increased by four percentage points since the previous survey in 2001/02
- Ambulance trusts scores were outstanding, with 98% of users giving a positive rating, and of these 72% rated the service as 'excellent'
- More people reported quicker access to their GP, up 10 percentage points; and faster admissions to wards via A&E, up 8 percentage points
- The mental health survey showed that patients have very high rates of trust and confidence in staff and felt that they were treated with respect and dignity.

These surveys give valuable feedback from the people who matter most; the patients and service users. The chart below shows successful results overall, but with some variations. We must continue to celebrate the successes and respond quickly where patients tell us there is room for improvement.

Graph G: Patients were asked: 'Overall, how would you rate the care you received?'



Base: All valid responses – adult inpatients (85,487), children inpatients (61,467), ambulance trusts (11,535), mental health services (26,068)

Notes:
1. The adult inpatient survey did not include a response category of 'very poor'
2. Percentages have been rounded to the nearest whole number
3. PCT survey results are not included here as they do not include an 'overall rating' question

Expert Patient Programme

The Expert Patient Programme is a generic, lay-led self-management programme for people living with long term conditions. It aims to support people to increase their confidence and improve their quality of care.

After a two year pilot, it is now being embedded within NHS activity and 17,000 people have been through the programme so far.

This programme is a cornerstone of a much wider range of initiatives to enable people to manage their own care and become more actively involved in healthcare in their local community.

Diversity and ethnicity

Not all patients are the same and services need to be better tailored to the different groups in our society. There is evidence that patients and staff from black and minority ethnic groups are less satisfied with services than the majority of the community. There is now a real drive in the NHS, and one which is building momentum, to improve the experiences of patients and staff from black and minority ethnic groups. The NHS Chief Executive has put race and other equality issues at the centre of the leadership agenda.[7] Some of the progress so far includes

- The first ever Equality and Human Rights Director for the NHS, Surinder Sharma, has been appointed to spearhead the equality agenda
- In July, SHAs launched their equality performance management framework entitled *The Strategic Health Authority Race Equality Guide 2004*.[8] This links to the work on tackling inequalities referred to in chapter 4

7 Sir Nigel Crisp (Department of Health), *Taking Forward the Leadership and Race Equality Action Plan: Mentoring*, (22 March 2004). In a letter to NHS CEs and Directors, I said that the challenge for us as leaders of the NHS is to make sure that our services meet the needs of people from ethnic minorities and to face up to the serious questions being asked of the NHS about our progress in tackling racism.

8 *The Strategic Health Authority Race Equality Guide 2004*, (July 2004), http://www.cre.gov.uk/pdfs/sha_race_equality_guide.pdf

- 7.5% of executive directors are from black and minority ethnic communities
- Nearly 900 senior NHS leaders offer personal mentoring to black and minority ethnic members of staff to help improve leadership development.

The multi-cultural menu at **Leeds Teaching Hospitals NHS Trust** has been providing a range of Halal, Kosher and vegetarian meals for several years. It has recently been extended to include a range of African and Caribbean meals. This move followed discussion between the Trust's Equal Access Department, the City Council's Social Services Department and the city's various African and Caribbean communities. The broader menu is particularly important as some African and Caribbean food choices are based on tradition, culture and faith.

3.7 Reform and redesign: world class standards and world class service

The NHS Improvement Plan, published in June, sets out the major programme of reform which is underway in the NHS. We are moving towards a new NHS where patients are firmly in the driving seat. They will be able to choose from a variety of different services – provided by different providers – who are operating to national standards.

During the course of the year, the early reforms are being put into place. The first twenty NHS Foundation Trusts have been established under the supervision of the new regulator, Monitor; national standards have been published for the first time; and the new Healthcare Commission has been established. Payment by Results, the new method by which finances flow round the system, has begun to be introduced. This brings new incentives for the commissioners and purchasers of services alike.

These reforms will accelerate the changes and improvements already underway.

Over the last four years there has been a very active process of identifying best practice and spreading it through the NHS. The NHS Modernisation Agency, created in 2001, has been particularly successful in redesigning services and introducing changes across the NHS. It is notable that many of the improvements described in this report have been supported by the Modernisation Agency. Over the last three years they have established themselves as a world leader in innovation and best practice in health services.

Over the last three years, no fewer than 150,000 staff within the NHS have been engaged in the Agency's work. The Agency has helped to make improvement a core discipline in the NHS. It recognised that excellence in leadership at all levels would be a key element in modernisation, so made it a priority to develop clinical and management leaders for the frontline. To date, more than 45,000 nurses, allied health professionals, healthcare scientists, doctors and managers have completed world class development and training programmes run by the Agency's Leadership Centre.

The Agency has recorded its learning over the last four years; its methodological legacy to the NHS. In September 2004, it published *10 High Impact Changes for Service Improvement and Delivery*.[9] This important document sets out key principles of best practice in improvement and is part of a move towards evidence-based innovation.

9 NHS Modernisation Agency, *10 High Impact Changes for Service Improvement and Delivery*, (September 2004), http://www.content.modern.nhs.uk/cmsWISE/HIC/HIC+Intro.htm

The NHSU was established to promote learning across the NHS, secure wider participation in education and integrate learning across the disciplines. Over the last year it has begun to produce results with, for example, the induction programme and a health specific Customer Care Programme.

Over the last year, the Healthcare Industries Task Force, co-chaired by Health Minister Lord Warner and Sir Christopher O'Donnell, Chief Executive of Smith & Nephew, has identified ways of improving the pace and methods by which the NHS adopts new technology. Its recommendations included the establishment of an NHS Innovation Centre.

Earlier this week we announced the establishment of the NHS Institute for Learning, Skills and Innovation, which will bring together the work of the Modernisation Agency, the NHSU and the Innovation Centre to provide an agency to drive improvement in the NHS. Over the next six months, building on the excellent experience to date, we aim to put in place an organisation which will be a world leader in health services improvement.

Changes in the way staff work underpin many of the changes described in this report. New contracts have been introduced for consultants and GPs. There has been staff support for introducing Agenda for Change and overwhelming support for a new pharmacy contract. Negotiations continue on dentistry. Through these new contractual arrangements we aim to introduce greater flexibility and reward staff and organisations for learning, development and the quality of service.

These changes – the reform and the redesign of work and jobs – will continue over the next few years and will provide the levers and impetus for further improvement. Increasingly, as the National Programme for IT is rolled out, we will see services enabled by IT to provide fast and modern ways of supporting staff and looking after patients.

3.8 Improving services: the future

These service improvements have been brought about by the hard work, skills and dedication of thousands of people. They have done this at a time of great change whilst managing external pressures and events.

Looking forward, the challenges remains the same: to improve services for patients and service users, giving them more choice, more flexibility and a higher quality of care. Progress is good; but as one challenge is met, others become more prominent.

In maintaining momentum over the next year the NHS will need to pay even more emphasis to:

- joining up our services. As the range of services increase we must make sure they are well coordinated – through, for example, emergency care networks – and that members of the public know how to access them easily
- the basics of care and personal attention. Chris Beasley, the new Chief Nursing Officer, is leading the work on making sure standards of care are improved and infection rates – including MRSA – reduced
- ensuring that everyone is treated with dignity and respect, as well as receiving high quality care
- continuing to widen out improvement to other services and areas

4. Improving the health of the population

As the individual problems of service delivery are dealt with and services improve, the NHS is able to turn more attention to promoting health and well being. This chapter sets out:

- a brief summary of *Choosing Health*, the new national plan to improve the health of the population
- the continuing progress which is being made to reduce premature mortality from cancer, coronary heart disease and suicides
- the work underway to deal with health inequalities and respond to the needs of a diverse population.

4.1 The NHS as a health service, not just a sickness service

The first half of this year has seen 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*[10] and the Public Health White Paper *Choosing Health*.[11]

The NHS Improvement Plan, which provides the blueprint for the development of the service over the next four years, describes how the NHS will increasingly take a proactive approach to promoting health and preventing ill health, rather than just curing sickness. The drive to improve health will aim particularly to narrow inequalities between different sections of the population. This strategic direction was backed up by the operational targets in *National Standards, Local Action*, more than half of which are aimed at accelerating improvements in the health of the population.

Choosing Health, launched in November, sets out the national strategy to enable people to change their lifestyles so that they eat more healthily, exercise more and smoke less. It also outlines moves to improve sexual health, encourage sensible drinking and improve mental well being.

Measures announced in the White Paper include:

- A ban on smoking in the workplace. Restaurants that serve alcohol and pubs that prepare food will have to be non-smoking unless they apply for a special license to allow smoking in self-contained areas

- An overhaul of sexual health services

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

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

- Action to ensure that children have the healthiest possible start in life, including curbs on the promotion of unhealthy foods to children
- Clear, unambiguous labelling of the nutritional content of food
- NHS Health Trainers to provide advice to individuals on how to improve their lifestyles
- Specialist obesity services within every PCT
- New approaches to mental illness, for example, to help people manage their own care
- The promotion of joint action by Local Authorities with business and voluntary groups to tackle local issues
- A wide range of measures to tackle social and geographical inequalities in health, both in children and adults.

PCTs will be increasingly active in promoting good health, such as in the example below.

Westminster PCT, in partnership with the **Westbourne Park Family Centre**, is running a fresh fruit and vegetable food cooperative at the Family Centre. It aims to improve the health of the local population by making sure good quality fresh fruits and vegetables are accessible and affordable, particularly to the more deprived sections of the community. This has the potential to narrow health inequalities, as well as promoting a good diet to the community at large.

There is already much good practice in the NHS aimed at preventing ill health and minimising the impact of long term conditions.

Lambeth and Southwark Health Community is running a pulmonary rehabilitation programme for patients with chronic obstructive pulmonary disease. The programme offers patients a 7-week programme of tailored exercises and education on how to manage their condition effectively. The scheme has brought demonstrable benefits in patients' health:

- They improved by 40% on a walking test by the end of the course
- 52% showed significant improvement in breathlessness
- 60% reported they were feeling better emotionally
- 68% said they were feeling less fatigue
- 76% said they felt more confident about managing their condition.

Staff and patients in **Oldham PCT** have been delighted with the results of an innovative scheme which uses musical instruments as part of a programme to tackle childhood asthma. Children are invited to visit the scheme after school where they have a drink and some fresh fruit and a 30-minute group session on either the flute, clarinet or cornet, including breathing exercises and games.

They also talk to a nurse who gives them advice on managing their conditions through games and quizzes. Some of the benefits recorded so far are that:

- the proportion of children involved taking time off school because of asthma has reduced from 35% to just 5%
- the number of children sleeping through the night has doubled
- the number suffering problems from asthma during the day has halved.

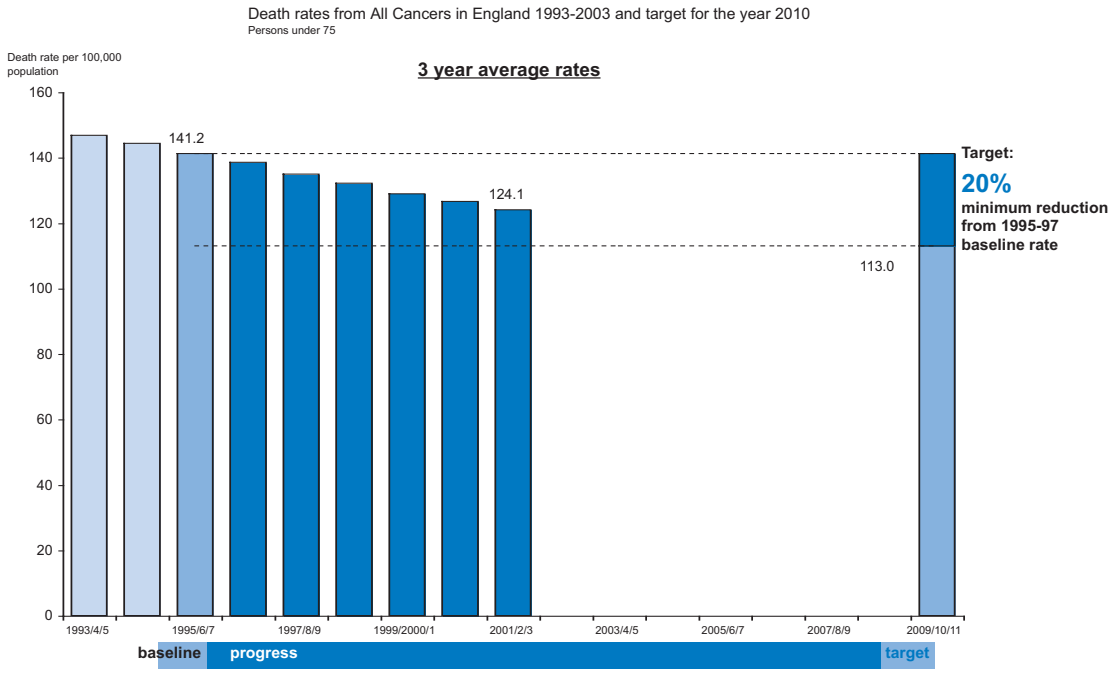
4.2 Reduced mortality rates, improved outcomes

Choosing Health sets out the challenges ahead and the Government's strategy for improving the health of the population. Whilst there is still much to do, the NHS has already made major and sustained progress in tackling premature mortality rates from the two biggest killers in England; cancer and heart disease. We are also helping people to stop smoking, as one of the main causes of these diseases.

Cancer

We have made significant progress towards the objectives set out in the *NHS Cancer Plan* to reorganise, standardise and rejuvenate cancer services so that we compare with the best in Europe. The NHS is delivering better cancer treatments, more quickly, to more people than ever before. The latest figures show that cancer mortality in the under 75s has fallen by 12.2% in the last six years. Within the overall cancer mortality rate, two of the biggest killers – breast cancer in women and lung cancer in men – are falling more quickly in England than anywhere else in the world.

Graph H: Cancer Mortality Target



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. Note that there are slight differences to the baseline and target figures given here and those published in *The NHS Cancer Plan and the new NHS*, due to revised ONS population estimates
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 140-209; ICD10 C00-C97)

The recent report, *The NHS Cancer Plan and the New NHS*,[12] covers the progress that has been made and shows how cancer services are adapting within the changing NHS to provide more patient-centred care. Some of the key points are:

- Since April 2001, over 250,000 more women have been invited for screening as a result of the expansion of the breast screening service to women aged 65-70 years
- We are rolling out liquid based cytology across England to help reduce by around 300,000 the number of unsatisfactory cervical screening tests
- Currently, over 99% of people with suspected cancer are seen by a specialist within two weeks of being referred urgently by a GP; over 97% of women with breast cancer receive treatment within two months of being referred urgently by their GP; and 100% of children with cancer are treated within one month of urgent referral by a GP
- There are 975 extra cancer consultants since 1999 (a 29% increase) and 2,157 (38%) more consultants in other specialties who spend a significant amount of their time caring for cancer patients
- Over 1,100 items of the most modern equipment to diagnose and treat cancer have been delivered since April 2000. This includes magnetic resonance imaging (MRI) scanners, computerised tomography (CT) scanners and breast screening equipment

12 Department of Health, *The NHS Cancer Plan and the new NHS: Providing a patient focussed service* (October 2004), http://www.dh.gov.uk/assetRoot/04/09/25/37/04092537.pdf

- The proportion of patients in England entering clinical trials for the latest drugs and treatments has more than doubled in the past three years.

A key initiative that will help us to build on these successes is that, in April 2006, we will begin the phased roll out of a National Bowel Cancer Screening Programme; one of the first of its kind in Europe.

There are many examples of good practice in the NHS in caring for patients with cancer. The following examples from Dorset and the West Midlands show how Trusts are streamlining the journey for cancer patients and speeding up diagnosis and treatment, which helps to alleviate some of the anxiety that they feel.

The **Dorset Cancer Network** has redesigned the pathway for patients with haematuria (blood in the urine) to provide a one-stop specialist clinic for those patients where cancer is suspected. In the past, patients had to visit the clinic up to four times and could wait up to 16 weeks for definitive treatment to commence. In the redesigned system, GPs fax their referrals to Royal Bournemouth and the patient is contacted within 48 hours to agree a single appointment at the clinic. Ultrasound and cystoscopy treatments can now be performed at the same visit with results given that day. This has reduced the pathway to diagnosis from several months to only 14 days.

The **University Hospitals Coventry and Warwickshire NHS Trust** has appointed cancer team facilitators to ensure that the journey of each cancer patient runs seamlessly. These key individuals liaise with relevant professionals in the multi-disciplinary team, such as consultants, surgeons, pathologists, radiologists, oncologists, and medical secretaries. Assigning individual facilitators to patient journeys can be effective in promoting multi-disciplinary working and cutting through the barriers that had traditionally existed between professional groups.

Coronary heart disease

The NHS continues to deliver major improvements in outcomes for patients with coronary heart disease. Some of the main achievements include:

- Premature deaths from heart disease, stroke and related diseases fell by more than 27% between 1995/97 and 2001/03

- The decline in mortality rates for heart disease and stroke in the under 75s is also having an impact on health inequalities. Over the past six 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 19%. Further sustained effort will be needed to secure the 40% closing of the absolute gap that we are aiming to secure by 2010

- An estimated 1.8 million people are currently receiving statins (cholesterol lowering drugs), potentially saving thousands of lives every year, as well as reducing the number of heart attacks. These life-saving drugs have now been made available over the counter rather than just by prescription, so that more people can benefit and obtain their medicine in a convenient way

- 681 defibrillators have been installed in busy public places, such as stations and airports. So far, the evidence suggests that this has saved the lives of fifty heart attack sufferers already

- By the end of November, two million children will be receiving a free piece of fruit or vegetable every school day

- Excellent progress has been made in speeding up access times for heart surgery patients. Not so long ago, it was not uncommon for patients to wait up to two years for a heart operation. Now no one waits over six months and we are confident that by March 2005, if not sooner, everyone who needs it will have their heart surgery within three months

- From April next year, all cardiac patients will be able to choose their place of treatment from a selection of hospitals at the time they are told they need their operation.

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

	In 1999/2000	In 2003/04	Increase over last 12 months at Sept 2004	Increase since *NHS Plan*[1]
CHD revascularisations[2]	46,000	65,900	5,590[3] (9.3%)[3]	19,900 (43%)
Lipid regulating drug prescriptions items[4]	9.0 million[5]	25.9 million[5]	6.4 million (30%)	16.9 million (188%)
Time to thrombolysis (% treated within sixty minutes of call)	24%[6]	48%[7]	6%[8]	25%[6,7,8]

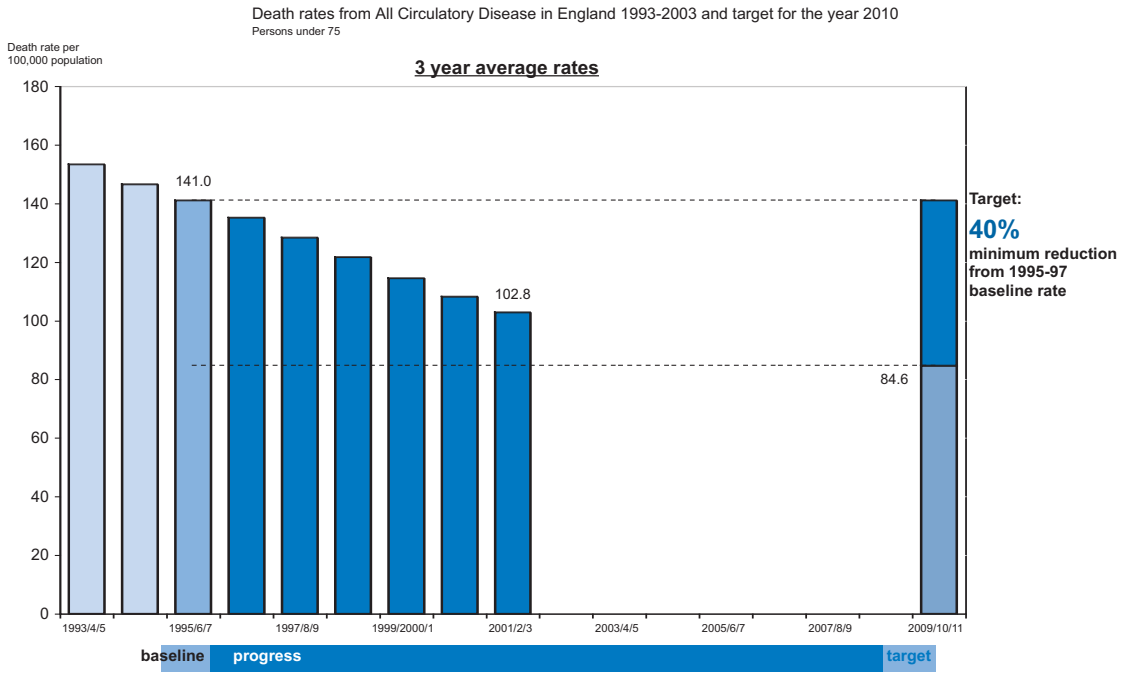
1 Change since the *NHS Plan* takes as a baseline the last annual figure before July 2000 (i.e. the 1999/2000 figure), compared to latest annual position (usually March 2004)
2 Figures include non-England residents and private patients treated in NHS hospitals
3 Increase in 2003/04 financial year
4 Lipid 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
5 Year to June
6 Only 39 (out of 216) hospitals in England were collecting this data in 1999/2000
7 Percentage is the aggregated national average for the whole of 2003/04, and excludes Welsh hospitals
8 Percentage point change

Table L: There is faster access for heart surgery

	April 2002	March 2004	Sept 2004
Number of patients waiting over six months for a heart operation (revascularisation)[1]	2,788	1	0

1 Data collection started in April 2002

Graph I: Circulatory Disease Mortality Target



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 390-459; ICD10 I00-I99)

Smoking cessation

The increased investment in, and expansion of, the NHS Stop Smoking Service continues to be highly successfully in helping people give up smoking. This helps with our aim of preventing serious diseases, such as cancer and heart disease, and will help to save thousands of lives each year.

The NHS Stop Smoking Service is part of an overall tobacco control strategy, which includes public education, reducing tobacco promotion, tobacco regulation and reducing availability and supply. Although overall performance of smoking cessation services is good, there are still notable variations between different areas and we need to continue to spread the best practice. The table below shows that last year 205,000 people had stopped smoking at the four-week follow up stage.

Table M: More people are stopping smoking

	In 2000/01	In 2003/04	Increase over last 12 months at June 2004	Increase since *NHS Plan*[1]
Number of people who had successfully stopped smoking at four-week follow up	64,600	205,000	17,000 (46%)	140,000 (217%)

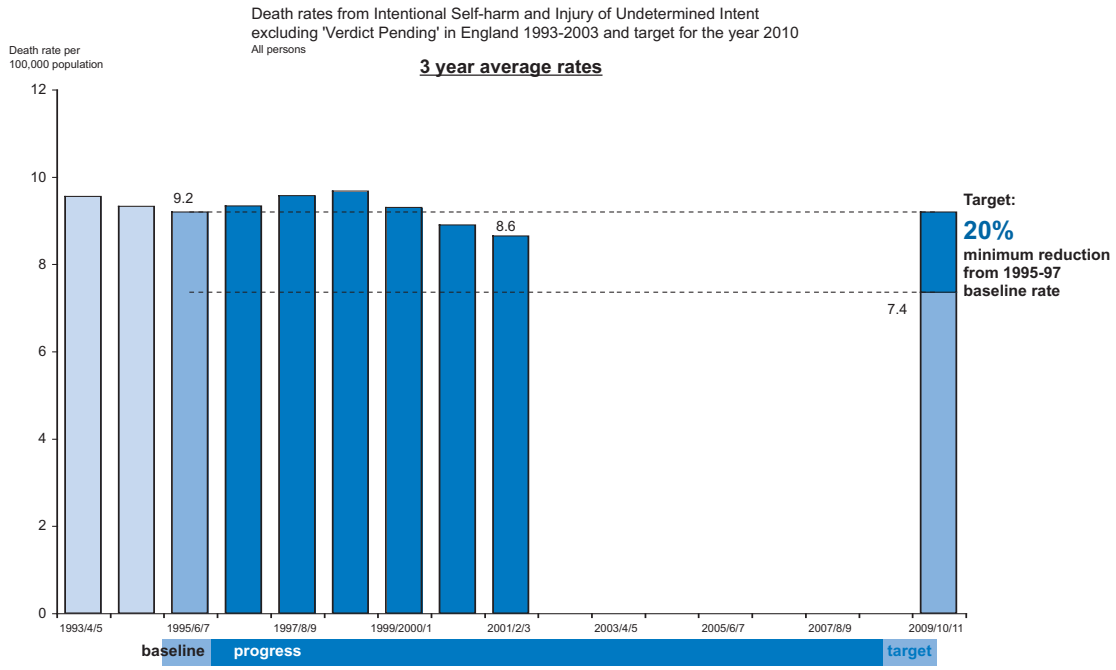
1 Change since the *NHS Plan* takes as a baseline the first available financial year figure (i.e. the 2000/01 figure), compared to end March 2004 position (i.e. the 2003/04 figure)

The Harrow Stop Smoking Service is extending its reach into the local community to deliver advice and support to people who want to give up. The service is now actively delivered by fifty pharmacies, making it readily accessible to the whole community. As well as running one-to-one sessions at pharmacies, a number of pharmacists are running outreach clinics in places as varied as bus depots, hospitals, mosques and supermarkets. These new outreach clinics have had an 80% success rate in helping people who attend them to stop smoking.

Suicide prevention

The National Institute for Mental Health in England is leading the implementation of the National Suicide Prevention Strategy, as well as improvements in mental health more widely. The suicide rate in England is continuing to fall and is now at the lowest level recorded to date. The suicide rate for young males aged 20–34 is 19.2 per 100,000 in the period 2001–2003. This is the lowest rate for young men since 1986–1988. Inpatient suicides have also fallen from 215 in 1997 to 156 in 2002.

Graph J: Mental Health Target



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))

4.3 Tackling inequalities in a diverse population

Choosing Health builds on a whole population approach across a range of key public health issues, such as smoking, obesity, physical activity and alcohol. It underlines the importance of tailoring measures to the needs of the different groups within the population, including black and minority ethnic (BME) groups. As part of the planning process, all PCTs need to carry out an equity audit to look at the needs of all groups in their population, with particular reference to the needs of people from BME backgrounds.

Mental health is a particular issue for BME communities. *Choosing Health* committed to the Delivering Race Equality programme, which is designed to tackle inequalities in mental health.

Other key issues for tackling health inequalities in our diverse society include

- redressing inequalities in access to information to tackle disadvantage through programmes such as Skills for Life (health literacy) and Health Direct
- promotion of good health among children, particularly among looked-after children, disabled children and BME children, who often have more problems and less access to services
- building community leadership through the local government responsibility to promote well being, and identifying specific needs of different population groups
- proposals for personal health trainers and personal health plans will be rolled out first in areas of highest need

We have recently identified a 'Spearhead' group of PCTs – those in the bottom fifth in terms of life expectancy and deprivation – to reinforce efforts to meet the national commitment to reduce health inequalities.

4.4 The future: *Choosing Health*

The key challenges for the future are set out clearly in *Choosing Health* – working with the population to help them choose health, whilst making sure that our efforts reach all parts of the population and reduce health inequalities.

5. Investing in capacity and achieving value for money

This chapter describes

- investment in more staff, more beds and equipment
- how the extra investment is being used
- how we are creating a more efficient and productive NHS.

5.1 More staff

Over the past five years, growth in the total NHS workforce has increased by an average of 3.7% every year. The total workforce in the NHS is now at its highest level yet. Current trends will continue over the next four years in order to further increase the size of the workforce, focusing on growth in clinical staff.

The most recent information we have on all staff numbers is from the September 2003 annual workforce census. That showed that staff numbers had grown considerably since the *NHS Plan* with:

- A total NHS workforce of 1,282,900, growth of 185,500 since 1999 equivalent to 153,800 staff working full time.
- 84% of the current NHS staff have a direct role in patient care, 13% support the infrastructure and 3% are managers
- 386,400 nurses, 56,700 more than in 1999
- 28,800 consultants, 5,400 more than in 1999
- 30,400 GPs, 1,900 more than in 1999
- 122,000 AHPs and Health Care Scientists, 19,700 more than in 1999.

Following the September census, we have had further counts of nurses, consultants and GPs. These have shown further increases in staff. We are also making the NHS a better place to work, so that people are happier in their jobs.

- Childcare provision is increasing in the NHS
- 73% of staff are satisfied with working in the NHS.

Table N: Increase in doctors and nurses

	Sept 1999	Sept 2003	Increase over last 12 months at Sept 2003	Increase since *NHS Plan*[1]
Doctors	94,000	109,000	5,640 (5.5%)	15,000 (16%)
Total qualified nursing, midwifery (including practice nurses) and health visiting staff	330,000	386,000	18,800 (5.1%)	56,700 (17%)

1 Change since the *NHS Plan* takes as a baseline the last annual figure before July 2000 (i.e. the September 1999 figure), compared to the latest annual position (i.e. the September 2003 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 O: Numbers of training places for doctors and nurses

	In 1999/2000	In 2003/04	Increase over last 12 months at March 2004	Increase since *NHS Plan*[1]
Medical school intake	3,972	6,030	753 (14%)	2,058 (52%)
Nursing and midwifery training commissions	18,707	24,284[2]	1,328 (5.8%)	5,577 (30%)

1 Change since the *NHS Plan* takes as a baseline the last end of March figure before July 2000 (i.e. the 1999/2000 figure), compared to end March 2004 position (i.e. the 2003/04 figure)
2 Figure published in May edition of report was estimated and has now been finalised

5.2 More beds and equipment

Recent years have seen an increase in the bed capacity of the NHS, as well as more efficient use of that capacity. We have hit our *NHS Plan* targets to increase general and acute and critical care beds. There has also been a particularly fast increase in the number of intermediate care beds, which is helping NHS staff to deliver more care outside the acute setting.

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

	In 1999/2000	In 2003/04	Increase over last 12 months	Increase since *NHS Plan*[1]
Total number of general and acute beds	135,000	137,000	598[2] (0.4%)[2]	2,200 (1.6%)
Total number of intermediate care beds	4,242	8,697[3]	834[4] (10%)[4]	4,455 (105%)
Total number of open and staffed critical care beds	2,362[5]	3,160[6]	32[7] (1.0%)[7]	798[8] (34%)[8]

1 Change since the *NHS Plan* takes as a baseline the last end of financial year figure before July 2000 (i.e. the 1999/2000 figure), compared to end March 2004 position (i.e. the 2003/04 figure)
2 Increase at March 2004 compared to March 2003
3 Figure published in May 2004 edition of the report was estimated and has now been finalised
4 Increase at September 2004 compared to September 2003
5 Figure as at January 2000, as target measured from this point
6 Figure as at July 2004
7 Increase at July 2004 compared to July 2003
8 Increase at July 2004 compared to January 2000

Bed capacity is also being used in ways which are more sensitive to patients' preferences: 99% of NHS Trusts now provide single sex sleeping accommodation and have robust arrangements in place to protect patients' privacy.

The extra investment going into the NHS means that patients are now benefiting from high-tech equipment and state-of-the-art facilities.

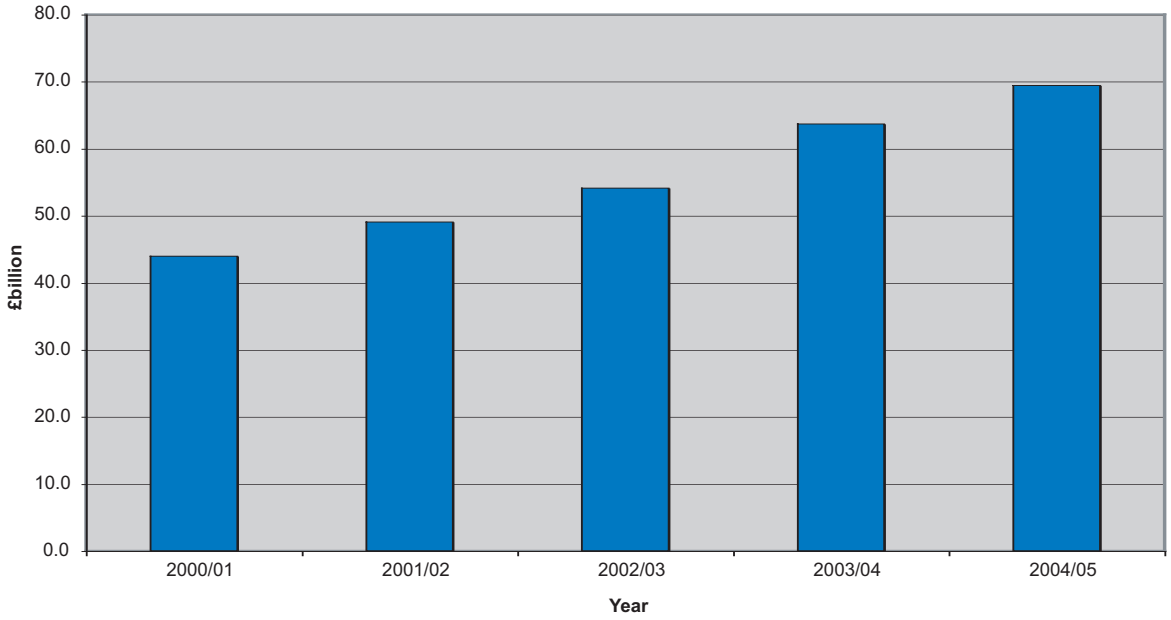
Charing Cross Hospital and **Chelsea and Westminster Hospital** are using state-of-the-art technology to modernise their pharmacy services. 'Pollyanna' is a robotic drugs dispenser that has been installed in the hospitals' pharmacy departments. It dispenses and labels drugs so that pharmacists can spend more time on wards. The robot will also help to speed up access, and to reduce delayed discharges and drug errors.

Experts at **Liverpool Women's Hospital NHS Trust**, a centre of excellence in obstetrics, can now analyse the ultrasound scans of patients in remote locations. A live telemedicine link is being used to transfer information on ultrasounds to the hospital, so that women can receive first class maternity care without having to travel to Liverpool. As they can have an expert opinion straightaway, despite their location, it reduces the anxiety that they may feel whilst waiting for results. Staff and patients who have used the high-tech service over the last few months have found it to be of great benefit.

5.3 Extra investment

The graph below shows that there has been a sustained increase in total NHS expenditure in recent years.

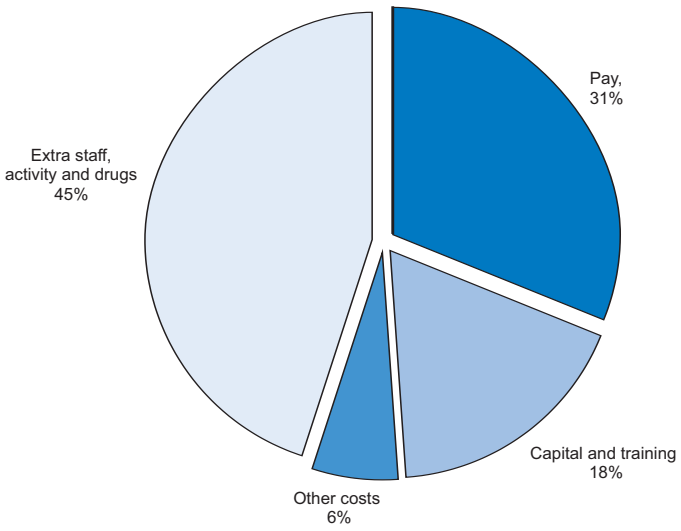
Graph K: Total net NHS expenditure in England 2000/01 – 2004/05



Note: Expenditure for 2003/04 onwards is not directly comparable with earlier years due to (a) the move from stage 1 to stage 2 resource budgeting and (b) a transfer of funding for NHS pensions from HM Treasury.

Total NHS expenditure in 2003/04 rose by £5.9 billion, of which £5.2 billion was increased revenue expenditure and £0.7 billion increased capital expenditure.

Chart B: High level breakdown of the additional £5.9 billion NHS expenditure in 2003/04



This extra funding has been used to:

- **improve access to, and quality of, services** – £2.7 billion of the increase has been used to employ additional staff, increase prescribing and purchase more goods and services. Approximately £1.6 billion was spent on additional staff and £0.9 billion on increased prescribing. The balance was used to purchase more goods and services

- **invest for the future** – to achieve world class service standards, the NHS needs to invest in people and infrastructure. Investment in training, capital and research increased during the year by £1 billion. This has helped, amongst other things, towards the opening of 12 hospital schemes (4 of which were major), towards increasing nurse training places by nearly 6% and to increasing the medical school intake by 14%

- **ensure that pay levels are sufficient to attract and retain staff** – around £1.8 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 an extra 5,640 doctors and an extra 18,800 nurses, midwives and health visitors

- **meet unavoidable cost increases** – such as inflation on goods and services.

5.4 A more efficient and productive NHS

As well as increasing investment, it is essential that we increase the cost efficiency and productivity of the NHS to provide the best value for tax payers' money. This year has seen several major developments that will help to

- reduce bureaucracy

- provide efficient procurement

- and increase NHS productivity.

Reducing bureaucracy

The Department of Health has recently undergone an 18-month programme of change, so that it provides more effective strategic leadership to the NHS and social care and a better service to the public. The first and largest programme of its type in Whitehall, it will lead to a 38% reduction in staff at the Department. The reduction of staff and functions at the centre reflects the continuation of shifting the balance of power from Whitehall to frontline NHS staff and organisations.

This 38% reduction will be complete by the end of the financial year and will eventually result in savings of £60 million after redundancy costs have been settled.

The Department is also undertaking a programme to reconfigure its Arm's Length Bodies (ALBs) to reduce the burden of oversight and bureaucracy on frontline NHS services. This includes plans to reduce the number of ALBs from 38 to 20, with a 25% reduction in posts and a £0.5 billion reduction in the overall cost of the sector.

Efficient procurement

We have recently agreed a 7% price reduction for branded prescription medicines, as part of a new Pharmaceutical Price Regulation Scheme (PPRS) agreement with the pharmaceutical industry. The five-year deal comes into force on 1 January 2005 and will enable the NHS to save more than £1.8 billion on these medicines. PCTs will channel this money (at least 300 million per annum) back into frontline services.

It is important that we continue to encourage the pharmaceutical industry in its first class research and development work to deliver new and improved medicines for patients. For this reason, the PPRS agreement includes greater incentives for the research and development of new medicines, including those for children.

At the same time, we will benefit from the dividends being delivered by the Supply Chain Excellence Programme. The key objective of the Programme is to deliver better value for the NHS by using our purchasing power more effectively. We will benefit from at least £100 million in savings in 2005/06 from the initial wave of more efficient procurement led by NHS PASA. We will introduce the first of the Collaborative Procurement Hubs, driving significant benefits at the local level. By 2007/08, we expect these procurement activities to be delivering at least £500 million in savings annually to be used for patient care.

Another recent boost for NHS procurement is the nine-year agreement we have reached with Microsoft on the renewal of the licensing of its desktop products. This will bring initial savings of £112 million over the next three years, which will rise to more than £330 million over the length of the contract.

The agreement will allow the NHS to use up to 900,000 licences, compared to the current 500,000, with the licences being held on a perpetual basis rather than being renewable annually. NHS staff will have access to the latest software through this agreement, which will support the improvements led by the National Programme for IT.

The Microsoft deal represents not only substantial savings over previous NHS pricing, but also over other public sector purchasers. This is an exceptionally good deal that reflects the buying power of the NHS and our commitment to value for money procurement.

We have also recently entered into a new partnership with private sector firm Xansa to improve and expand the range of corporate services provided for the NHS. Under the partnership, Xansa will invest people, resources and expertise in order to provide increased capacity, optimise services, and expand the service portfolio to include, for example, payroll and e-commerce.

The resulting company will be called NHS Shared Business Services Limited and will be formally established on 1 April 2005. It will save over £220 million of NHS money over the next ten years by getting more NHS Trusts to use centralised service centres to carry out back office work, such as payment of invoices, VAT returns, debt collection and bank account reconciliation.

NHS Trusts contracting to the new partnership will save at least 20% on their current in-house costs. Savings will be available for investment in frontline services and patient care.

NHS productivity

We are now getting closer to a reliable way to measure NHS productivity in a way that takes account of the quality and breadth of services.

Historically, measuring NHS productivity has been difficult and flawed by the way NHS output has been estimated. Productivity measures have placed undue emphasis on hospital activity and have not taken account of the improved quality of services that the NHS has delivered. Indeed, a recent article by the Office for National Statistics (ONS) illustrated how imprecise a science NHS productivity estimation is by showing over ten separate estimates.[13]

In October, the Department of Health published an experimental estimate of NHS cost efficiency for 2002/03 that begins to take account of investment in the quality of services for the first time. Under this new measure, the value for money, as measured through cost efficiency, of the NHS increased by 0.4% in 2002/03. Early indications are that NHS cost efficiency for 2003/04 will have improved by the same or more than the 0.4% for 2002/03.

This interim measure for cost efficiency is a replacement for the increasingly outdated and unreliable Cost Weighted Efficiency Index (CWEI) and offers an improvement because:

- Greater detail in activity classification (1,700+ categories, and rising, as opposed to 12) allows a much better account of changing case mix
- New types of NHS activity are included, such as NHS Direct.

The interim measure has been reviewed by several leading academics. Whilst viewed as an interim measure, it is considered to be an improvement over CWEI. However, in common with all previous productivity measures, this new measure is still unable to take full account of the improved quality of NHS services and does not give credit for clear improvements, such as:

- Faster access times
- More patients being treated in modern, fit for purpose hospitals
- Falls in deaths within thirty days of surgery.

The Department of Health recognises that more work is required on NHS productivity measurement, so has commissioned the University of York and the National Institute for Economic and Social Research to produce a report on this next year. As part of the Atkinson Review of Government Outputs and Productivity, the Department of Health and ONS will continue to work closely to develop a comprehensive measure of health service productivity. This is an important task in helping to ensure the public continue to get good value from the extra investment in the NHS.

This report shows that, on any measure, the quality of service in the NHS has improved considerably since the *NHS Plan*.

13 Office for National Statistics, *Public Service Productivity: Health*, (October 2004), http://www.statistics.gov.uk/articles/nojournal/Public_Service_Productivity_Health.pdf

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