audit commission

the performance of the NHS in England: developing an independent commentary

Contents

Preface	2
Introduction	3
Setting the scene	
How the NHS works	5
The NHS in England	6
Health check in England	6
Health inequalities in England	6
Resources: staff and money	
Spending on healthcare	8
Nurses and doctors	10
NHS efficiency	12
Management costs	14
Waiting for care	
Waiting for an operation	16
The ambulance service	18
Waiting times in accident & emergency	20
Delays in leaving hospital	22
The patient's experience	
Hospital food	24
Improving the appearance of hospitals	26
GP surgeries	28
Outcomes	
Helping people to stop smoking	30
Preventing suicides	32
Survivng cancer	34
Deaths following heart bypass surgery	36
Comments and further information	38

Preface

The Government's *NHS Plan* aims to 'redesign the system around the patient'. It also recognises the potential of information to enhance the accountability of the NHS and to empower those who use its services. The Plan included the proposal that the Audit Commission, together with the Commission for Health Improvement, should contribute to the publication of an annual 'report card' setting out how well the NHS in England is performing.

The concept of a report card could be taken to mean a simple listing of results, coupled perhaps with brief evaluative comments. It is clear, however, that a minimal approach cannot do justice to the complexity of many of the performance issues that face the NHS across England. If the public is to gain a real understanding of performance, then results must be set in the context of a clear and balanced explanation.

This report represents a stage in the development of the Audit Commission's thinking on how NHS performance could best be reported to the public. This thinking has been informed both by a survey of the public's views and by the Commission's involvement in the recent development of the NHS Performance Assessment Framework. Beyond these specific initiatives, we have drawn on our experience of working with the NHS to understand and tackle many of the challenges discussed in the *Commentary*.

Our aim in sharing the results of this work more widely is to widen the debate among those with an interest in the public reporting of NHS performance. We are doing this at a time when the Department of Health has underlined its commitment to public accountability and independent reporting. *Delivering the NHS Plan* proposes the establishment of the Commission for Healthcare Audit and Inspection. This new body will have a key role in explaining to the public how NHS resources have been deployed and how they are being translated into improved performance. We hope that the Audit Commission's work will be of value to the new body as it considers how to fulfil its responsibilities. We are therefore circulating this prototype to encourage comments from a wide audience. Contact details are given at the end of the document.

Introduction

Commenting on the performance of the NHS

The Government has said that the public should receive an independent annual 'report card' that sets out the performance of the NHS in England. This document is the Audit Commission's first response to this call. In it we report on some important aspects of NHS performance. For each topic we have gone behind the facts and figures to explain how the NHS is doing, why there are sometimes problems, and how things might change in the future.

The *Commentary on the Performance of the NHS in England* has been written for everyone who uses, or who has an interest in, the NHS. It has not been written for experts or for those who work in the NHS – although we hope that they will also find the *Commentary* interesting, and the lack of jargon refreshing.

Clearly, anyone who is interested in the NHS will already find plenty of health service coverage in the media. However, we hope to do more than simply add to the mountain of NHS stories. For more than ten years the Audit Commission has worked with the health service to understand and tackle the problems it faces. Our knowledge of the NHS means that we can explain what is going on and why. Our independence is equally important – it allows us to be objective about how the health service is performing.

A balanced approach

There is much to celebrate in the everyday achievements of the NHS. For example, the way in which the ambulance service has continued to cope despite a huge increase in the number of emergency calls; and the fact that heart surgery results are improving even though surgeons are taking on more difficult cases.

The NHS can be proud of this kind of performance, but there are also problems – even in these successful areas. For instance, how is the ambulance service going to meet its new response-time targets; why do some hospitals have much better heart surgery results than others?

This is the pattern of performance we have seen many times while compiling this *Commentary*. The health service usually performs well, but there is often room for improvement. This overall assessment is backed-up by a recent opinion poll. Of those who had visited either their GP or their local hospital, around four out of five were either 'fairly' or 'very' satisfied with the care they received. Nobody should be complacent about the one in five patients who are not satisfied, but neither should we allow descriptions of health service 'failures' to make us forget how well the NHS performs for most of its users.

Selecting the topics

Planning the Commentary, we wanted to cover aspects of NHS performance that were important to patients and/or likely to be of interest to the public. This plan could have led to a very long list of potential topics – too many to deal with in a single report. However, that long list was cut down to size by an extra restriction: we can only comment on those issues where there is reliable nationally-collected information. This practical limitation has meant we have not been able to include many topics that would otherwise have been prime candidates. For example, we are not able to comment on the success of common NHS treatments. In many cases national results are not collected at all – and where they are, they hardly ever include the patient's view of 'the outcome'.

We would also have liked to include more about family doctors – as visiting a GP is how most people come into contact with the NHS. Unfortunately, up-to-date national information on the quality of care in general practice is currently very limited.

Similarly, while we comment on some issues that are relevant to patients' experience of the NHS, the areas that we cover have been severely limited by the current lack of national data on what patients think about their care.

However, new data sources are on the way. For example, a comprehensive survey of the views of NHS hospital patients has just been completed. Once the results are available, it will be possible to look at a much wider range of issues that matter to hospital patients. If the Commentary were produced annually, it would be able to tackle different issues as reliable information becomes available. We hope that future Commentaries will be able to examine particular themes – services for older people for example – or the treatment of specific conditions, such as diabetes.

Despite the present limitations, much of the currently available national information has an interesting story to tell. As a result we have been able to select 15 important topics that say something about NHS performance – both in hospitals and the wider community.

Data sources

For the last few years the Department of Health has published a set of statistics that are designed to show how well the NHS in England is performing. There are currently 80 of these NHS Performance Indicators. They cover a wide range of issues including waiting lists, the success of cancer treatments and how many doctors there are.

While much of the *Commentary* draws on the NHS Performance Indicators, we have also used indicators from other national sources, including the Department of Health, the Office for National Statistics and the results of our own research*. New data becomes available all the time – we aimed to consider all relevant sources available to us by the beginning of June 2002.

When deciding which indicators to use in this first *Commentary* we considered how accurate the information is likely to be. Some NHS data has a poor reputation for accuracy, and our own research shows that the criticisms are sometimes deserved. As a result, we have focused on those sources reliable enough to provide, at the very least, sufficiently accurate England-wide summary figures.

How the Commentary is organised

We have divided the Commentary across four broad areas of NHS performance:

- *Resources* – does the NHS have the money and the staff it needs to provide good quality care? Does it spend that money wisely?
- *Waiting* – getting NHS care usually means having to wait, from minutes for an ambulance to perhaps many months for an operation. How long are the delays and what problems do they cause?
- *The patient's experience* – once patients get the care they have been waiting for, is it provided in pleasant surroundings? And is everything we hear about hospital food true?
- *Outcome* – how well does the treatment work? For example, how successful is the NHS in helping people to survive cancer?

For selected topics in each of these areas we have examined the overall national picture and differences around the country. We have also looked at how things have changed in recent years and at how they might change in the future.

To put the Commentary in context we have also provided four 'scene-setting' sections:

- How the NHS works – a diagram that shows how the different parts of the NHS fit together.
- The NHS in England – facts and figures that demonstrate the huge scale of the work of the NHS.
- Health Check England – indicators of the health problems that the NHS and its users must tackle.
- Health inequalities – how health problems vary around the country, and between different groups in the population.

Local Reporting

The *Commentary on the Performance of the NHS in England* is part of a wider programme to develop methods to report to the public on health service performance. In addition to the national *Commentary* we are working with others on the development of new approaches to local reporting. We are aiming for them to complement the national *Commentary*, which will provide the England-wide context for the local information, as well as a summary of overall performance.

*In this version of the Commentary we have not provided detailed references to each of the data sources we have used. This is simply to reduce 'clutter' in the presentation of the text. A version of the document that includes references is available from the Audit Commission website: www.audit-commission.gov.uk

Setting the scene	Resources: staff and money	Waiting for care	The patient's experience	Outcomes
How the NHS works	Spending on healthcare	Waiting for an operation	Hospital food	Stopping smoking
The NHS in England	NHS efficiency	The Ambulance service	Improving the appearance of hospitals	Preventing suicide
Health check England	Nurses and doctors	Waiting times in A&E	GP surgeries	Surviving cancer
Health inequalities	Management costs	Delays leaving hospital		Deaths after heart surgery

How the NHS works

The NHS in England is a large and complex organisation. It employs more people than any other organisation in Europe and includes many professionals working in a whole array of different settings - surgeons in specialist hospitals like Great Ormond Street to General Practitioners in local surgeries, midwives, nurses, cleaners, managers, engineers, radiographers, car park attendants, chefs and gardeners. This diagram attempts to show the main organisations that make up the NHS in England, but the full picture is obviously more complex than can be shown here and it cannot describe the important relationships between the NHS and other agencies, such as local authorities, that have a major impact on health in local communities.

Government

Department of Health

The Department of Health develops policy, allocates resources, sets targets and manages the NHS

Planning

Strategic Health Authorities

(28)

A Strategic Health Authority is responsible for planning and overseeing health services

Secondary Care

NHS Trusts
(290)

Hospitals
(1,627)
General hospitals
Specialist hospitals
Mental health hospitals
Community hospitals
Maternity hospitals

Ambulance services
(32)

Secondary care includes local hospitals and specialist institutions, such as children's hospitals and cancer centres. It includes services for people with learning disabilities and mental health problems, as well as ambulance services.

All of these services are run by NHS Trusts

Primary Care

Primary Care Trusts
(300)

Doctors (GPs)
(28,800)

Dentists
(17,715)

Care Trusts
(4)

Opticians
(7,517)

NHS Walk-in Centres
(43)

Pharmacists
(27,000)

Patient information

NHS Direct

NHS Direct provides advice and information to patients and carers, free of charge, over the telephone or via its website.

Primary Care includes professionals such as family doctors (GPs), dentists, district nurses, health visitors and chiropodists.

Primary care also includes NHS walk-in centres, which are open seven days a week to provide fast access to healthcare and advice to anyone who needs it.

Primary Care Trusts were launched in 1999 to bring together family doctors and other community-based health services in local areas.

Care Trusts were created this year to provide both health and social services in a single body.

The diagram represents the NHS as it is expected to be in October 2002

The NHS in England

The National Health Service was set up in 1948 to provide healthcare for everyone in Britain, based on need, not the ability to pay. It is made up of a wide range of health professionals, support workers and organisations. This page gives some facts and figures that demonstrate the size and complexity of the NHS in England.

- There are 13 million visits a year to Accident and Emergency departments.
- In a year, almost one in twelve people stay in hospital.
- The NHS spends £45 billion every year. That's £980 a year for every person.
- The NHS has 186,000 hospital beds. That's one hospital bed for every 268 people.
- The NHS employs 1,036,000 staff. Just over one in 20 people in work is employed by the NHS.
- The NHS supplies 529 million prescriptions a year.
- There are 28,800 GPs working for the NHS. That's one family doctor for every 1,700 people.

Health check England

The population

The population of England is currently around 50,000,000. About 600,000 babies are born each year. About one in five of the population is under 16 years old, and one in six is over 65. On average, women live to be about 80 years old, and men 75.

Illness and disease

- Almost half of all adults have a long-standing illness.
- One in five people of working age has a long-term disability.
- More than a quarter of people aged over 16 years old smoke tobacco.
- At any one time, one in six people of working age has a mental health problem – usually anxiety or depression.
- Almost three hundred thousand road traffic accidents led to serious injury or death in 1998.
- The numbers of people who died from some of the most common causes of death in 2000 are shown here:

All types of cancer	124,000	1 in 400 people
including lung cancer	*27,000*	*1 in 2,000 people*
including breast cancer	*11,000*	*1 in 2,500 people*
including prostate cancer	*8,000*	*1 in 3,000 people*
Circulatory diseases	194,000	1 in 260 people
including coronary heart disease	*101,000*	*1 in 500 people*
including stroke	*49,000*	*1 in 1,000 people*
Respiratory diseases	88,000	1 in 600 people

Health inequalities in England

Your health can be significantly affected by a number of factors, including:

- your age and sex;
- where you live;
- your ethnic group;
- whether you have a job and
- if you do, what job it is;
- how much money you have;
- whether you smoke, drink or use other drugs;
- your diet and how much you exercise;
- the standard of healthcare available to you.

Life Expectancy

How long people live is a simple barometer of how healthy a nation is. In England, life expectancy has been increasing but there are still large differences in how long people can expect to live. It is influenced by your work and where you live, among other factors.

- Men in unskilled jobs can currently expect to live to around 71 years on average. Men in non-manual, professional occupations can expect to live to 79 years of age – around eight years longer.
- The average life expectancy for a boy born today in Merseyside is around 73 years, compared to 79 years for a boy born in East Dorset.
- For a girl born today in Westminster the average life expectancy is 84 years, compared to 79 years for a girl in Merseyside.

There are also large differences in the number of years that people stay healthy. While people in poorer areas are living longer than they used to, they continue to suffer poor health for longer than people in more affluent areas. For example, the average healthy life-span in Manchester is 61 years, compared with 73 years in Surrey.

Coronary Heart Disease

- Your chance of developing serious heart disease depends on factors that include your job and your ethnic identity.
- A woman in a manual occupation is twice as likely to develop heart disease as a woman in non-manual work. The difference for men is not quite as marked.
- Rates of heart disease are higher than average among particular ethnic groups. Early deaths from heart disease are 50 per cent higher among South Asian men than for the population as a whole.

Infant Mortality

The likelihood that a child will die in their first year of life is low. The latest figures showed that less than 6 in every 1,000 babies die. This is the lowest level ever. However, the risk is much higher in some groups than others.

- The infant mortality rate among poorer families is higher than that among more affluent ones. While this gap closed between 1999 and 2000, it was still wide. In 2000, the babies of fathers in unskilled manual occupations had infant mortality rates more than double those for babies of fathers in professional occupations.
- Infant mortality rates also vary between different ethnic groups. In 2000, the highest rate was among the children of mothers born in Pakistan. Around 12 in every 1,000 babies born to Pakistani mothers died in their first year, which is double the overall infant mortality rate for the population as a whole.

Smoking

Smoking dramatically increases the chances that a person will develop serious illnesses and that they will die early.

- Men in unskilled jobs are three times more likely to smoke than non-manual, male workers in professional jobs.
- Some ethnic groups smoke more than others. For example, Bangladeshi men are twice as likely to smoke as the population as a whole

Teenage pregnancy

The Government aims to reduce the number of teenage pregnancies.

- Young women in the poorest social group are ten times more likely to have a baby than teenagers from the most affluent families.
- Compared with other age groups, babies born to mothers under 20 years old are at greater risk of dying within their first year of life. One in every 100 babies born to mothers under 20 is likely to die in its first year. This is double the rate for babies born to women in their early thirties.

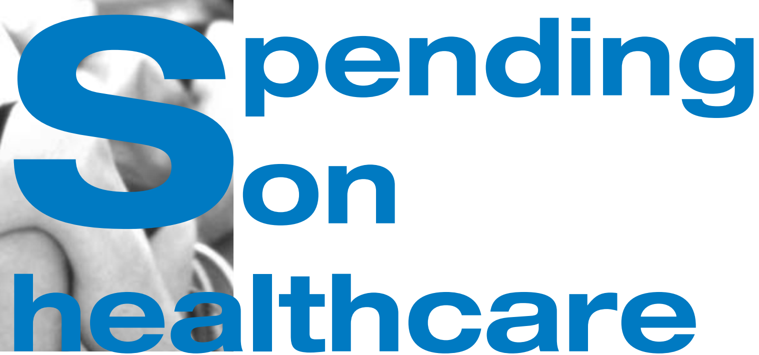
Access

Patients' access to care may be limited in different ways.

- Some areas are better provided with services than others. For example, there are nearly 50 per cent more GPs per person in Richmond and Kingston in Surrey than in Barnsley or Sunderland.
- The type of treatment that people receive varies. For example, a large amount of evidence suggests that African Caribbean people with psychoses are more likely to be treated compulsorily than are White people with the same diagnosis.

Access to the appropriate treatment may also be limited by communication difficulties between staff and patients, which are sometimes caused by differences in language or culture. As difficulties like this may be present during the whole course of a patient's treatment, they can seriously affect the care that people receive.

resources



Spending on healthcare

The NHS in England spent £44.6 billion in the year 2000 • Spending on the NHS has risen much faster than inflation • The Chancellor has set out plans to raise health spending significantly over the next five years

what is the issue?

Every year 15 per cent of total Government expenditure is spent on healthcare. This is more than is spent on education and more than twice the amount spent on defence. Only spending on social security is higher.

Spending on health has almost doubled since 1980. Reasons for this include:

- the introduction of new treatments and advances in medicine and surgery;
- patients and carers' higher expectations and greater awareness of healthcare issues have led to increased demands;
- an increasing population; and
- longer life expectancy and an increase in the number of elderly people needing treatment.

The Government recently commissioned a review (the 'Wanless Review') of the amount that the UK will need to spend on healthcare over the next 20 years. The report concluded that pressures of the kind listed above will continue to increase demands on the NHS and recommended a big rise in health spending in order to deal with them.

development papers

how is the NHS doing?

now

In 1998, the UK* spent £56.3 billion on healthcare, including NHS and private spending. This represents £970 for every person in the UK. A comparison with a selection of similar countries shows that expenditure per person in the UK is low, £700 per person lower than Germany.

We can also look at how much of the nation's wealth (Gross Domestic Product, GDP) is spent on healthcare. In 1998, the UK spent 6.7 per cent of its GDP on healthcare (including private and NHS expenditure), compared with the European average of 8.7 per cent. Germany, the highest spending EU country spent 10.6 per cent of GDP.

differences around the country

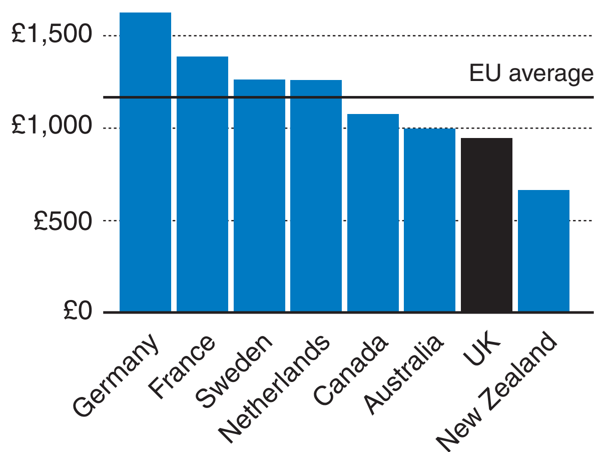
The amount of money that is spent on each person in England varies depending on where they live. Reasons for this include:

- variations in salaries and the costs of goods and services;
- differences in the need for healthcare in different parts of the country; and
- variations in the number of people with private healthcare.

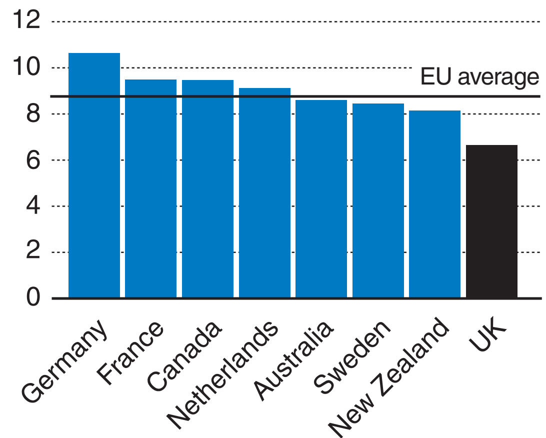
*The international comparisons discussed in this section are most readily made for the United Kingdom, rather than for England only.

Healthcare expenditure per head of population (1998)

Including private and state funded health expenditure



Total spend on health as percentage of GDP (1998)



In 2002/03, the planned level of NHS spending will be highest in London and lowest in East Anglia. On current plans, £957 per person will be spent in London in 2002/03. In East Anglia spending will be a fifth less – £756 per person over the same period. Allocations to NHS areas are decided by a complex formula that is designed to ensure equity, and reflects historical patterns.

trends

Spending on the NHS has risen continuously throughout its history. In 1980 the NHS cost £23.8 billion to run (at today's prices). In 2000 the figure was £44.6 billion. This means that, after taking out the effects of inflation, spending on the NHS has almost doubled since 1980.

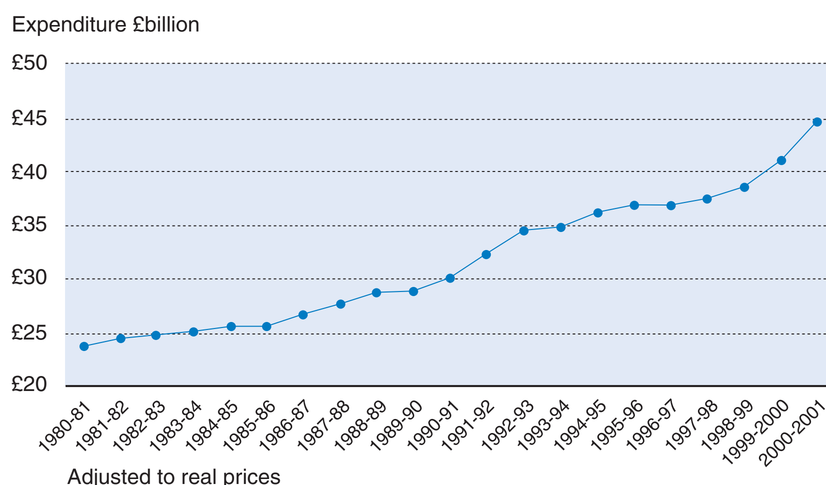
The amount of money spent per head of population has risen over the same period by 75 per cent, but the proportion of GDP spent on healthcare overall has increased only by about a fifth from 5.3 per cent to 6.7 per cent.

how might things change?

The Government has promised to increase UK health spending to the European average seen over the last ten years. This is around 8 per cent of GDP. Its current plans would take us from today's level of 6.7 per cent, to 7.7 per cent in 2004 and to 9.4 per cent of GDP by 2008. While this is a substantial increase, other countries may also increase their spending. Given that the European average has already reached 8.7 per cent, it remains likely that we will still be spending less than our European neighbours in 2004.

Getting better performance from the NHS requires more than simply increasing its funding. The money that the NHS receives has to be spent wisely. In the next section we examine this issue by asking whether the NHS gives the taxpayer good value for money.

NHS expenditure in England (1980-2000)



resources

The numbers of nurses and doctors have increased substantially since 1997 • The Government has recently achieved its target for increasing the number of nursing staff • Additional steps will need to be taken to achieve the targets set for increasing the number of doctors

what is the issue?

The biggest constraint the NHS faces today is… shortage of human resources – the doctors, nurses, therapists and other health professionals who keep the NHS going day-in and day-out. NHS Plan, July 2000.

The NHS Plan has committed the Government to significantly increasing NHS staff levels by 2004. However, although new posts can be created and funded, there may not be enough qualified people to fill them. It takes a long time for a person to qualify as a health professional, which means that there are considerable delays in getting new staff into posts in the health service. For example, any increase in hospital consultants over the next five years is largely dependent on the number of doctors in training now.

how is the NHS doing?

now

The Government has increased the numbers of medical and nursing staff since 1997. There are now 350,000 qualified nursing staff (almost 10 per cent more than in 1997), over 24,000 hospital consultants (20 per cent more) and 28,800 GPs (around 3 per cent more).

development papers

differences around the country

A survey of nurse vacancies in 2001 showed that recruitment problems are particularly common in London and the South East. The Government is trying to tackle this by introducing schemes such as a new £1,000 per year cost of living supplement and by offering low cost housing for nurses. It is too early to say whether these schemes are working.

There is considerable variation in the number of GPs in different parts of the country, with more affluent areas having higher levels of GP cover. The Government is hoping to reduce this variation by introducing a new type of GP contract that offers greater incentives to work in deprived areas.

trends

In the NHS Plan, the Government set targets to increase the numbers of staff in three groups by 2004:

- consultants: 7,500 more;

- GPs: 2,000 more; and
- nurses: 20,000.

These are increases in the total numbers of NHS staff whether working full- or part- time. The Government has taken a number of steps to increase the numbers of nursing and medical staff. These include expanding the number of training places; incentives for people returning to the profession; intensified overseas recruitment; and increases in salaries.

The latest official figures show that the Government has already met its target for increasing the number of nurses. A large number of the additional nurses are overseas' recruits.

For consultants and GPs, projections of recent trends show that the increases in these groups will have to be further accelerated if the targets are to be met.

Part of this possible shortfall may be made up by a new initiative to recruit at least 1,000 specialists and GPs from abroad. The pilot scheme has had some success in recruiting from Spain, where there is a surplus of specialist doctors, and it is likely to be expanded.

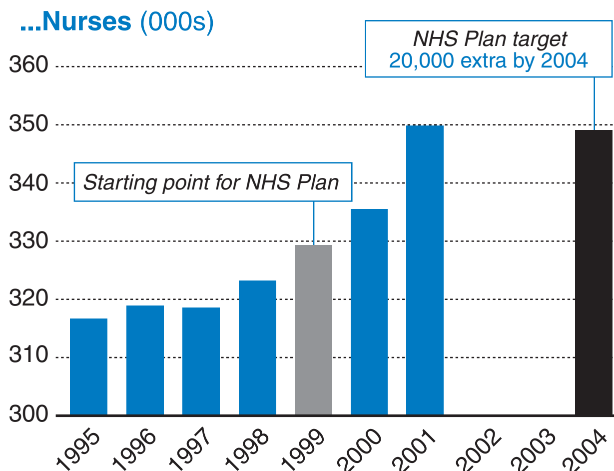
how might things change?

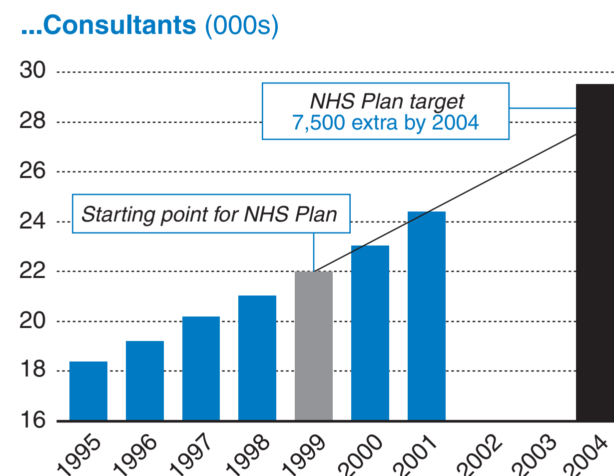
The Government has recently set out new targets for NHS staffing, covering the period up to 2008. However, there are several developments that may make further progress more difficult. For example:

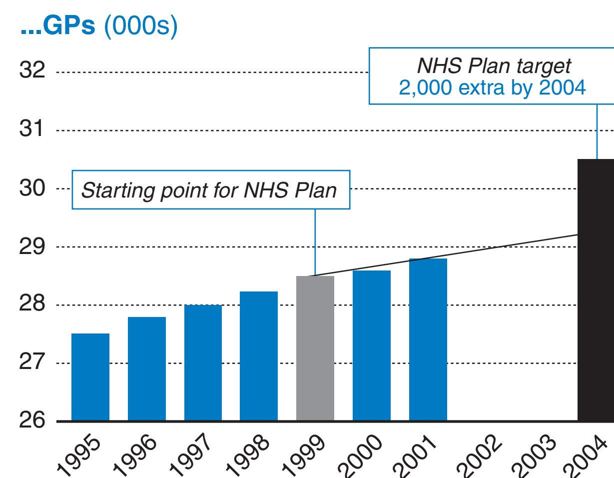
- There are increasing restrictions on the working hours of hospital doctors. As the NHS increases the number of hospital doctors, regulations – such as the European Working Time Directive – are reducing the number of hours that each one may work.
- Many GPs are approaching retirement age. To encourage them to work until their 65th birthdays, they are being offered a 'golden goodbye' of £10,000.
- Increasing numbers of GPs are opting to work part-time. Some of the value of recruiting extra GPs will be offset by their tendency to work shorter hours than was the case in the past.
- Many of the current nursing staff are also coming up to retirement and it will therefore be difficult to maintain the current workforce.

While the health service can turn to overseas recruitment to fill both medical and nursing vacancies, this may not be a long-term solution: we do not know how long these staff will wish to work in England.

Progress towards the NHS Plan target for...







resources

NHS efficiency

Spending more on healthcare does not necessarily mean that the public will get better services • The NHS must operate efficiently to give value for money • There is some evidence that it does so and there are plans to improve its efficiency over the next few years

what is the issue?

The Government has promised to increase health spending up to the European average. But any extra money will bring improvements only if the NHS spends efficiently. Efficiency can be defined as the relationship between the cost of the NHS and the results that it achieves – in other words, value for money.

how is the NHS doing?

now

One way to judge the efficiency of the NHS is to compare it with that of health services in other countries. This is difficult to do, however, because health services in different countries are organised in very different ways. Additionally, poor performance in some areas may be offset by good performance in others. For example, the NHS has a worse record on cancer survival than Germany but England has better overall life expectancy.

A recent report by the World Health Organisation (WHO) attempted to make a comparison of the efficiency of 191 countries' health services. The UK was ranked ahead of countries including the United States, Australia and New Zealand (England was not considered separately). Among our European neighbours, comparisons make clear that higher expenditure does not automatically equal better healthcare. For example, although France achieves better results than the UK, while spending more per head, Germany spends even more than France while achieving less than either of the other two countries.

Although international comparisons are difficult to do accurately, the WHO analysis provides some evidence to show that the NHS gives relatively good value for money. The WHO scored UK healthcare highly for increasing the healthy life span of the population, and also for the fairness of the way in which it is funded. However, a lower rating for 'responsiveness' – covering factors such as waiting times and how easy it is to choose who cares for you – reduced the UK's overall score.

differences around the country

Within England, the measurement of health service efficiency has focused mainly on hospitals. The NHS monitors the quality of hospital care using a wide range of measures – including many of

development papers

those discussed in this Commentary. However, to calculate 'value for money' we need to know something about cost, as well as quality. The NHS now requires every hospital to estimate the cost of each of a standard set of treatments. These estimates are known as 'Reference Costs' and show, for example, that giving someone an artificial hip joint costs an average of £4,179, while restoring a person's eyesight by removing a cataract costs £583.

WHO ranking of health services (2000)

	Results (1st is best)	Health spending ($ per head)
France	6th	1,634
UK	9th	1,156
Germany	14th	1,832

The tables of Reference Costs published by the Department of Health reveal just how much costs vary from hospital to hospital. For example, some 200 hospitals provide hip replacement operations. However a quarter of these hospitals report that the operation costs less than £3,500, while 50 or so of the most expensive hospitals have costs in excess of £5,200.

Some of this variation will be to do with factors outside the hospitals' control, such as the costs of staff and of goods and services in different parts of the country. There may also be some variation in the way that hospitals work out their costs. However the scale of the variation suggests that some hospitals will have scope to improve their efficiency by reducing costs while maintaining quality.

trends

Until recently, the NHS measured its overall efficiency by comparing how many cases were treated in hospital with how much was spent. After accounting for inflation, this simple measure shows that efficiency was maintained throughout the 1990s.

Recently, the NHS has begun to use Reference Costs to track whether the costs of specific treatments are going up or down. Across the first two years of this scheme, many reductions in cost were achieved. In some cases this is due to the increasing number of operations undertaken without the need for an overnight stay in hospital ('day case surgery'). The latest set of Reference Costs shows a more mixed picture, with some costs falling and others rising. For example, the average cost of hip replacements has gone up by 7 per cent, while the cost of removing cataracts has fallen by 2 per cent.

how might things change?

Reference Costs will continue to be used as a way of measuring NHS efficiency and may be used to help to make comparisons with the costs of private treatment in the future.

The Department of Health recognises that efficiency is not necessarily improved by simply driving down costs. High quality care is not necessarily more expensive than poor quality care – and it may well be cheaper if, for example, the need to correct mistakes is avoided.

The need to balance cost and quality is also recognised in the Public Service Agreement between the Department of Health and the Treasury. This agreement encourages hospitals to match the costs of the best performers on waiting times and quality, as opposed to reducing costs to match those of the cheapest services. It is clear to the Government that the extra money now being given to the NHS must be spent efficiently, and that this efficiency must be demonstrated to the taxpayer.

resources

Management costs

The NHS needs managers to plan and organise its services • The proportion of NHS money spent on employing managers has fallen to around 4 per cent • The ideal level of spending on managers is difficult to determine. If it is cut too far, then services may suffer

what is the issue?

The NHS exists to treat patients and to try to prevent illness and disease – this work is carried out by doctors, nurses and other clinical and support staff. However managers help them to organise and run the services they work in. They are needed to bring together all of the people and facilities necessary to provide the best health services for the money available.

Health service management includes a wide range of roles. Senior managers must provide leadership for organisations that are often large and complex. The directors of a typical NHS trust are accountable for managing a budget of around £90 million, as well as for the quality of the services provided by the clinical staff. Managers are also responsible for some of the more day-to-day aspects of running health services. A lot of paperwork and record-keeping is needed to ensure that patients receive the treatment which their doctors prescribe, that hospital bills are paid and that medicines and equipment are available in the right place at the right time.

While the staff required to do all of this work are a necessary expense, the NHS needs to control how much is spent on management. If too much is spent then there will not be enough money to provide the frontline staff; but if too little is spent then the frontline will not have the support it needs.

how is the NHS doing?

now

The NHS currently spends £1.9 billion per year on managers. However, this huge sum of money must be put into perspective. Overall NHS expenditure is £45 billion so £1.9 billion represents just over 4p of every £1 spent.

While this is a small proportion of expenditure, this figure covers only those whose main job is in management. Senior doctors and nurses also have a management role – leading clinical teams and contributing to the planning of services, for example.

Because of this kind of 'hidden' management cost, it is difficult to compare our management spending with that of other countries. However we do know that because the NHS is funded through the tax system this probably reduces the cost of the management

and administration needed to run it. In countries such as the United States, where most people pay for healthcare through private insurance, a lot of staff are needed to work on the additional paperwork of checking claims and making payments.

differences around the country

The amount that is spent on health service managers varies from one part of the country to another. Each region of the NHS receives an allocation of money, and the proportion that each spends on managers varies from 4.2 per cent in the South West, to 5.4 per cent in London and the South East.

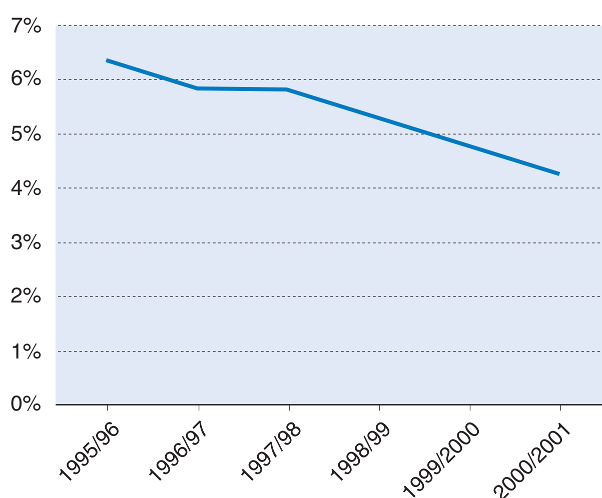
While some of this difference is due to the higher costs of employing staff in and around London, this is unlikely to explain it all. There are other possible explanations for the variation in management costs. For example, some areas may:

- provide a particularly complex range of services that need more managers to plan and run them;
- they may spend more on management and provide a better service as a result; or
- they may be more efficient – spending less on management but still giving a good service.

trends

The proportion of NHS money that is spent on management has fallen in recent years. In 1995/96, management costs accounted for 6.3p of every £1 spent on the NHS. By March 2001 this had fallen to 4.2p.

Management costs as a percentage of all NHS spending



how might things change?

Although the NHS Plan recognises that good management is central to delivering good care, the Government remains committed to ensuring that 'more money goes into frontline services rather than into bureaucracy'. But just how far should the NHS go to try to cut spending on management?

The immediate future may see an increase in the problems that managers face. The NHS is currently going through a major reorganisation: the 95 health authorities that are responsible for planning local healthcare services are being abolished, with responsibility for this work passing to 300 new Primary Care Trusts (PCTs). Big reorganisations of this kind can lead to a period of poorer performance as staff take on new roles so this may not be the best time to look for further cuts in the money spent on management. There is particular concern that some PCTs may not have enough managers with the right skills to provide all of the improvements in services promised in the NHS Plan.

There is a minimum amount that must be spent on management in order to keep the NHS running and to improve the services it provides. Unfortunately it is very difficult to say what this minimum amount is. We do know, however, that the performance of the NHS sometimes falls short because of failures in management. To solve these problems we might need to spend more on management, rather than less.

Waiting for an operation

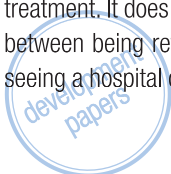
waiting for care

Just over one million people are waiting to go into hospital for treatment • The number of people waiting for more than a year has fallen from a peak in 1998, but this downward trend has now levelled off • By 2005 the Government plans to reduce the maximum waiting time for treatment from eighteen months to just six

what is the issue?

Around half of all patients staying in hospital are originally admitted as emergencies following incidents such as a heart attack or road accident. The other half have been waiting for treatment that has been planned in advance of their arrival at hospital. The delay between a decision to treat a patient and their admission to hospital is the waiting time. The waiting time should normally be as short as possible in order to achieve the best result and experience for each patient. There is also much discussion about how many people are waiting to be admitted, or the waiting list. From a patient's point of view, the amount of time that they have to wait is probably more important than the total number of people who are waiting.

This section looks at the amount of time between a decision to admit a patient into hospital and the day of their admission for treatment. It does not include the wait that a patient may have had between being referred to the hospital by their family doctor and seeing a hospital consultant as an outpatient. For about one in five patients, the wait to see a consultant can add more than three months to the overall waiting period, although most patients get an appointment in less than 13 weeks.



how is the NHS doing?

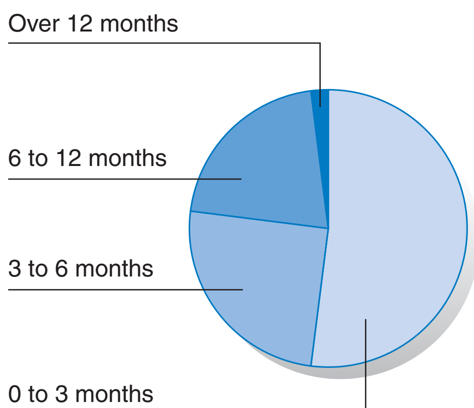
now

At the end of March 2002 just over a million people were waiting to be admitted to hospital. As the piechart shows, just over half had been waiting for less than three months and a further quarter had been waiting between three and six months. Twenty two thousand people had been waiting for between 12 and 17 months, and a handful had waited longer than the fifteen month target period.

differences around the country

There are significant differences between waiting lists in different areas of the country. For example, in September 2001 in the West Midlands, 17 people in every 1,000 were waiting to be admitted to hospital. In the North West the equivalent figure was 25 people

Amount of time people had been waiting for inpatient treatment in March 2002



in every 1,000 – a difference of 50 per cent. In most of the country around 20 people in every thousand were waiting to go into hospital.

trends

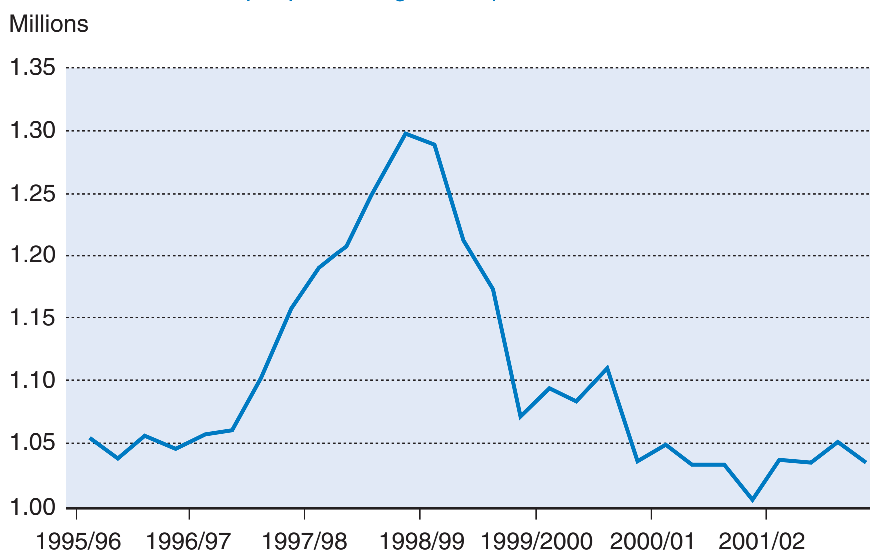
The graph below shows that over one million people are currently waiting to go into hospital. This is almost exactly the same as the number of people who waited in 1996. The number rose to a peak of over 1.2 million in 1998. The fall since then reflects substantial investment in treating people who have been waiting longest, as well as some use of private sector facilities. However, there are signs that this trend is levelling off.

how might things change?

The Government has provided significant additional resources to bring down waiting times. This includes £30 million to reduce the maximum waiting time to 15 months by March 2002. This target was narrowly missed and it is likely to be achieved in the near future. It is also intended that by 2005 the maximum wait to be admitted to hospital will be reduced from eighteen to six months, with no more than a three month wait for an outpatient appointment. This is an ambitious target and it may be difficult to meet as large numbers of people are waiting between six and eight months. In addition, increasing the capacity of the NHS to carry out operations may result in more patients joining the waiting list, simply because the prospect of being treated in a reasonable time has improved.

To help the NHS achieve these targets the Department of Health has started a range of initiatives that aim to increase the capacity of the NHS to treat patients who need surgery. In addition to increases in NHS staff, premises and equipment, these initiatives include: increasing the use of private hospitals to carry out operations on NHS patients; patients travelling to hospitals in other European countries for treatment; and surgical teams from abroad coming to carry out operations in England. There are also specific plans for patients who have been waiting more than 6 months for heart surgery. From July this year, they will be able to discuss the option of being treated in hospitals that can do the operation more quickly.

Number of people waiting for hospital admission 1995 to 2002



The ambulance service

The ambulance service is a key part of the NHS, making nearly three million emergency journeys and transporting 16 million non-urgent patients a year • During the 1990s, in spite of increased demands, the service continued to respond to over 90 per cent of calls within overall target times • Up to April 2001 most services were not meeting the new target for responding to 75 per cent of life threatening calls within eight minutes

what is the issue?

The ambulance service is facing pressure from rising demand as well as from new performance targets. These targets require greatly improved response times to the most urgent calls. All services have now introduced the new system of call prioritisation that assesses calls as either immediately life threatening or as less urgent, with differing responses times for each. Results in 2000/01 indicated that some services were having problems reaching the targets, but the data from 2001/02 shows that all are now doing so. More effective use of equipment and better planning of ambulance deployment, extra investment and increases in staff are clearly having an impact, though the target remains challenging.

how is the NHS doing?

now

Over the last ten years, the ambulance service has coped with a significant increase in the number of emergency journeys. In 2000/01 the service took 4.4 million calls, which is almost 50 per cent more than in 1990. The service has succeeded in continuing to respond to nine out of ten calls within 14 minutes in urban areas and within 19 minutes in rural areas.

In 2000 a system of call prioritisation was introduced. Calls are categorised either as:

A	immediately life threatening;
B	serious; or
C	neither serious nor life threatening.

Target times for categories B and C remained the same but a new target for Category A calls was introduced. This was that 75 per cent of Category A calls should be responded to within 8 minutes.

Ambulance services have gradually introduced this system and all services now operate call prioritisation. In 2000/01, 60 per cent of Category A calls (life threatening calls) and just over half of the less urgent Category B and C calls, were responded to within these target times.

In 2000/01, only 3 services out of 31 responded to over 75 per cent of their Category calls within 8 minutes; 12 responded to between 65 per cent and 75 per cent within this time. Sixteen responded to less than 60 per cent of Category calls within the target time. However the Department of Health has reported initial figures for 2002 from Ambulance Services that suggest that almost all services are now meeting the target. Whether this early trend is maintained remains to be seen.

differences around the country

There is no clear link between the type of area – urban or rural – and the response time, although some of the larger urban and rural services initially found it difficult to meet the new targets, particularly London, West Country Ambulance and Greater Manchester.

The performance of the best and worst performing ambulance services remained the same after call prioritisation, although a few services did significantly improve their performance, notably Avon and Mersey. In the majority of cases performance improved following call prioritisation.

Overall, there was a wide range of performance against the eight-minute target. In London 41.8 per cent of Category A calls are met, while in Staffordshire the figure was 87.4 per cent.

The range of performance on the 14 (and 19) minute targets is narrower; it was 88.3 per cent in the West Country compared with 99.6 per cent in Staffordshire, for example. Staffordshire had the best performance on both indicators and the London Ambulance Service had the worst.

trends

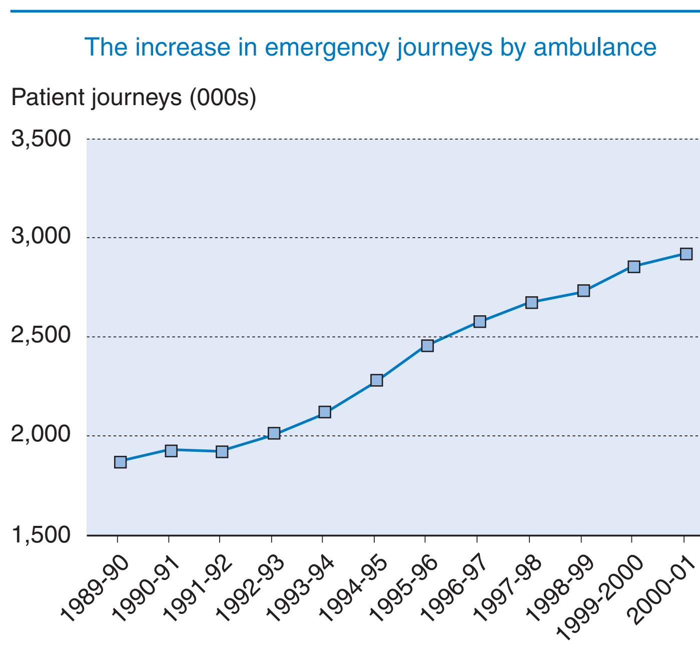
The ambulance service has coped with a major increase in demand during the 1990s, as the graph below shows. It has continued to meet over 9 out of 10 calls within 14 minutes in urban areas and within 19 minutes in rural areas.

In almost all services, performance has improved over the decade and, on average, progress improved following call prioritisation.

how might things change?

Almost all services are steadily improving their performance against the new targets. The majority should be responding to 75 per cent of the life-threatening Category A calls within 8 minutes by 2004, based on current trends. The initial figures for 2002 suggest that improvements in performance are continuing. However, it is still possible that a minority may not meet this target.

The Department of Health has announced that it intends to further develop the system of call prioritisation. They plan to divert calls to the NHS Direct telephone helpline, if they are not serious enough to require an ambulance to attend. This new system is being tested in the West Midlands and will be extended if it is successful.



Waiting times in accident & emergency

waiting for care

In recent years, waiting times have increased for many people who attend Accident & Emergency (A&E) departments • Some progress has been made towards ending very long 'trolley waits' for those patients who need to be admitted to hospital • Delays in A&E are often caused by problems elsewhere – both inside and outside the hospital

what is the issue?

More than 15 million people are treated in A&E each year. Around two in every five A&E patients are judged to need urgent attention, and almost one in five needs to be admitted to hospital as quickly as possible. However, there is concern that some people have to wait too long for treatment in A&E. Some patients wait only once, for treatment from a doctor or nurse. Patients who need to be admitted to a ward may have a second wait (a 'trolley wait') while staff find them a bed. Patients find long waits distressing and medical conditions can worsen during the delay.

Long waits are caused by a combination of factors. Some are to do with the A&E department itself, such as the number of cubicles for seeing patients, the number of staff in the department, and so on. Some are to do with other parts of the hospital – the wards may not have enough free beds, or there may be delays in providing x-rays and blood tests.

Factors outside the hospital can also have a knock-on effect. For example, if the local area does not have enough places in residential or nursing homes, then some patients may not be able to leave hospital when they are ready to do so (see *Delays in leaving hospital*). This can reduce the number of free beds on the wards, and result in trolley waits in A&E.

how is the NHS doing?

now

An Audit Commission survey of Trusts in England in 2000 found that:

- around half the people attending A&E were seen within an hour for treatment by a doctor or senior nurse; the other half waited longer; and
- around three out of four patients who needed admission were found a bed in under four hours from their arrival; one in four waited longer.

differences around the country

The Audit Commission survey found that there were differences around the country in how long patients had to wait. In some hospitals almost everyone was seen within an hour of arrival. Other hospitals were able to see less than one in four patients in that time.

Hospitals also vary a lot in terms of how quickly they are able to find beds for patients who need to be admitted. Hospitals that admitted relatively few patients within four hours also tended to keep patients waiting for longer than an hour to be seen for their initial consultation with a member of staff.

trends

Since the mid-1990s, the number of visits made to A&E has increased by about 150,000 each year. The Audit Commission has followed changes in waiting times up to 2000. As the graph shows, waiting times got worse over this period: the proportions of people seen within an hour, and admitted within four hours, reduced.

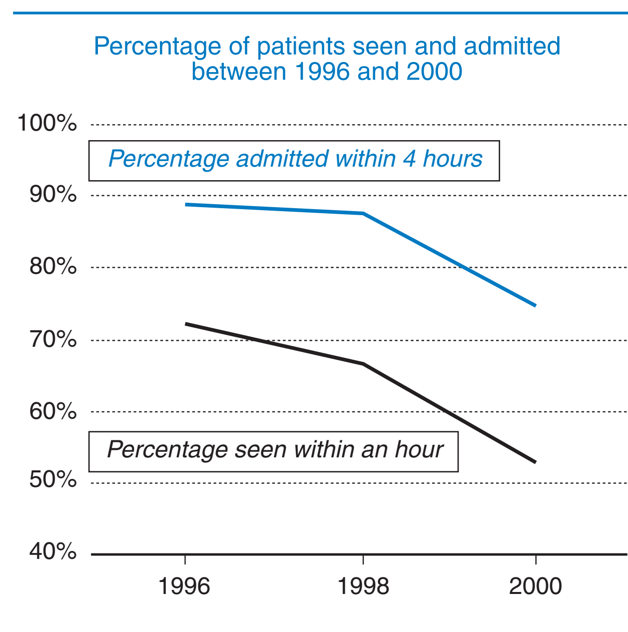
However, progress has been made in reducing the number of extremely long trolley waits. An official report showed that between 1999 and 2001 trolley waits of more than 24 hours had been 'virtually eliminated', and waits of over 12 hours had more than halved. While this progress is welcome, waits of more than 12 hours for admission could mean that urgent treatment is seriously delayed.

how might things change?

The Government's aim is that by 2004 no-one should wait for more than four hours from their arrival at A&E until they are either admitted, transferred to another hospital, or discharged home. As this applies to *all patients* visiting A&E – from patients with minor cuts and bruises, to the most complicated of cases – this is an ambitious target. While detailed performance figures are unavailable, early indications are that around three-quarters of patients are currently spending less than four hours in A&E. Because it will be especially difficult to achieve this target for people who need to be admitted, the Government plans to give particular attention to them by separately monitoring the total amount of time they wait.

The fact that waits in A&E are influenced by the performance of other services can make them complicated to resolve. The approach being taken by the Audit Commission and others, including the NHS's own Modernisation Agency, is to first understand how the whole system of local services operates, and then to find ways of dealing with the 'bottlenecks'.

Nationally, the Government's plans to reform emergency care also aim to deal with some common bottlenecks. Proposals to increase staff numbers (see *Nurses and doctors*) and to provide new services to those people who have non-urgent problems may be important factors in reducing the amount of time that people wait in A&E.



waiting for care

Delays in leaving hospital

Many older patients have to stay in hospital longer than they need to because arrangements for their continuing care have not been made • This causes problems for patients and their carers, and for the NHS • The NHS and local authorities need to work together to improve the situation

what is the issue?

Many older NHS patients are well enough to leave hospital, but find themselves staying unnecessarily for days, or even weeks, because arrangements have not been made for their care when they leave. This problem of delayed discharge is sometimes called 'bed blocking'.

Older patients often need extra care after they are discharged from hospital. Some move into a nursing or residential home; others can return to their own homes if home care staff are available, or if adaptations are made – if stair lifts are put in, for example. These arrangements need to be in place before the patient can leave. A delay means extra time in hospital for the patient.

how is the NHS doing?

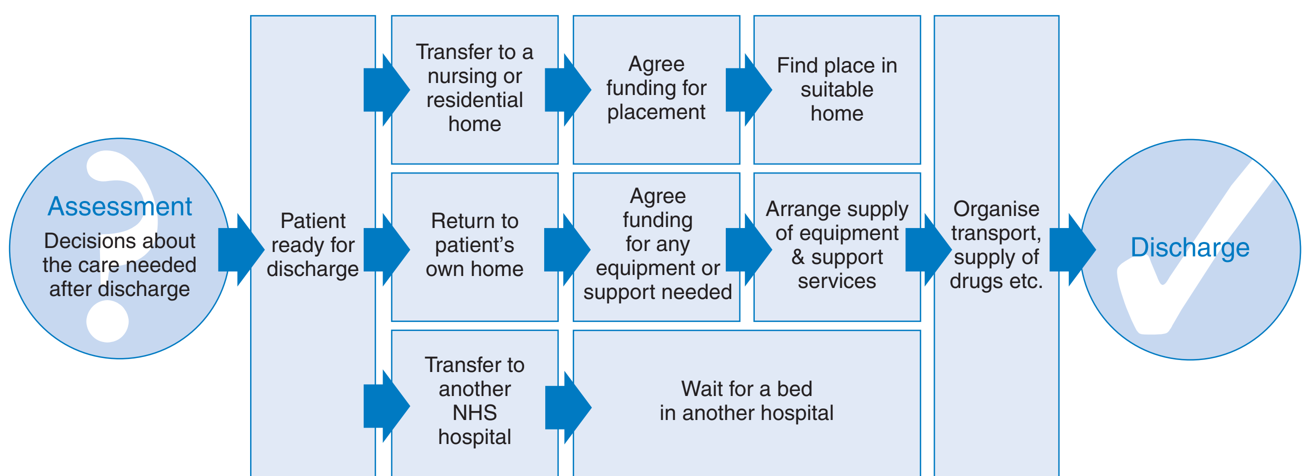
now

Official figures show that nearly one in ten patients over 75 years old have their discharge from hospital delayed unnecessarily. This still means that on any one day nearly 4,700 of these 'well' patients take up 2.5 per cent of the NHS hospital beds in England.

Delayed discharge causes serious problems:

- It delays the patient's return to a more comfortable and independent life.
- The patient may pick up an infection while in hospital.
- Money is spent on hospital care for a patient who does not need it.
- Other patients who do need hospital care have to wait to be admitted – this can mean longer waiting lists or long waiting times in A&E.

The diagram sets out some of the steps that have to be taken before a patient can leave hospital. It is a complicated process and delays can occur at any stage. For example, even where a patient is returning home with no need for care services, the hospital may need to arrange transport and ensure that the patient's 'take home' drugs are ready. A delay to either arrangement can mean that the patient spends an extra night on the ward.



Longer delays occur when a patient has more complex needs that may need to be assessed jointly by social workers and NHS staff. Assessments take time and should begin before the patient is ready to leave hospital. However, an official survey in 2001 revealed that 21 per cent of older patients were waiting for discharge because their assessments had not been completed. A further 29 per cent of discharges were held up because no suitable care home place was available. In some areas there are not enough care home places to cope with demand.

Even when a suitable place is available, 14 per cent of older patients find that their move is delayed because the money to pay the care home has not been made available by the local social services department.

differences across the country

The extent of the delayed discharge problem varies across the country, with 'clusters' of high and low rates. Interestingly, high rates tend to occur in the more prosperous areas of the country. One reason for this may be that where property prices are high, fewer residential care places are available because care homes have been closed and the buildings sold.

trends

In the year to March 2001 around one in eight older patients had their discharge delayed. The Government aimed to reduce the rate to one in ten by March 2002 and the latest figures show that this target was met. As a result of this, over 1,000 beds have been 'unblocked' for patients who need them.

how might things change?

By March 2003, the Government aims to have achieved a further 20 per cent reduction in delayed discharges of older patients. Reaching the new target would release another 1,000 beds for patients who need a stay in hospital.

As levels of delayed discharge vary throughout the country, the Government is targeting extra money at the worst affected areas. Local councils have been asked to use this money to increase the availability of care homes and services. Money has also been spent on providing an extra 2,400 'intermediate care' beds for people who are well enough to leave hospital, but are not yet ready to return to their own home or to move to a residential home. Another 2,600 of these beds are planned.

To encourage local councils to provide access to care home places as quickly as possible, it is likely that, in the future, they will have to reimburse hospitals for the costs of keeping older people in hospital unnecessarily.

Delayed discharge is a complicated issue involving hospitals, GPs, social services and care home providers, as well as patients and their families. While new resources and incentives may help, difficulties are sometimes caused by poor communication. Solving the problem of delayed discharge will also require closer working among those people who help patients to move from hospital back to the community.

Hospital food

In contrast to its general reputation, most patients rate their hospital food as at least 'good' • Hospitals need to make sure that they help patients who are in danger of being malnourished

what is the issue?

The food offered in hospitals is an essential part of patient care. Patients need nutritious and appetising food to help them to recover fully from their illnesses. Every year the NHS spends £275 million on hospital catering and produces approximately 220 million meals for patients.

how is the NHS doing?

now

The NHS appears to be doing well – the majority of patients rate their hospital food as either 'good' or 'excellent'. A recent Audit Commission study found lots of examples of high quality service including, for example, pureed foods were available for patients who needed them; it was possible for meals to be cooked to order; and some menus included food from various cultural traditions.

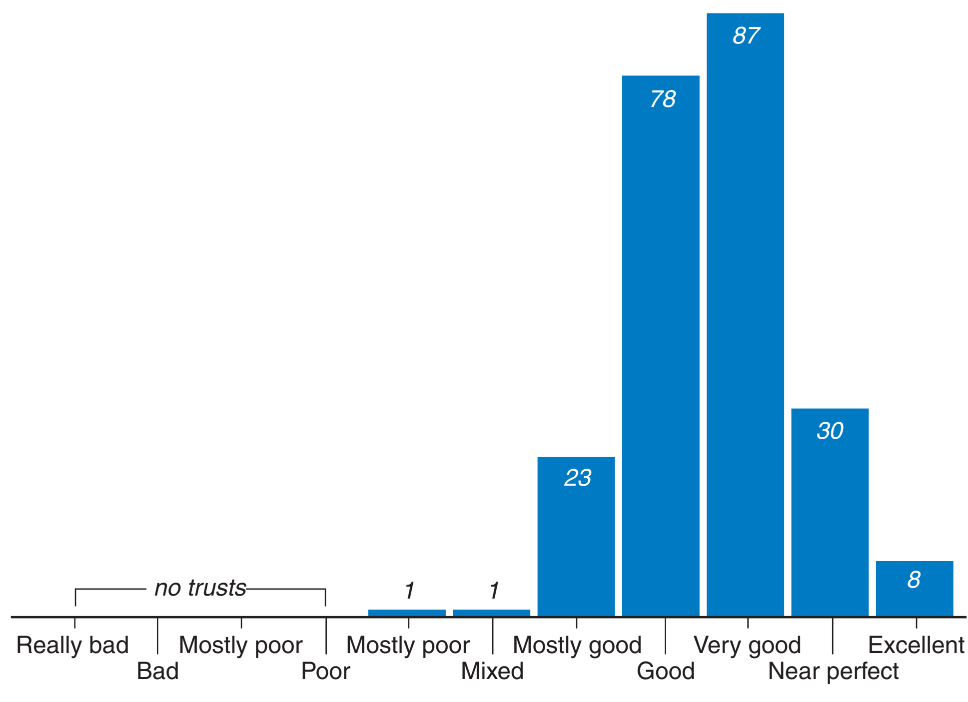
But there were some common problems with the quality of the service. For example:

- elderly patients were not always given the help they needed to feed themselves and the amount they ate was not checked in many hospitals;
- the time taken to hand out meals meant that hot food was sometimes cold by the time it reached patients;
- meal times were not always respected as an important part of the patient's day and they were often disturbed by doctors carrying out ward rounds and nurses undertaking routine observations; and
- maternity patients sometimes missed set meal times and so went without food for long periods.

Hospital meals need to be more than hot and appetising. They must also be a good source of nutrition. Four out of ten adults admitted to hospital are either malnourished when they arrive, or become malnourished during their stay. But we found that around one hospital in four does not have a system for finding out the nutritional needs of their patients when they are admitted. When there is a serious risk of malnutrition, patients should see a hospital dietician. At many hospitals however, dieticians report that they are unable to visit all the patients they are asked to help.

development papers

Average satisfaction scores for catering at 228 NHS Trusts



differences around the country

Patients' satisfaction with hospital food does vary from place to place, as the graph shows. While most hospitals generally get good ratings from their patients, a few hospitals had more than their fair share of bad reviews. Oddly, the hospitals with poor ratings were not those spending the least money on food. In fact, we found that hospitals spending as little as £4 per patient per day often had the same good scores as hospitals spending twice as much.

So, it is not just about money. Getting the right food to the right patient at the right time is a complicated task. It involves nurses, porters and other NHS staff, as well as catering staff. High quality food can go to waste unless everyone involved works well as a team.

trends

We only have results from one set of hospital surveys, so we do not yet know how things compare with previously.

how might things change?

Most hospitals currently meet the Department of Health's minimum standard which is that:

- seven out of ten patients give a score of at least 7/10 – meaning 'good'; and
- only one in ten gives a score of less than 5/10 – meaning 'mixed'.

The Audit Commission's auditors are working with hospitals that do not make the grade to discover why patients are not satisfied and how the service can be improved.

It is vital that hospitals make sure they have systems to identify and respond to the individual nutritional needs of patients. The Commission will look at their progress when it re-examines hospital catering in two years' time.

The NHS has now launched a 'Better Hospital Food' initiative. Over four years, £38.5 million is being spent to improve hospital catering. Changes include making it easier for patients to get snacks around the clock, and a modernised 'NHS menu' featuring dishes designed by well-known chefs. While many hospitals failed to make the required changes by the December 2001 deadline, there is evidence that some are now catching up. Future surveys of patient satisfaction will show how successful the overall initiative has been.

Improving the appearance of hospitals

An extra £60 million has been made available to help clean up hospitals • All hospitals visited in the latest round of inspections were judged to provide at least an 'acceptable' standard of cleanliness and appearance • It has been estimated that the backlog of repairs and maintenance across the NHS in England will require approximately £3 billion to clear.

what is the issue?

Hospitals need to be kept clean, well maintained and welcoming. Not only are patients are entitled to be cared for in pleasant surroundings, keeping premises clean and tidy can help to avoid accidents.

how is the NHS doing?

now

Patient Environment Action Teams (PEATs) were set up by the NHS to check how clean, comfortable and well-decorated NHS hospitals are. The PEATs grade each hospital, examining entrances and reception areas, visitors' and ward toilets, cleanliness and the state of the decoration. Each hospital is allocated a traffic-light colour:

- **Green** hospitals provide high standards that meet the needs and expectations of patients

- **Yellow** hospitals provide standards that are acceptable. While there is much to be proud of, there is room for improvement
- **Red** hospitals provide a poor quality environment for patients. Standards here need to be raised as a matter of priority.

In the NHS Plan, the Government promised an immediate 'nation-wide clean-up campaign' for hospitals. Launched in July 2000 as the Clean Hospitals Programme, the campaign has provided £60 million to pay for additional cleaning, furniture repair and replacement, improved decoration and new signs. Each of the 290 NHS Trusts that run hospitals in England received over £200,000 on average.

The NHS Plan also identified £3 billion-worth of outstanding repairs and maintenance across the NHS. A third of all NHS buildings were built before the NHS was established in 1948. So the age and state of repair of some hospitals adds to the difficulty of providing pleasant and clean surroundings for patients.

differences around the country

There is significant variation in the standards achieved by hospitals in different parts of the country. In November 2001, the South East region had the smallest proportion of 'Green' hospitals - less than one in three reached high standards. The North West region had the highest proportion – more than four out of five hospitals were reported to have a high standard of cleanliness.

trends

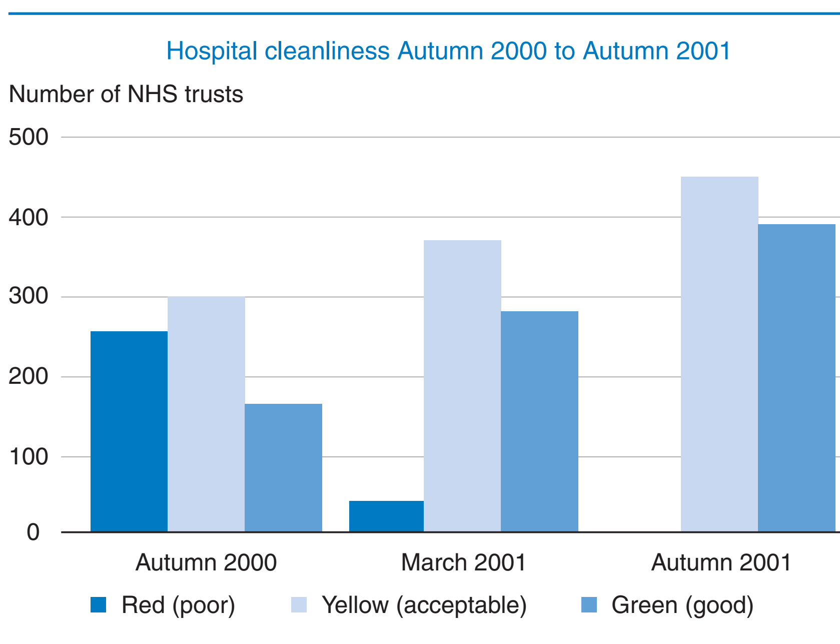
In Autumn 2000, in the first round of inspections under the Clean Hospitals Programme, more than one in three hospitals were given a Red rating to reflect the poor standards of the patient environment and of cleanliness. In November 2001 a second check was made, and many improvements were reported: all of the hospitals that were previously rated as poor or acceptable were judged to have reached either acceptable or good standards, as the graph shows.

how might things change?

Although the PEATs will be making further monitoring visits, and the Clean Hospitals Programme will continue to offer advice on maintaining standards, the £60 million already provided was intended to be a one-off payment. Without on-going funding some hospitals may see standards decline if they have to rely on cleaning and maintenance budgets.

Evidence from the next round PEAT inspections will be supplemented by the first national survey of NHS inpatients, which will include questions about hospital cleanliness. The survey, which has now been conducted, will be the first fully independent assessment on this topic, and will provide a patient's eye view of the success of the Clean Hospitals Programme.

The Government is also trying to tackle the wider problem of the NHS's ageing and dilapidated buildings, recognising that a one-off clean-up campaign will not solve this much larger underlying problem. In addition to a programme of building new hospitals (with 15 currently under construction) the NHS plans, over four years, to clear at least a quarter of the £3 billion maintenance backlog that was identified in 2000. The latest provisional figures, however, emphasise how difficult this will be to achieve, as they show there has been little change in the first year.



patient's experience

GP surgeries

One in ten GP practices did not meet basic minimum standards and only one in five were accessible to disabled people, according to recent official figures • The NHS Plan promised to refurbish 3,000 – about a third – of all GP surgeries by 2004 • The Department of Health has major investment plans and progress is being made, but the scale of this task is considerable

patient's experience

what is the issue?

A GP's surgery is often a patient's first point of contact with the NHS. Dismal and outdated buildings can leave patients and staff depressed and insecure. They can also prevent some groups of people, such as people in wheelchairs, actually accessing the services that are based there. On top of this, in the last couple of years, unsuitable premises have seriously hindered the modernisation of services. For example, they have made it difficult to expand the range of services that are provided, and to house the increasing range of practitioners who work in them. However, making changes to buildings is often complex and costly.

The Government wants to refurbish 3,000 GP surgeries, and to set up 500 one-stop primary care centres by 2004. The one-stop centres will extend the range of services currently available to include physiotherapy, chiropody, pharmacy, dentistry, social care and welfare advice from convenient locations. Under the Disability Discrimination Act (DDA) 1995, disabled people should have physical access to all services by the same date.

how is the NHS doing?

now

The Government has set minimum standards for GP surgeries, such as:

- waiting rooms must have enough seats;
- facilities should be kept clean and in a good state of repair;
- there should be adequate lavatory and washing facilities; and
- there should be proper fire escapes, emergency exits, and so on.

However, official figures showed that nearly one in ten practices fail to meet these most basic standards in March 2001.

Furthermore, the same figures showed that only one in five practices complied with the part of the DDA that concerns physical access to services. This means that most practices had not yet made it possible for patients with mobility problems and other disabilities to easily enter and move around their premises.

Of course there are many practices with high quality premises. We know that almost half met the Government's latest standards for spaciousness – a key factor in providing comfortable conditions for patients and staff.

differences around the country

The standard of GP premises varies considerably around the country. London consistently stands out:

- one in three GP practices in London did not meet the minimum physical standards for GP practices, as opposed to the Northern and Yorkshire region, the North West and the South West where most do; and
- almost no practices in London reported an adequate level of adjustments to improve access for people with disabilities.

Factors contributing to these differences are likely to include the facts that:

- property prices are highest in London; and
- there are more old, listed and historic buildings in London.

trends

The Government figures that will show whether standards have improved over time are not yet available.

how might things change?

There are signs that progress is being made. In a recent report the Department of Health estimated that one in five of the surgeries being refurbished or replaced, and one in five of the one-stop centres being set up, would be ready by the end of March 2002. Final figures for this period are not yet available.

The Department of Health and the Disability Rights Commission have produced 'how to...' guidelines to help surgeries to improve their premises, and access to them. However, some surgeries are likely to continue to find it difficult to secure the management time, planning permission and funds to do this, which has led to concern that they may not meet the 2004 targets in time.

New investment has been promised through the extension of the Private Finance Initiative to primary care. While 18 pilot sites have been agreed and awards made, it is too early to tell whether this scheme will be successful.

Helping people to stop smoking

The NHS has an important role to play in preventing, as well as treating, ill health • Smoking causes many diseases and it is a contributing factor in one in five of all deaths in England • Encouraging people to stop smoking can prevent long-term illness and premature death and so releases NHS resources for other uses

what is the issue?

As well as treating people who are ill, the NHS, working with local authorities and voluntary services, also works to promote better health and knowledge of how to avoid illness, disease and early death.

Smoking greatly increases the risk of heart disease, strokes, most common cancers, bronchitis and many other illnesses. It is a contributing factor in 120,000 deaths in England every year – a fifth of all deaths.

Once someone has stopped smoking, their risk of having a heart attack or stroke reduces by around half within two years of their last cigarette. Getting people to stop smoking has major health benefits.

Smoking is much more prevalent among the poorest social groups and may be responsible for inequalities in death rates and life expectancy between the poor and the better off. Smoking also varies between ethnic groups – for example, nearly half of Bangladeshi men smoke, compared with almost a third of men in the general population.

development papers

how is the NHS doing?

now

Many anti-smoking campaigns have been based on general advertising, and have had the most success among the better off. In the last few years the NHS has taken a different approach, supporting more varied 'smoking cessation programmes'. These include specialist advice, encouragement and the prescribing of nicotine patches, nicotine chewing gum and drugs to reduce nicotine cravings. Initially these schemes were based in 20 areas, known as Health Action Zones, that tended to report the highest rates of smoking. Today, all areas are able to offer these services to help people to quit. The schemes have had some success, with about half of the 153,000 participants reporting that they gave up for at least four weeks.

For the current year smoking cessation will cost the NHS about £21 million, but it is estimated that treating the effects of smoking costs the health service up to £1.7 billion a year. This means that NHS spending on preventing smoking is only around 1 per cent of

that spent on treating its effects. If the short-term success of smoking cessation programmes leads to people giving up smoking permanently, then they would be a very cost-effective way of improving health.

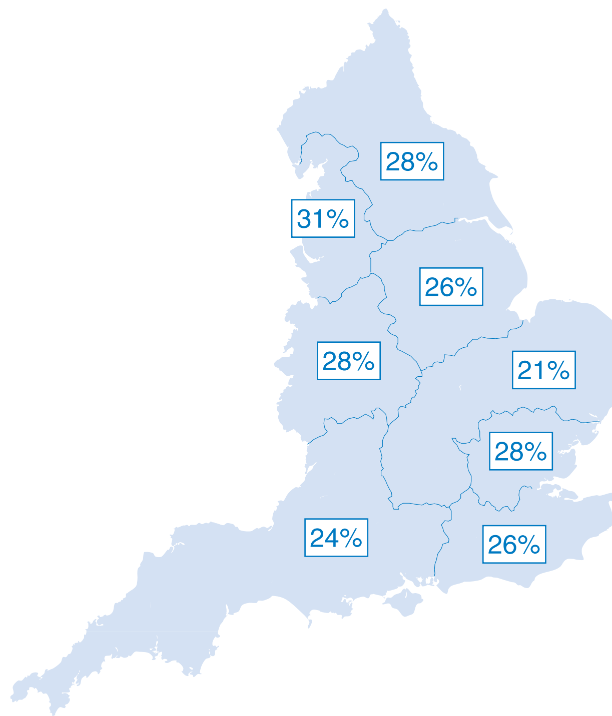
differences around the country

Smoking rates vary across the country. In England as a whole, just over a quarter of adults smoked in 1998. People living in the Anglia and Oxford NHS Region smoked the least, with 21 per cent of adults regularly smoking tobacco products. The figure was 31 per cent in the North West Region, which reported the highest rate in England.

trends

In 1978, 40 per cent of all adults smoked. This fell over the next 20 years to a low of 26 per cent in 1994. The number of people smoking has since risen slightly to about 28 per cent, due to an increase in the number of younger smokers. The number of smokers aged between 20 and 24 has risen to 40 per cent, and smokers in the range 16 to 19 years have risen from 27 per cent in 1992 to 31 per cent in 1998. However, recent figures do show a reduction in the number of smokers aged 14 and 15 years old.

Smoking rates in regions of England 1998

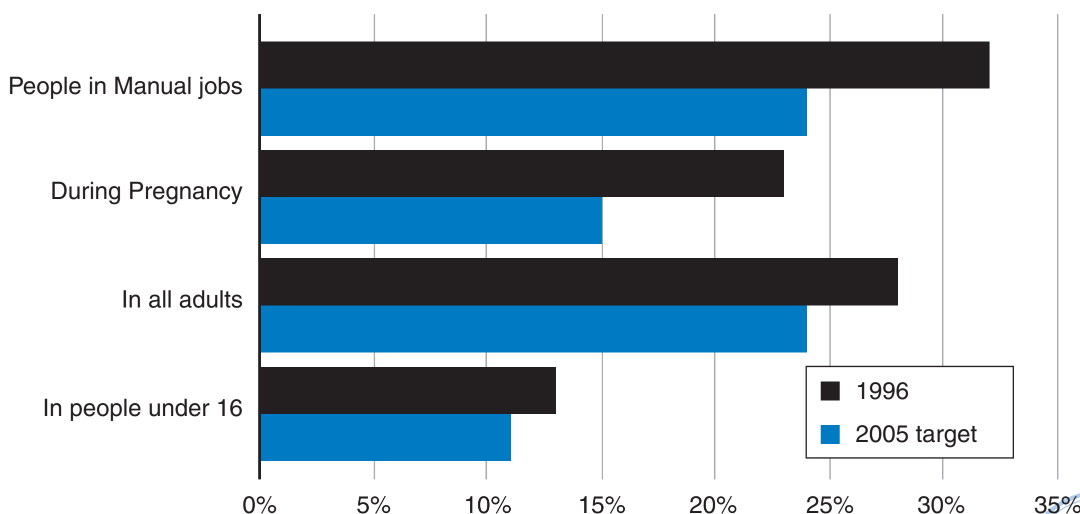


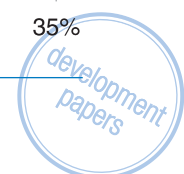
how might things change?

The Government has published plans for reducing the numbers of deaths from heart disease and from cancer. Both of these diseases are greatly affected by smoking and Government targets for reducing the proportion of people who smoke have been set. The chart shows the proportion of key groups of people who smoked in 1996, and the targets the government has set for reducing these rates by 2005.

Smoking cessation programmes have been useful in helping people to stop smoking. If those people who do quit remain non-smokers in the longer term, then the schemes would represent very good value to the NHS. Smoking cessation schemes are now being set up across the country. If the expanded programme is able to maintain the early rate of success, over 500,000 people will have quit smoking with the help of the NHS by 2010.

Progress towards targets for reducing smoking in key groups





outcomes

Preventing suicides

Every year, more people kill themselves than are killed in road accidents • The NHS has a particular responsibility to care for some of those people who are most at risk of suicide. There is room for improvement in primary care, A&E and mental health services. • Government plans take a sensible approach to reducing the number of suicides, but there is concern about the difficulty of putting them into practice

what is the issue?

Around 5,000 people kill themselves each year in England. This amounts to about 13 people every day – more than the number killed in car accidents. Many factors contribute to the risk of suicide:

- mental health problems;
- physical illness;
- major life changes, such as job losses and relationships ending;
- lack of social support;
- poverty, low income and poor housing;
- drug and alcohol misuse; and
- having access to lethal methods.

While the NHS can help to reduce the impact of some of these factors, it has a particular responsibility to care for those people who are most at risk - such as those who have already attempted suicide. There are opportunities for NHS staff to help as many of those at high risk have contact with services (as the box shows).

how is the NHS doing?

now

GPs have an important role to play in detecting early signs of depression and organising care for those at high risk. This is a difficult task however, and it has been shown that GPs may miss around half the cases of depression among their patients.

We know that once someone has attempted suicide, or deliberately harmed themselves, they are more likely to kill

development papers

themselves in the future. So it is important that they get appropriate help once they come into contact with services. Most of this group will find themselves in A&E, where their medical needs will be treated. Their risk of suicide should also be assessed so that they can be referred for more specialist care if necessary. However, studies have shown that more than half of these people may be discharged without their suicide risk being assessed and so they may be missing out on the specialist care they need.

A quarter of people who committed suicide between 1996 and 2000 had been in touch with mental health services in the previous year.

Last year, A&E departments dealt with 130,000 incidents in which someone had attempted suicide or had seriously harmed themselves.

A study of older people who had committed suicide showed that almost half had visited their GP in the month before.

People with serious mental health problems – who are cared for on psychiatric wards or by teams working in the community – are at much greater risk of suicide than the general population. A national inquiry found that for some of these patients, risks are highest in the fortnight following discharge from psychiatric hospital. As a result, the NHS aims to have all patients judged to be at particularly high risk of suicide seen by a specialist social worker or nurse within a week of discharge. However, the most recent official figures show that only seven out of ten of these patients were seen within this time. This means that around one in three of this very vulnerable group was not seen when they were most at risk.

differences around the country

The suicide rate varies around the country. It is higher than average in the London, North West and Yorkshire regions. The rate is lowest in the Eastern region. These rates will be affected by the factors listed above, as well as by the effectiveness of local health services.

The proportion of high-risk mental health patients who are followed up after discharge from psychiatric hospital also varies. In the North West, more than eight out of ten patients are seen within a week. In Northern and Yorkshire region, fewer than five out of ten are seen within this time, and in the Eastern region the figure is even smaller.

trends

In the last 20 years or so, overall suicide rates have fallen – by more than 12 per cent since 1982. But there are exceptions to this general trend. Over the same period, the rate among young men has risen to the point that suicide is currently the most common cause of death in men under 35 years old. There is also consistent evidence of higher rates among young Asian women, particularly those from Hindu and Sikh communities, and of a quite dramatic increase in the suicide rate among prisoners.

It is not yet possible to assess whether the follow-up of high-risk patients is improving, as the necessary information has only been collected for a year.

how might things change?

The Government aims to reduce the annual number of suicides in England to 3,600 by 2010. This is an ambitious target, and a previous target was missed. As suicide has such a mix of causes – psychiatric, psychological, social and economic – progress needs to be made on all of these fronts to reduce rates. The Government recognises this. As well as initiatives to reduce poverty and social exclusion, they aim to improve mental health services.

The plans look promising. They recognise the range of factors involved in causing suicides and the different groups that need to be involved to reduce them. Within the NHS, they recommend specific improvements to the services that are most used by people at risk – A&E, hospital and community mental health services, and prison services. They also stress the importance of primary and social care in assessing and managing suicide risk, and of care being properly co-ordinated.

The benefits of the plans will only become clear as they are put into practice. There are early concerns about progress – for example, are there sufficient staff, with the appropriate skills, to provide mental healthcare where it is needed? The Commission for Health Improvement and the Audit Commission will be monitoring the changes as they take place.

Surviving cancer

Cancer survival rates in England are lower than in other comparable countries • The NHS Cancer Plan aims to improve cancer services to the level of the best in Europe • Over nine out of ten urgent cancer referrals are now seen by a specialist within two weeks; how this will impact on cases classed as less urgent is not yet clear

what is the issue?

Every year, 120,000 people die from cancer. A recent survey found that the public wants a reduction in cancer deaths to be made a top priority for the NHS – a higher priority than reduced waiting lists or avoiding deaths from heart disease.

There are two ways to reduce deaths from cancer: prevention and treatment. While the NHS has a role in cancer prevention – by helping people to stop smoking, for example – its efforts are mainly concentrated on treating cancer patients to give them the best chances of survival.

how is the NHS doing?

now

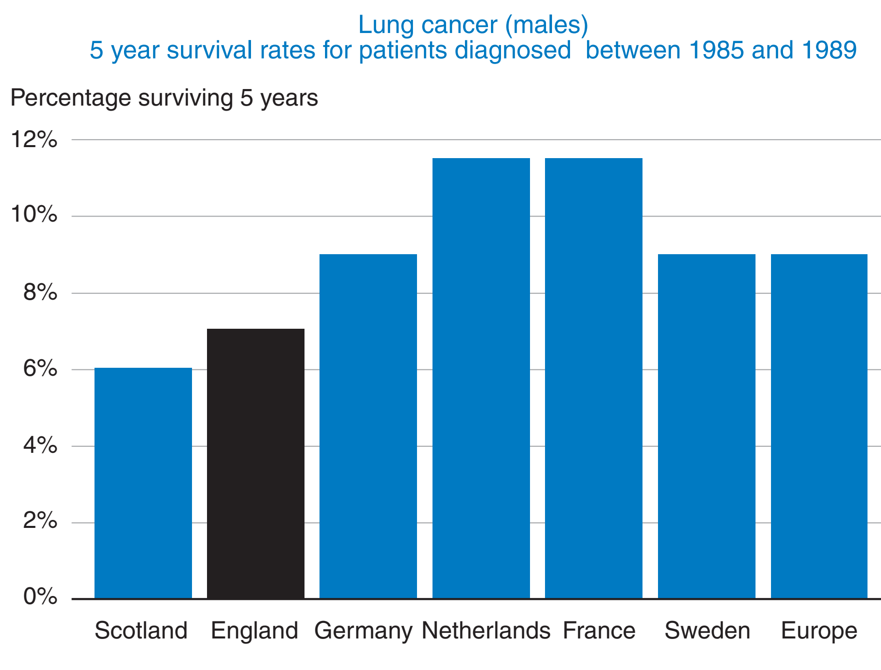
There are many different kinds of cancer and the chances of surviving them vary. For some cancers treatment offers considerable hope. For example, over three-quarters of women found to have breast cancer survive for at least five years. For other forms of cancer, treatment is much less successful. In the case of lung cancer, the five-year survival rate is less than 6 per cent.

This variation in survival rates is found in other countries too. But for most kinds of cancer, the survival rates in England have been lower than in other European countries such as France, Germany and the Netherlands.

Although this international research covers patients diagnosed in the late 1980s, it is the latest available – and the Government has acknowledged that there may still be a problem today. In its 'NHS Cancer Plan', several possible reasons are suggested:

- for some cancers, patients in England tend to have a more advanced form of the disease by the time they are treated. This may be because patients put off going to see the doctor, or because it takes longer to diagnose their problem and start the treatment;
- some NHS equipment for detecting and treating cancer is outdated;

development papers



- the NHS has too few cancer specialists;
- the NHS has been slow to adopt new ways of treating patients.

differences around the country

The chances of surviving cancer vary depending on where a patient lives. The latest figures for breast cancer five-year survival in the 95 English health authorities vary between 65 per cent and 87 per cent. For lung cancer the figures range between 2.2 per cent and 8.8 per cent. Generally, survival rates tend to be better than average in wealthier parts of the country and worse in poorer areas.

Some of this variation may be due to differences in the treatment provided around the country. The recent Audit Commission/CHI national review of cancer care found many examples of local services failing to meet best practice standards that were the norm elsewhere.

Differences in the general health of people living in wealthy and deprived areas are also likely to affect patients' chances of survival. There could also be differences in how quickly people in different parts of the country consult their doctor about the first signs of illness.

trends

Survival rates for most forms of cancer have been improving slowly but steadily. For example, nearly 50 per cent of women diagnosed with breast cancer in the early 1970s died within five years. For women diagnosed between 1992 and 1994 – the latest group for which five year survival figures are available – less than 25 per cent died within five years.

how might things change?

The Government has made cancer services a high priority. The NHS Cancer Plan aims to achieve a 20 per cent reduction in the number of deaths from cancer in people under 75 years old by 2010.

Some experts have questioned whether the Government will reach this target. Preventative measures – such as giving up smoking and eating more fruit and vegetables – may not have enough effect on the overall figures until after the Government's deadline of 2010 has passed.

To make a difference within the target time, cancer services need to improve. On current trends it looks likely that the NHS will have nearly 1,000 extra cancer specialists by 2006 – almost 30 per cent more than in 1999.

There is good progress towards another Cancer Plan target. The Government has promised that patients needing an 'urgent' referral to a cancer specialist will not have to wait more than two weeks. The latest figures show that this happens in over nine out of ten cases. While this is encouraging, it is important to remember that diagnosis is not an exact science. Some 'routine' referrals will be patients who also have cancer. If their treatment is delayed by the prioritisation of 'urgent' patients, then the overall benefit of the two-week rule will be reduced.

Deaths following heart bypass surgery

About 3 per cent of heart bypass patients die within 30 days of their operation • In recent years, the chances of dying after a bypass have been reducing, even though surgeons are taking on more difficult cases • Death rates for bypass surgery can vary considerably from one hospital to another. Where death rates are high, the causes need to be investigated

what is the issue?

The heart bypass is the most common major operation performed by heart surgeons. In the operation, a blood vessel transplanted from the patient's own leg or chest is used to bypass blockages found in the heart's arteries. These arteries feed the heart muscle with the oxygen and nutrients that it needs to pump blood around the body. If they are left blocked, the patient is in danger of having a heart attack.

Over 20,000 of these operations are performed in the NHS every year. All major surgery carries risks, and many bypass patients are very ill – not all of them survive the operation and recovery period.

how is the NHS doing?

now

There are many ways to measure the success of heart bypass operations – for example, whether patients eventually have a heart attack or, how healthy the patient feels a year after the operation. However, one easily measurable statistic is widely used: the number of patients who die within 30 days of their operation.

The Department of Health's most recent figures show that for every 100 patients having bypass surgery, it is likely that three will die within 30 days of the operation. A recent comparison with bypass surgery in the US showed the UK death rate to be very similar to that in the US.

development papers

differences around the country

A patient's chance of dying after a bypass operation varies from hospital to hospital. The Department of Health recently published figures for the 29 hospitals that carry out almost all of the bypass operations done by the NHS. The national average rate for deaths within 30 days is 3 per cent. Rates at individual hospitals vary widely from less than 1.5 per cent to more than 4.5 per cent. In other words, bypass patients at some hospitals are around three times more likely to die than patients at others.

Naturally there is a lot of public interest in these figures as they could imply that some hospitals are not providing the safest possible surgery. Detailed investigations of deaths following surgery have shown that patients sometimes die because the care provided by the hospital was not all it should be.

But some hospitals' results may appear to be worse than they actually are. Some hospitals have more deaths because they take on more difficult cases. They operate on patients who have more severe problems and these people have a greater chance of dying after the operation. While official figures do take into account some aspects of difficult cases, they ignore others - such as whether patients have other illnesses at the time of the operation.

Despite the difficulty in interpreting figures like these, hospitals can treat them as a 'warning light' – showing that they may have a problem in a particular area. The hospital with the highest death rate in the latest official figures conducted a detailed investigation of its own performance, and has identified some aspects of care that could be changed to improve results.

trends

The results for NHS bypass surgery have been improving. A recent report shows that death rates for bypass patients have fallen from around 5 per cent in 1993 to its present level of around 3 per cent. At the same time, increasingly difficult cases were being treated. These included older patients, patients with more severe heart disease and patients who have other diseases.

how might things change?

The NHS does not have a specific target for reducing bypass surgery deaths. The death rate could never be zero, and it might not be possible to go much below 3 per cent while still offering surgery to those patients who are most ill.

However, heart disease is high on the list of NHS priorities. Targets for bypass surgery focus on:

- increasing the number of operations that are done;
- making sure that surgeons have sufficient experience; and
- reducing the time that patients have to wait for surgery.

The recent inquiry into children's heart surgery at the Bristol Royal Infirmary highlighted another area for improvement. The Inquiry concluded that more needs to be done to ensure the accuracy of the information that is used to calculate hospitals' results. The Department of Health is now working with leading cardiac surgeons on methods for improving the information available on the results of heart surgery.

If doctors and managers are confident that the 'warning lights' they see are fair and accurate, then they will find it easier to act on them to improve patient care.

Comments and further information

Commenting on the Commentary

We welcome your comments on all aspects of the NHS Commentary. Please contact us at:

NHS Commentary
Audit Commission
1 Vincent Square
London
SW1P 2PN

Email: nhscomm@audit-commission.gov.uk

Further information

Details of the Audit Commission's other work in the health service can be found on our web site:
www.audit-commission.gov.uk

Copies of the Commentary (stock code HNR2760) may be ordered from Audit Commission Publications, freephone **0800 502030**, and are also available from the web site.

An alternative version of the document, that includes details of all the information sources used in the Commentary, is also available from the web site.

development
papers