King's Fund

Briefing paper

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Has the Government met the Public's Priorities for the NHS?

A King's Fund briefing for the BBC 'Your NHS' Day 2004

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This independent briefing is the basis for a number of reports screened on the BBC's 'Your NHS' Day on 24 March 2004. It was commissioned by the BBC and is published with their kind permission.

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Steve specialises in political ideas for health care, professionalism and regulation, and the nature of personal and organisational learning. As a non-medic with a background in operational research, he has nine years' experience in the NHS as a researcher and public health specialist, and as change manager in a district general hospital. He has written extensively on a range of health care issues.

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Pippa's background is in nursing and policy development. At the King's Fund her work runs across leadership and policy development and she leads work on workforce issues. She was previously Director of Policy at the Royal College of Nursing. Pippa believes that leadership development is the key to modernising the professions and the wider NHS health care workforce.

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Author: Public priority 1: Free long term care for older people (England)

Janice's main focus is on work to improve the integration of care and support for people who have continuing health and social care needs. She has published widely on the care of older people, including work on long-term care funding, age discrimination in health and social care, and the care service market.

Introduction

On 20 February 2002 the BBC held a 'Your NHS' day, with programmes across BBC radio and television examining the nation's NHS. As part of the event, the public were invited to vote for the NHS issues that they believed mattered most. Almost 150,000 people responded, and the top five priorities were presented as a pledge card to Prime Minister Tony Blair live on television.

The public's choice of issues in order of priority was:

- free long-term care for older people
- better pay for NHS staff
- shorter waiting times (for cancer and heart care)
- improved Accident and Emergency departments
- cleaner hospitals.

The BBC broadcast a follow up to the 2002 event on 24 March 2004, looking in particular at how much progress has been made on the five public priorities. As part of this, the BBC commissioned the King's Fund to provide a quick, independent review of developments in these areas. This document contains our full briefing to the BBC, and is the basis for a number of reports to be screened on the 2004 'Your NHS' Day.

The briefing does not purport to be based on exhaustive research but is rather, for each issue, a gathering of readily available key statistics, a review of the major policy and service developments, and analysis by King's Fund policy experts. The King's Fund is an independent charitable foundation committed to improving health and, as such, keeps a watching brief on health and health care policy.

Overall, our research paints a largely positive picture with improvements in most areas. However, it is still too early to judge whether the extra resources the Government has put into the NHS is delivering value for money and whether we will see better health outcomes for more people as a result. The research also illustrates sharp contrasts between approaches – and outcomes – across the four countries of the UK. Given the very different policies adopted in England and Scotland over long-term care for the elderly, these countries have been examined separately under the public's first priority – free long-term care for older people.

Public priority 1: Free long-term care for older people (England)

Some long-term care services have improved, but the system is seen as unfair, too complicated and of patchy quality.

Problems with long-term care funding are not going to go away. While there is no big campaign to reform the system at the moment, complaints and litigation concerning the current set up continue to rumble on. Public discontent could well lead to renewed calls for reform.

In terms of care services provided, there have been improvements in services that prevent people going into care homes unnecessarily and a wider range of long-term care options is coming into play. But as yet it is hard to see notable increases in either the quantity or quality of care services.

Only the most dependent older people can expect to receive publicly funded help at home. So older people with mild to moderate needs for care and support have to rely on their own resources, family and friends.

Background

In 2000 the Government rejected a key recommendation of the Royal Commission on Long Term Care. The Commission had called for all personal care – which includes help with feeding, dressing and personal hygiene – to be free at the point of delivery. In England the Government argued this was not the best way of using extra resources, unlike the Scottish parliament. *See* 'Free long-term care for older people (Scotland)'.

In England the Government did agree that residents of nursing homes should receive a contribution to meet nursing care costs on the grounds that, if they were in their own home, the NHS would provide free nursing care anyway. The Government defined nursing care as the time spent by a registered nurse in providing, delegating or supervising nursing care in any setting. Depending on the level of nursing care required, residents could expect to have their nursing home fees reduced by either £40, £75 or £120 per week. These figures will increase on 1 April 2004 to £77.50 and £125, with the low band remaining at £40 but with flexibility between the low and medium bands. It is generally accepted that these figures do not cover the real costs of providing qualified nursing care.

The Government argument was that more investment to pay towards fees of better-off residents was unjustified, and that investment in services to prevent people going into long-term care and the improvement of care services for older people is preferred. Much extra funding and new services have been pledged since then, including £2.3 billion over 1999/00 to 2005/06 (averaging £325 million per year) allocated as follows:

Increased funding

- £900 million was pledged to develop new intermediate care services between 1999/00 and 2003/4. These short-term services aim to aid recovery and rehabilitation thus reducing unnecessary admissions to hospitals and care homes.

- £1 billion of extra funding was pledged over three years for social care services for older people between 2003/4 and 2005/6 – effectively a 6 per cent increase for social services.

- £300 million as a 'building capacity grant' was pledged in October 2001 to enable local authorities, the NHS and the independent sector to provide more care services.

- An additional £100 million per annum was pledged for three years in November 2002 to enable local authorities to develop more care services.

A wider range of services

- The Government has pledged that 5,000 more intermediate care beds and 1,700 non-residential places in day centres, and community teams, will be made available by April 2004.

- There has been a slow but steady growth in extra care (or very sheltered) accommodation. Keen to speed up growth, in July 2003 the Government pledged £87 million over two years to create 1,500 more extra care units by 2006. In February 2004, the Department of Health announced that £29 million had been allocated to 16 organisations to develop 1,420 new extra care housing places.

Review

Funding long-term care has been seen as a problem for many years and that situation remains. There are still persistent problems with a funding system that is perceived by the public to be complicated and unfair.

In England, elderly residents of nursing homes have to be assessed to establish whether they are entitled to the nursing care contribution and if so, at what rate depending on their level of need. In 2003/4 the Government allocated £584 million to cover the nursing care costs of 130,264 nursing home residents.

There were problems in the early days of implementing this policy. Evidence collected by Help the Aged and Age Concern England showed that some care home owners simply increased their fees by some or all of the amount of the NHS contribution. Many elderly residents never benefited at all.

In addition to problems with free nursing care, there have also been difficulties with the NHS funding of continuing care. This applies to people who have long term conditions which require supervision by specialist medical or nursing staff. Since the last NHS Day, the Health Ombudsman has highlighted cases that illustrate the problem of distinguishing 'free' NHS care and means-tested long-term care. In February 2003, a Health Ombudsman report recommended that each health authority in England

should review all cases assessed since 1996 as having long term care needs with a view to compensating people who have been overcharged for their care. Since then thousands of retrospective reviews have been undertaken throughout England. These are ongoing and are not expected to be complete until March 2004 at the earliest. It has been estimated that the total cost of reimbursements nationally may reach up to £500 million.

While the intensity of public disquiet about funding has diminished, other problems with long-term care have intensified. There has been a huge reduction in care home places during a period when the Government pledged to spend more on services for older people. By April 2003 there were 74,000 fewer care home beds than in 1996. Between 2002 and 2003, total care home capacity fell at the rate of between 700 to 900 beds per month. This illustrated a trend of continuing contraction in the care home sector.

By contrast, homecare contact hours increased dramatically. In the period 1992–2002, homecare contact hours increased by 76 per cent. But the number of people receiving home care has been falling year on year (four per cent a year since 2000) as local authorities have tended to give priority to older people with high dependency needs. This means that many elderly people who would have received help at home in the past no longer receive any help at all.

Although the proportion of older patients aged 75 or over delayed in hospital beds fell from 13 per cent in 2001 to 8.9 per cent in 2003, concern about so-called 'bed-blocking' in hospitals has increased during this period. One of the reasons why a significant proportion of older people – who are fit to be discharged from hospital – continue to occupy a bed for longer than they need, is a shortage of residential or home care services. Older people with dementia in particular can often experience difficulties finding suitable care arrangements, and most 'bed-blockers' are people with dementia who do not get nursing care outside hospital. Their numbers are predicted to increase. Since February 2000, local authorities have had to offer older people money that they can use to buy their own care and support directly, rather than have services arranged for them by local councils. So far, take up has been low.

In relation to other pledges, progress is more difficult to assess. For example, by June 2003, the Government claimed that 3,600 additional intermediate care beds for short-term rehabilitation had been commissioned (target: 5,000 by April 2004). The target for non-residential places in day centres, community teams and so on was exceeded ahead of time with 12,800 places identified. A total of 43,000 more people used these services in 2002/03 than in 1999/00.

The Department of Health has asked strategic health authorities to check the data for the last six months, as there are doubts about the validity of these figures. It is suspected, for instance, that some care home beds have merely been 're-badged' as intermediate care beds.

Two years ago, most people thought that social care in general, and long-term care in particular, was underfunded. A report for the Joseph Rowntree Foundation in 2002 estimated that the care home sector had been effectively underfunded by around £1 billion as a result of a cap on the level of fees paid to care homes. While more money has been spent on care services for older people, many groups argue that there is still not enough money in the system to provide enough good quality care for older people. Care providers complain that fees paid by local authorities are still too low and

organisations representing older people and carers complain that services are provided on the cheap and exclude many who need help. Social service departments in local councils stress that they are under pressure to spend more on services for children as well as for older people. The King's Fund has called for a fundamental review of social care funding, along the lines of the review of NHS funding carried out for the Treasury by Derek Wanless in 2002.

Public priority 1: Free long-term care for older people (Scotland)

Scotland's policy of free personal care appears to be working, with take up increasing over the last two years. But there are worries about its cost and financial sustainability

In England, if you have savings and need help to dress, brush your teeth or prepare your food you have to pay for it. In Scotland if you are over 65, you can claim up to £145 a week towards these costs, regardless of where you are being cared for.

People in Scotland still have to pay for some services, such as help with housework, but overall the system avoids the need to make so many difficult distinctions between care the state should pay towards and care that it should not.

The Scottish Parliament has allocated £250 million for this policy over two years, with additional sums of £147 million and £153 million for 2004/05 and 2005/06 respectively. A review of implementation and future funding for community care services for older people is underway. A final report is due to be completed by April 2004.

Since the introduction of free personal care in June 2002, take up has increased from 29,178 to 41,256 in September 2003.

With this increasing demand for care services, particularly at home, there is concern about whether the money will be sufficient.

Background

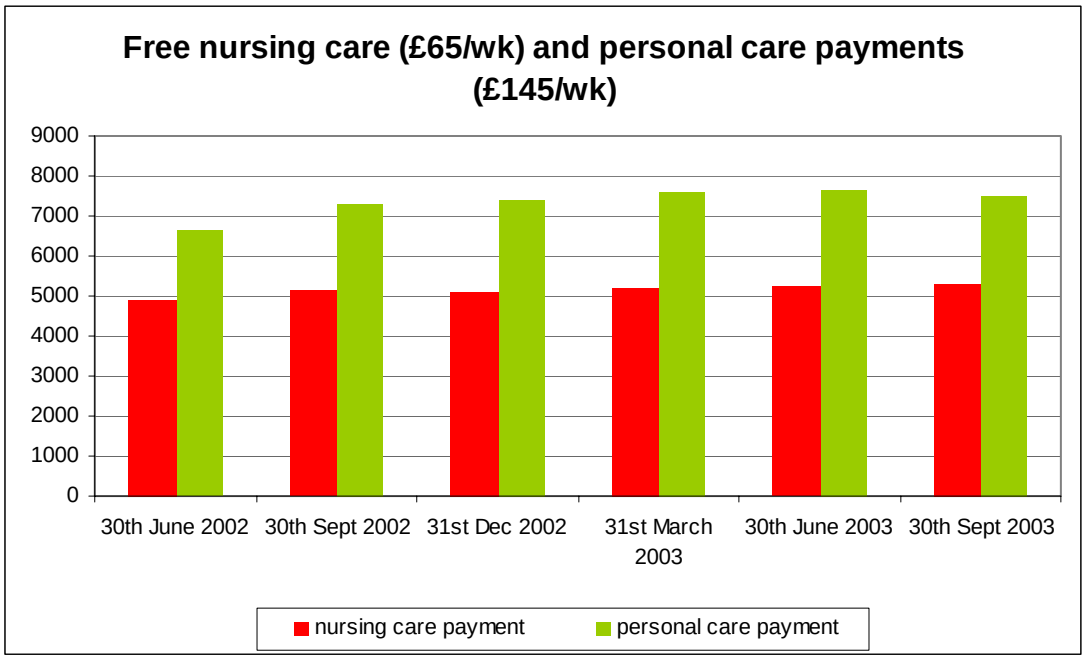
Unlike the Government in England, the Scottish Parliament accepted the recommendation of the Royal Commission on Long Term Care that all personal care should be 'free' for people of 65 and over. This has been in force since July 2002. Personal care includes help with dressing, bathing, preparing food and special diets, and getting around – needs that might arise from any illness or disability. The state contributes £145 a week towards personal care costs, depending on the results of an assessment.

Like the English system, the Scottish approach also includes a contribution to nursing care for care home residents of all ages. In Scotland this is at the rate of £65 a week, compared to England which is £40, £75 or £120 a week after assessment. This will increase on 1 April 2004. In Scottish care homes (residential or nursing homes), people may qualify for both contributions, and therefore receive £210 a week towards their costs. In both Scotland and England, residents who have the means to do so are still expected to meet the costs of their food and accommodation.

The scale of the commitment is illustrated by two factors – the number of residents in Scottish care homes (18,942 in residential care and 22,784 in nursing homes – 2002 figures) – and the high proportion of residents aged 65 or over (70 per cent and 92 per cent respectively), making them eligible for personal care payments. Similarly, the

provision of home care has increased during 2003 with greater numbers of people receiving care, increased contact hours and a higher intensity of hours per person being provided.

Figure 1



The Scottish Executive has earmarked £250 million for the implementation of 'free' personal and nursing care over the first two years (2002/04). This will increase to £147 million in 2004/05 and £153 million in 2005–2006. The figures on actual expenditure and service provision show that the demand on the budget is high. On top of the costs for residents in Scottish care homes implementation will require financial support for almost ten million hours of free personal care at home.

Review

It would appear that the Scottish approach to long-term care for the elderly has avoided some of the pitfalls encountered in England by accepting that older people have a range of care needs which should be paid for by public funds. This avoids England's stark and artificial distinction between nursing care, for which the state makes a contribution, and personal care which has to be paid for by better-off residents. But even in Scotland there are problems defining if services are part of a free personal care package, or if they are services for which local authorities should charge. Nor is the system necessarily easier for people to navigate. People wait for assessments, wait for services and wait for care home places. Free personal care payments are not backdated. And those assessed as needing a care home place often have to wait between one and six months, according to an Age Concern Scotland survey of local authorities in 2003.

Figure 2

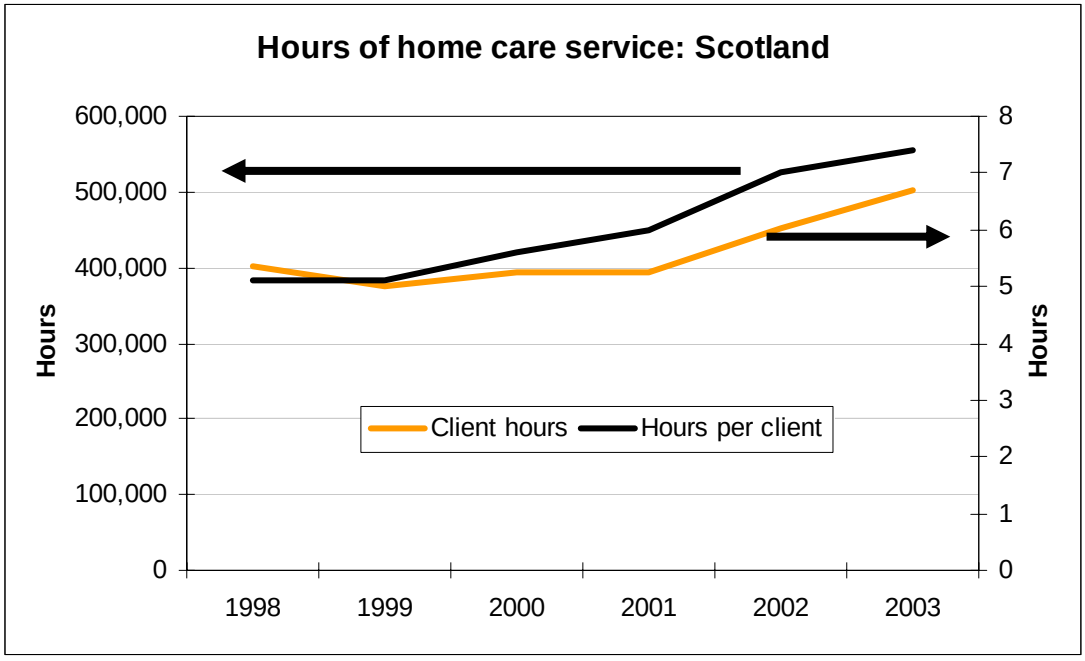
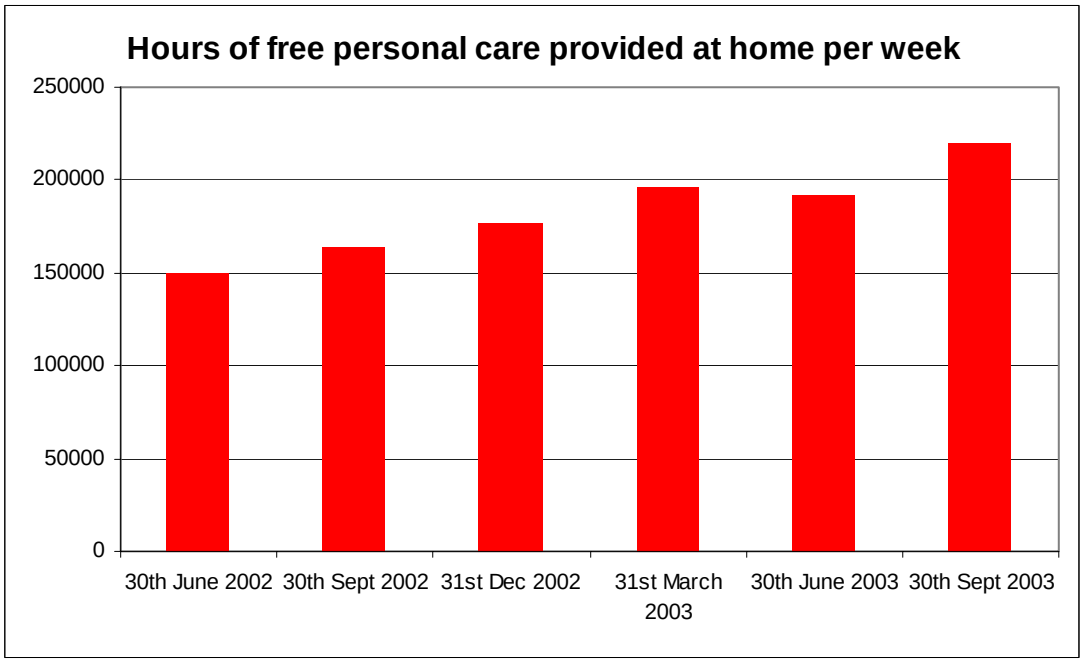


Figure 3



The difference between Scotland and England is more a matter of different priorities than money. Royal Commissioners who originally suggested that England might take a similar approach to Scotland recognise that the comparison between Scotland and England is not between one country that has been prepared to spend and another that has not. Rather, it is between the Scottish approach to fairness of funding and the English approach that stresses the need to improve and extend available services.

The Scottish solution is not without problems. Age Concern Scotland highlights the potential problem of inconsistencies in the delivery of services between local authority areas because of variable waiting lists for assessments, services and care home places. They also point out that Scottish Executive funding is not 'ring-fenced' or earmarked specifically for free nursing or personal care. In the absence of any duty on local authorities to publish waiting times or expenditure on services, the scale of these problems is hard to gauge, difficult to track and invisible to the public.

There are also concerns over the resources required to implement and sustain this approach. In Age Concern's survey of local authorities, respondents expressed two different worries. First, councils claimed that the 'current allocation of resources is probably not sufficient to meet demand' – meaning that everyone will get less and those without the means to buy additional help will suffer. Secondly, the survey revealed an anxiety that some of the extra money to fund care was being 'cancelled out' by price increases for the other aspects of local authority care or for the hotel element of care home costs.

Public priority 2: Better pay for NHS staff

NHS staff pay for all groups and grades has been increasing faster than inflation - particularly for the lowest paid. But more money for staff means less available for direct patient care. Getting the balance right is difficult.

Broadly, all NHS staff have seen their pay increase by more than the rate of inflation over the last few years. With Agenda for Change (the negotiations used to devise a new pay system for over a million NHS employees), staff are likely to see even higher increases – although there is difficulty in accurately estimating the size of these pay rises.

Pay is always a contentious issue, and many NHS staff may feel undervalued, despite these increases. A difficulty for any government with this issue is to try and get the balance right between fair remuneration for NHS staff and spending money to directly improve services for patients. Another problem is the sheer size of the NHS pay bill. For example, with over 500,000 nurses employed in the NHS across the United Kingdom, even a fractional increase in pay costs millions of pounds. Overall, for example, NHS staff pay across the UK has been increased by approximately £5 billion in the last two years – around 35 to 40 per cent of the total extra money given to the NHS across the UK.

Background

Pay rises in 2002/03 for health professionals spanning nurses, doctors porters, cleaners and managers were agreed at 3.6 per cent. However, pay deals for an organisation as complex and big as the NHS are never simple, and many different staff groups and particular grades within these groups received different settlements. For example, GPs saw their pay increase by 4.6 per cent on average. However, all pay rises were above inflation. And for low-paid groups, larger percentage rises were awarded through flat rate increases in pay.

In general, pay in the public sector in 2003/04 has been subject to two main influences: fundamental pay modernisation and reform, plus pressure from the Government to contain increases in basic pay rises. Nevertheless, all public sector pay increases in April 2003 ranged from 2.9 per cent to four per cent, slightly lower than in 2002, but still higher than inflation in the general economy, according to *Pay in the Public Services 2004* from Income Data Services. Moreover, lower paid staff once again received flat rate increases which provided higher percentage rises – up to 6.5 per cent – than other groups as a whole.

For the NHS, the Government's Agenda for Change programme for modernising pay, conditions of service and career structures has been under development and negotiation for some years. It provides a nationally agreed framework for all NHS staff, but no longer includes medical consultants and GPs following the withdrawal of the British Medical Association from negotiations. Since then, consultants and GPs have negotiated new

contracts with the NHS, again subject to much dispute. The new GP contract has now been agreed and is just starting to be introduced.

The plan is to introduce Agenda for Change to all staff, apart from doctors, in October 2004. It is anticipated that the largest staff group, nursing, will receive up to a 15.8 per cent pay increase during the first three years. Pay rises for doctors are hard to estimate due to their individual nature. However, it is suggested that consultants could receive anything from seven per cent to 18 per cent increases on their basic salary from the start of each new contract.

Some NHS trusts have been selected to test out the new system – these 'early implementers' of Agenda for Change are allowed to use special recruitment and retention premia of up to 30 per cent of basic pay in order to attract selected staff. This has given rise to fears of poaching staff from neighbouring trusts and the development of local pay spirals.

Review

In June 2003, the Department of Health published its latest Staff Earnings Survey based on data collected in August 2002 from all NHS trusts and strategic health authorities in England. This sets out the basic salary and corresponding total earnings for each staff group as it was paid during that month and added up to give annual equivalent amounts. As salaries do not differ significantly between the four countries of the United Kingdom – these are negotiated at a national and UK level – this English picture of NHS staff earnings can be taken as a proxy for the United Kingdom.

Doctors are by far the best remunerated staff group in the NHS. In 2002, medical consultants earned more than twice the highest paid nursing post and three-quarters more than a chief grade in allied health professionals – physiotherapy, occupational therapy and radiography.

The number of senior posts open to each professional group also affects access to higher salaries. The career structure of doctors means that most junior doctors expect to achieve a medical consultant post within nine to ten years of qualifying. Most nurses, however, are clustered at D and E grades (£16,525–£21,325), with far fewer consultant nurse posts being available. So, in practice, the discrepancy in pay between staff groups is exacerbated.

There is also a noticeable difference between each staff group in the rates of basic pay and the ability to earn over and above this through unsocial hours payments, discretionary awards and so on. Again, doctors do well, being able to enhance their basic salary by up to a third, bringing their total earnings, on average, from £45,900 to £59,900. For allied health professsionals their total earnings were on average only ten per cent higher than their basic salary. In the ancillary and administration groups this was down to four per cent.

Figure 4

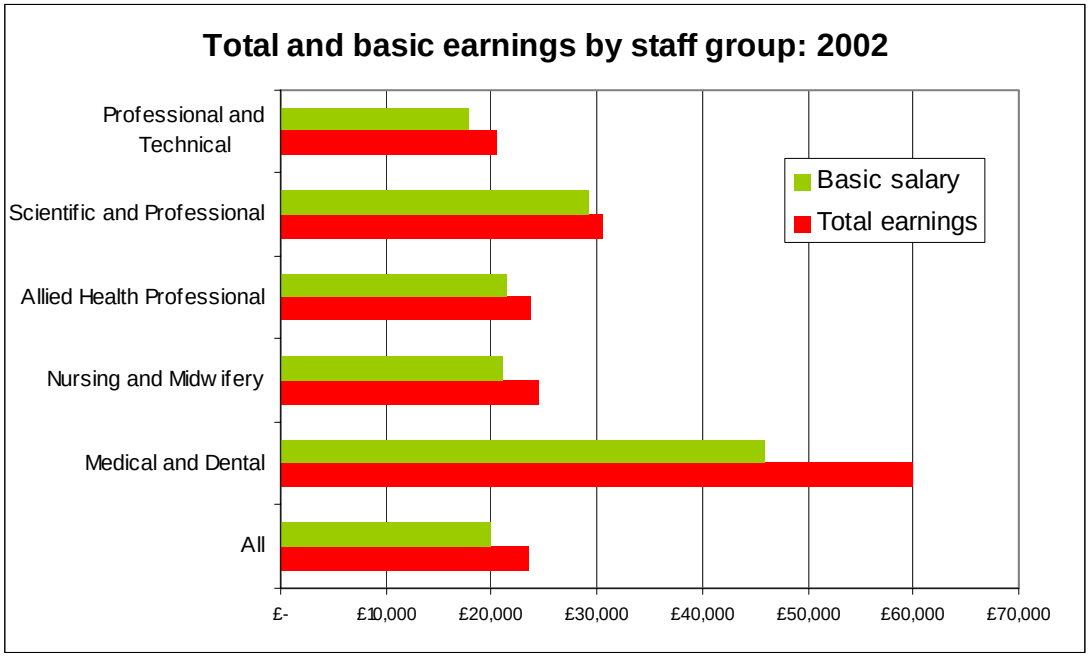


Figure 5

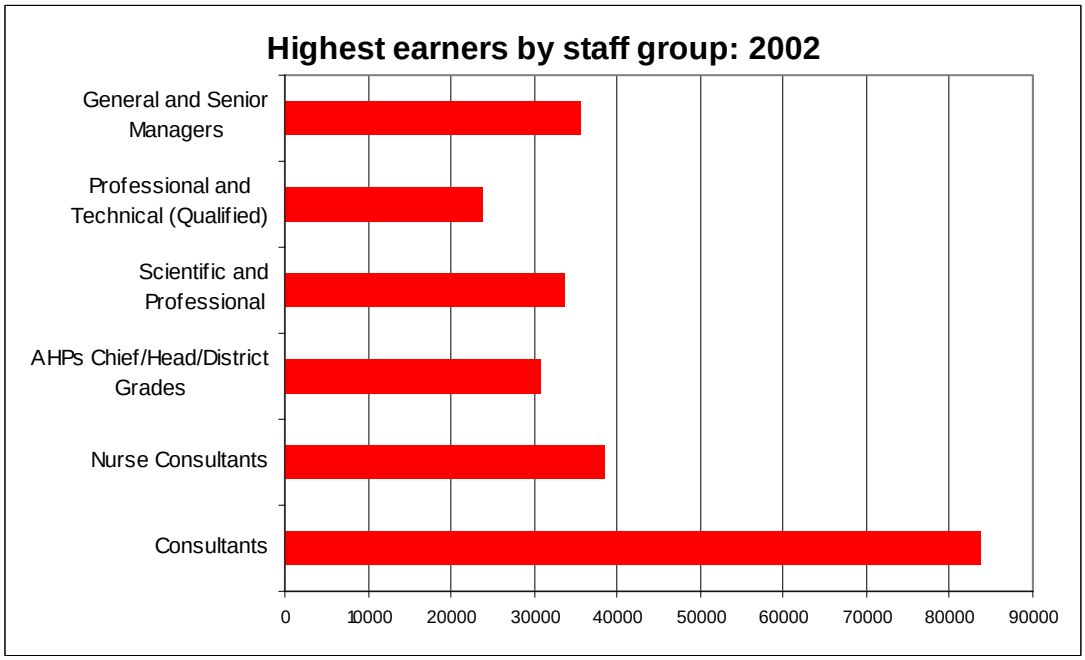
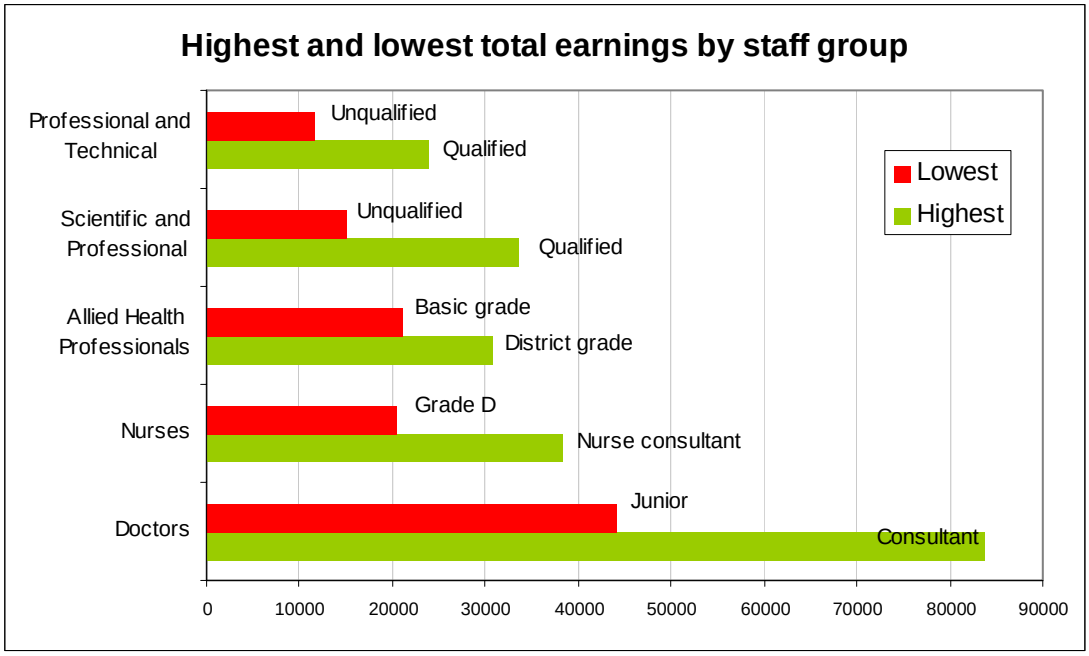


Figure 6

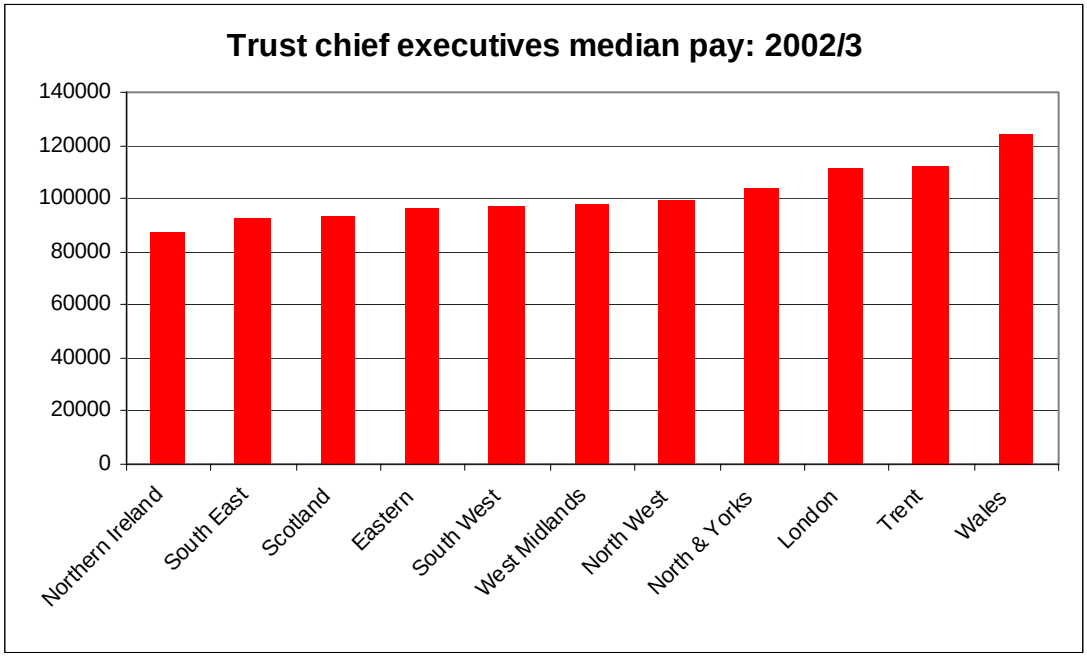


Within medicine it is well worth seeking promotion. In August 2002, junior doctors could go on to earn nearly twice their total earnings by achieving promotion to a consultant post. Within other staff groups this chance to double their earnings through promotion is less pronounced, possibly providing less incentive to seek promotion, with its additional responsibilities. For example, allied health professionals in basic grades could only hope to earn £9,000–10,000 more for taking a chief, head or district grade post.

In comparison to the staff groups detailed above, pay levels for NHS trust chief executives and other boardroom staff are significantly higher.

A recent report by Income Data Service, *NHS Boardroom Pay Report 2004,* shows that pay levels for directors of NHS primary care trusts are starting to escalate, with salaries of chief executives climbing to £92,500 – up by 28 per cent compared to the previous year. This compares with average rises of 5.5 per cent for hospital chief executives. Overall, 46 per cent of chief executives received salaries of over £100,000. For hospital trust medical directors, total remuneration amounted to £115,000 per year, while for finance directors it was £77,500.

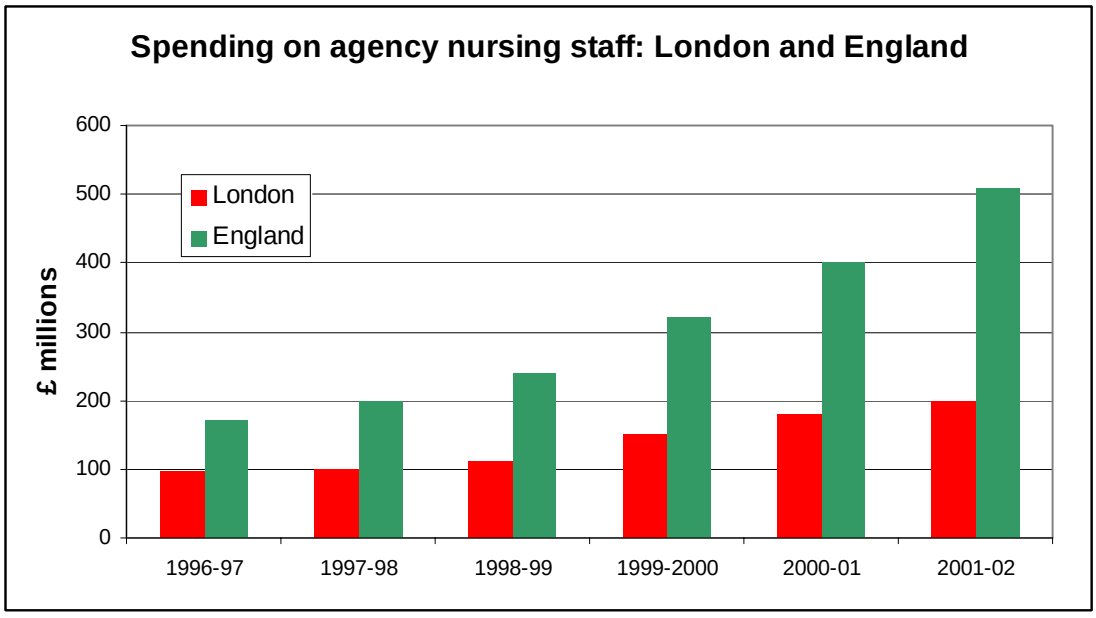
Figure 7



The NHS uses temporary staff – such as agency nurses and locum doctors – as short-term cover for permanent staff on sick leave and for longer-term vacancies. This raises questions about the impact on the continuity and consistency of care as well as on the overall pay bill.

The Royal College of Nursing's 2002 report *Valued Equally* found that almost 45 per cent of nurses in London have a second job in order to increase their income.

Figure 8



Public priority 3: Shorter waiting times for cancer and heart care

Waiting times are generally shorter than at any time in the history of the NHS. But not all parts of the UK are doing equally well. The real test for the NHS will be to build on success and keep waiting times low.

The reduction in long waits – including for cancer and heart disease – in the NHS over the last few years has been a considerable achievement – the result of large sums of extra money, new ways of working and organising care and intense ministerial and managerial pressure. In many parts of the United Kingdom, waiting times have never been as short as they are now. But success has been patchy, with Wales and Northern Ireland, for example, experiencing growing problems with their waiting times.

Reducing waiting times has, however, raised concerns amongst some consultants that they have been pressured by NHS managers to treat less urgent patients in front of more urgent cases in attempts to meet targets. There is also the question of the cost-effectiveness of reducing waiting times. No official estimates exist of the true costs of meeting waiting times targets, and it may be that some of the money – and effort and time – might have produced more gains in health if spent in other areas of health care. And crucially, it remains to be seen whether reductions in waiting times can be sustained.

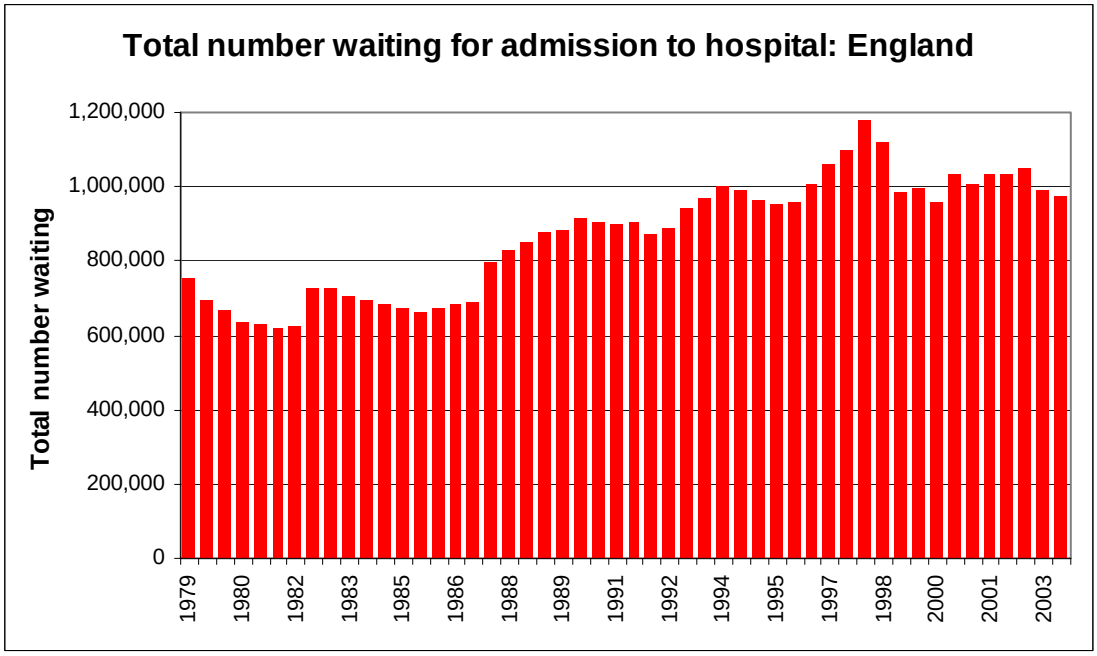
Background

While the total number of people on English inpatient waiting lists has hovered around one million for the last five years – just about maintaining Labour's 1997 pledge to reduce the total by 100,000 – for the patient waiting for treatment the main concern has always been how long they have to wait rather than the number of people ahead of them in the queue.

Although there have been various attempts to reduce waiting times since the 1970s, the Government's ten-year modernisation programme for the NHS, *The NHS Plan,* published in 2000, set out perhaps the toughest target-based timetable for significantly reducing waiting times. And not just for inpatients, for outpatients too, as well as for selected diagnoses and patient groups such as breast cancer, testicular cancer and children with suspected cancer.

The NHS has made an enormous effort to reduce waiting times and a significant chunk of the extra money allocated to the NHS over the last few years has been directed at tackling long waits. In addition, the expansion of patient choice in England, enabling increasing numbers of waiting list patients to choose another hospital for quicker treatment, has helped reduce the number of long waits. There has also been significant pressure from ministers on managers and others in the NHS to meet the targets set out in the NHS Plan. The ultimate goal of the Plan is that by 2008 no one should wait more than three months for admission to hospital. The target for the end of March this year is for no one to wait more than nine months for admission as an inpatient.

Figure 9



Since the publication of the NHS Plan there have been significant reductions in the number of long waits. There are now hardly any patients waiting more than 18 months – between April 2002 and December 2003 the number of patients fell from 105 to 68. To put this in perspective, in 1990, more than 78,500 patients were waiting longer than two years. The number of patients waiting between 12 and 17 months has also fallen – from 20,932 to 385; those waiting six to eleven months from 230,499 to 151,254, and the number waiting between three to five months has fallen from 279,346 to 254,989. As a result of these reductions in long waits, the numbers waiting under three months have risen slightly.

Another way of measuring waiting times is to calculate an average (mean) across all patients on lists or to calculate the median (that is, the point at which 50 per cent wait longer and 50 per cent wait shorter times). However, these average waiting times have not changed very much over the last few years.

Figure 10

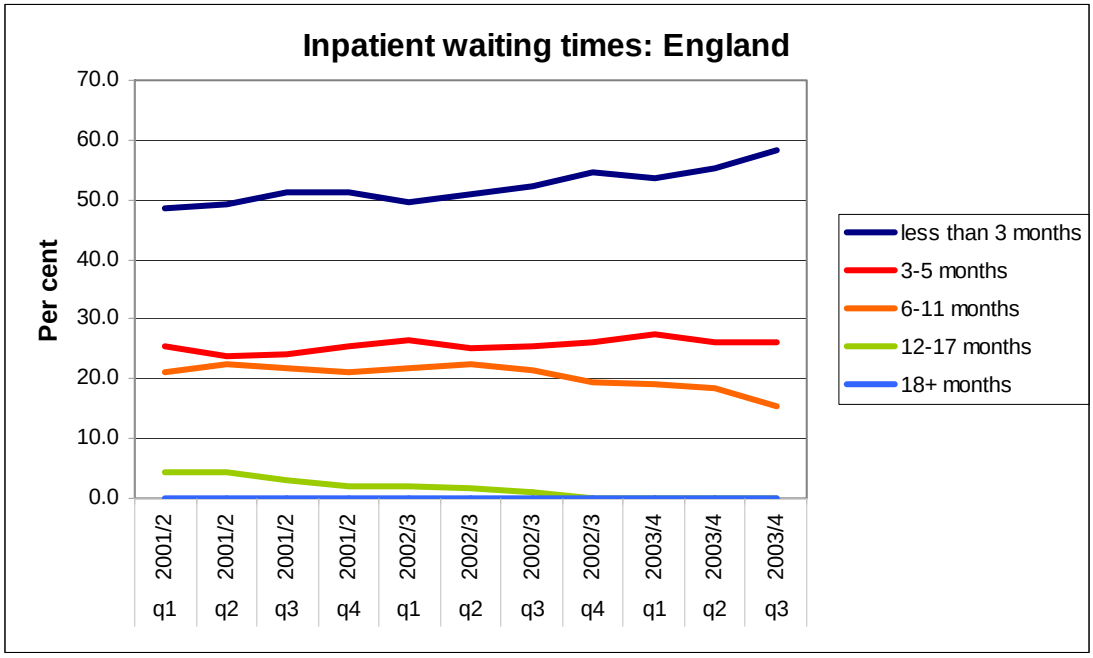
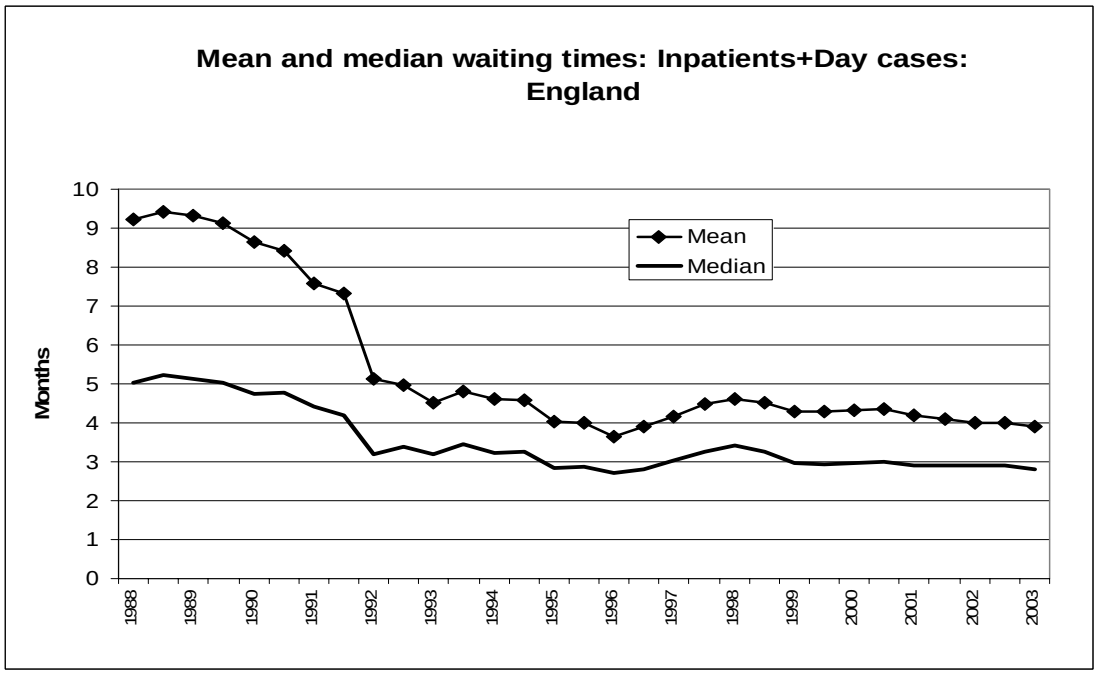


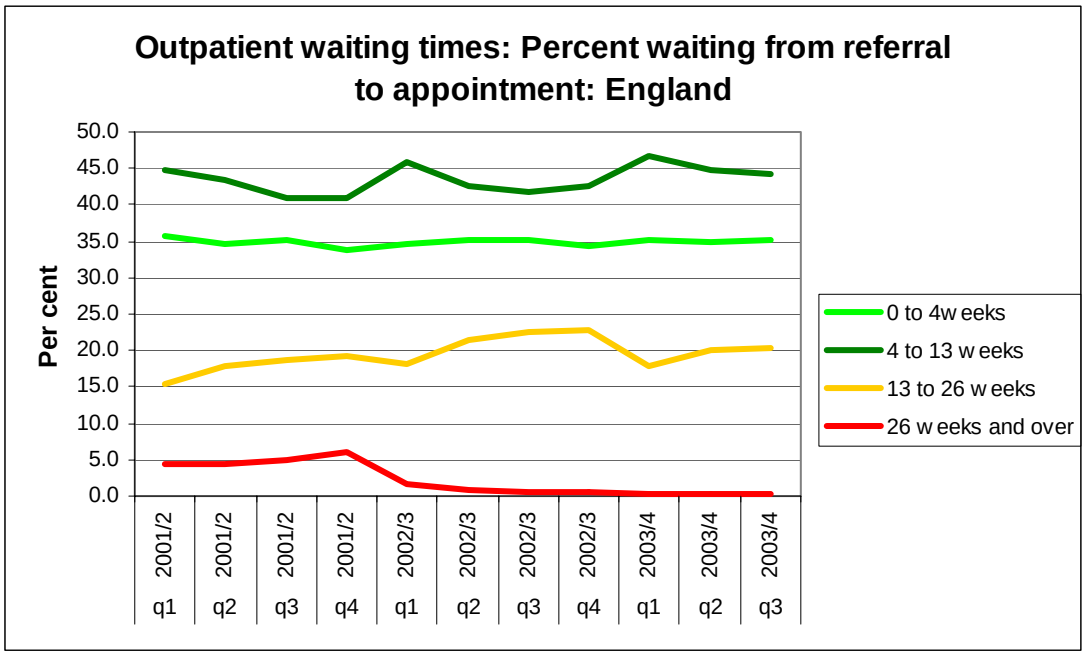
Figure 11



Outpatient waiting times have also been the subject of NHS Plan targets and, as with inpatient waiting times, there have been significant falls in the number of long waits. Since April 2002 numbers have fallen from around 30,000 to just under 3,000 for patients waiting over 26 weeks for an outpatient appointment. As with the inpatient list, this reduction has led to a bunching up across the rest of the outpatient list so that there are now more patients waiting between zero and 26 weeks than in April

2002. Overall, the total number of first outpatient attendances has remained at around two million each quarter.

Figure 12



NHS Plan targets for selected cancers promised a maximum wait of one month from GP referral to treatment for any child with suspected cancer, women with suspected breast cancer, men with suspected testicular cancer and anyone with suspected acute leukaemia.

Achievement of these targets has been variable, although for children's cancer the target has been met in every quarter but one since April 2001, and there have been steady improvements in the breast cancer target. However, as a recent report from the National Audit Office has noted, even if waiting times for referral have fallen, a continuing problem is the waiting time for treatment – particularly radiological treatment and chemotherapy.

In the speciality of cardiology, since the first quarter of 2002/03, no-one now waits over a year, and the number waiting between nine and eleven months has reduced from just over 1,000 to 564.

Figure 13

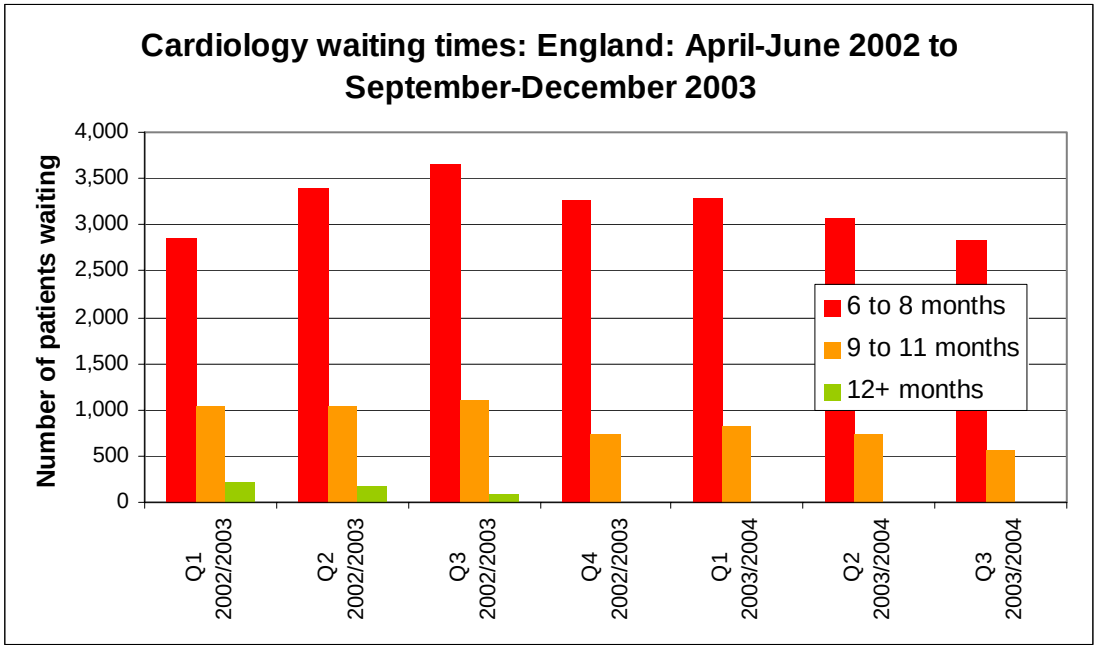


Figure 14

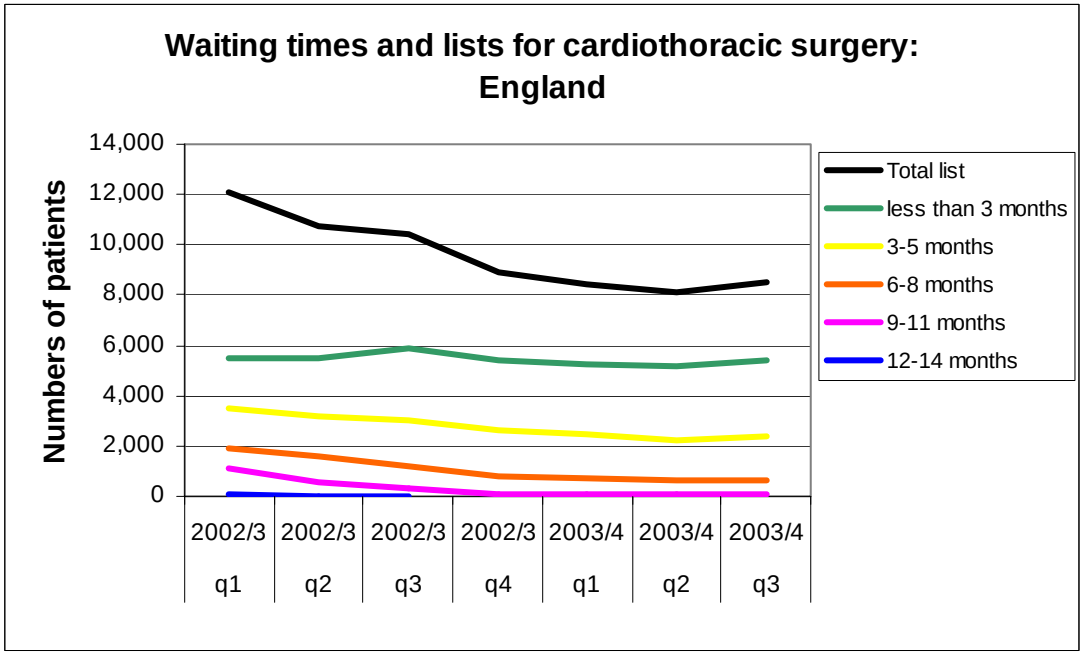
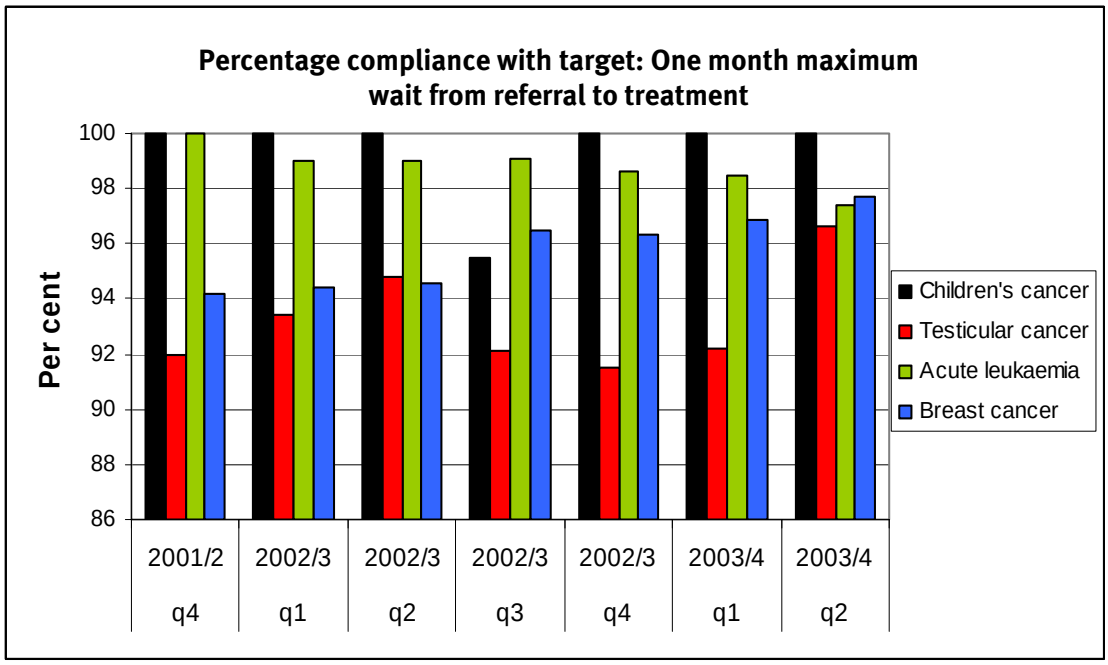


Figure 15



While the English NHS has been making progress in reducing waiting times, in Wales the situation has not improved. In 2000, around five per cent of the total English waiting list had been waiting over a year for admission, and virtually no one waited over 18 months. But in Wales the figure was over 14 per cent, with five per cent waiting over 18 months. By 2003, the English NHS had all but eliminated waits over 12 months; in Wales, however, the proportion of the list waiting over 12 months had risen to nearly 16 per cent, and up to seven per cent for those waiting over 18 months. The situation in Northern Ireland is even worse, with nearly 20 per cent of patients waiting more than 12 months in 2003 and 12 per cent waiting over 18 months.

In Scotland, as in England, excessive waits of over 12 months had all but been eliminated by 2003.

Review

Great strides have been made in reducing long waits, particularly in England, but not in Wales or Northern Ireland. There is some evidence that this has been achieved at some cost – and not just in financial terms.

A National Audit Office (NAO) report in 2001 – *Inappropriate Adjustments to NHS Waiting Lists* – found that nine NHS trusts had massaged their waiting-list figures in attempts to meet their waiting time targets. In one hospital, staff phoned patients to find out when they were on holiday – then sent out letters offering an operating date when they knew patients would be on holiday. When patients refused the date they were removed from the waiting list.

But the true scale of such inappropriate adjustments across the NHS is unknown. The NAO findings highlights the intense pressure hospitals faced to reduce their waiting

times. As NHS managers joke, reducing waiting times is the 'P45 target' – fail to achieve them and you can start to look for another job.

A previous NAO report also published in 2001– *Inpatient and Outpatient Waiting in the NHS* – raised a further potential problem arising from attempts to meet waiting times targets. In a survey of consultants, the NAO found that 52 per cent (300 out of a sample of 558 in three specialities) considered that '…working to meet NHS waiting list targets meant that they had to treat patients in a different order in 1999/2000 than their clinical priority indicated.' A fifth of consultants stated that treatment of patients in a different order had occurred frequently, and of the 300 consultants, 80 per cent stated that deferring treatment of 'urgent' patients had had a negative impact on patients' health.

Again, however, the true scale of this distortion problem is very hard to ascertain. It is also important to bear in mind that there are no definitive guidelines as to when to admit a patient from the waiting list, and clinical opinion on this varies considerably.

No official figures exist on the actual financial cost of reducing waiting times – but they are likely to be considerable, in part due to the use of private medical providers by the NHS to help boost the volume of care and so help meet the targets. And while reducing waiting times is clearly a good thing, there remains a question as to how cost-effective it has been or whether some of the resources devoted to meeting targets might not have been better spent on other areas of the NHS.

While meeting the waiting time targets over the last few years has been difficult for many hospitals, it is likely to get progressively more difficult as targets get tougher. By March 2005, for example, no one in England should be waiting more than six months for inpatient care. Hitting this target will be more difficult than meeting the nine-month target for March this year as there are over 150,000 patients currently waiting over six months, while a year ago there were around 85,000 patients waiting over nine months.

Public priority 4: Improved Accident and Emergency departments

With shorter waits for patients, Accident and Emergency departments are improving, but as the Government admits, there is more to do.

Hospital Accident and Emergency (A&E) departments have got better over the last few years. This is due to the considerable effort and resources – primarily to reduce waiting times, but also to better manage winter pressures.

But although there have been improvements, meeting the Department of Health's target that no A&E patient should wait more than four hours has proved difficult for many hospitals – around half failed to achieve the target. There is also a worry that in straining to meet waiting time targets, A&E departments may neglect other aspects of patients' needs. Or they may fail to deal with underlying problems such as poor primary care services in some parts of the country – leading to extra demands on A&E services – or fail to treat patients in order of their urgency every time.

However, through better planning and extra resources the NHS seems to be better at dealing with the inevitable increase in demand for A&E in winter, although the past few winters have been relatively mild.

Overall, as the emergency services 'tsar', Professor Sir George Alberti, has admitted, there is still some way to go to reach his vision for the service. Consultants take time to train as does changing the way services are run and organised.

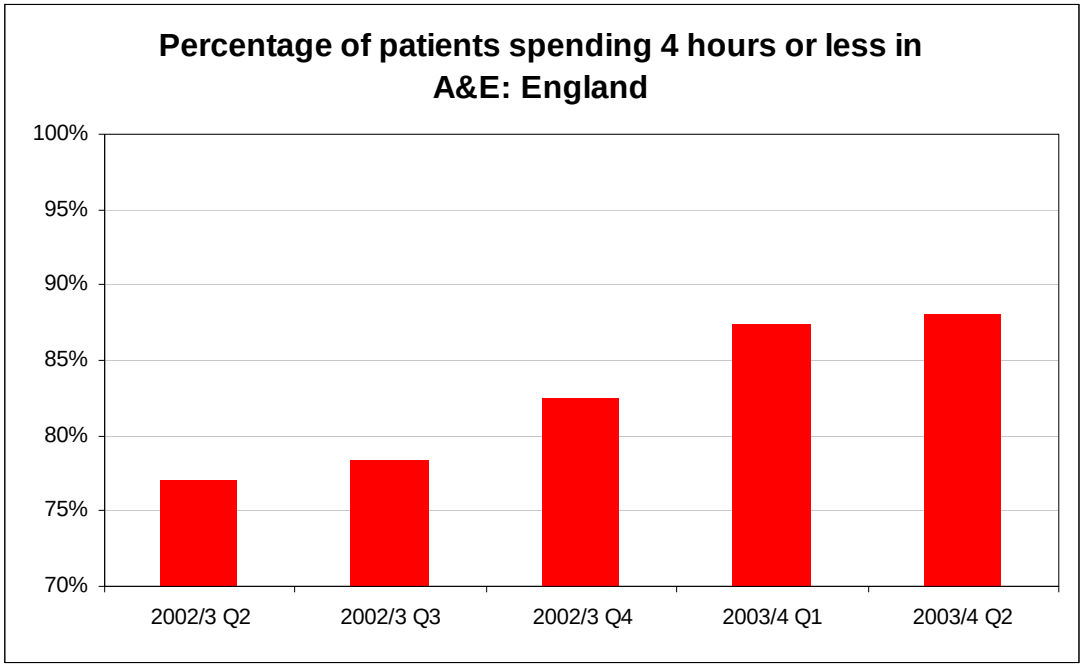
Background

The NHS Plan (2000) stated that: 'By 2004 no one should be waiting more than four hours in Accident and Emergency from arrival to admission, transfer or discharge.' Overall, official figures suggest that the NHS has been reducing waiting times in A&E.

In 2002 around three-quarters of A&E patients were either admitted, transferred or discharged within four hours and just over 700,000 waited more than four hours. By September 2003, 88 per cent were dealt with within four hours and just over 400,000 waited longer than this. However, half of all hospitals in England failed to meet the four hour target.

In Scotland, a sample survey of 10,000 patients conducted over three days in April 2003 showed that the median time for a patient to wait to see a doctor in A&E was around 30 minutes and that 90 per cent of patients were either admitted, discharged or transferred to another hospital within four hours. In Northern Ireland, however, between 2001/02 and 2002/03, the number of patients waiting over two hours increased by 67 per cent, from 15,041 to 25,131. Efforts are now being made to understand the reasons for this in order to address this problem.

Figure 16



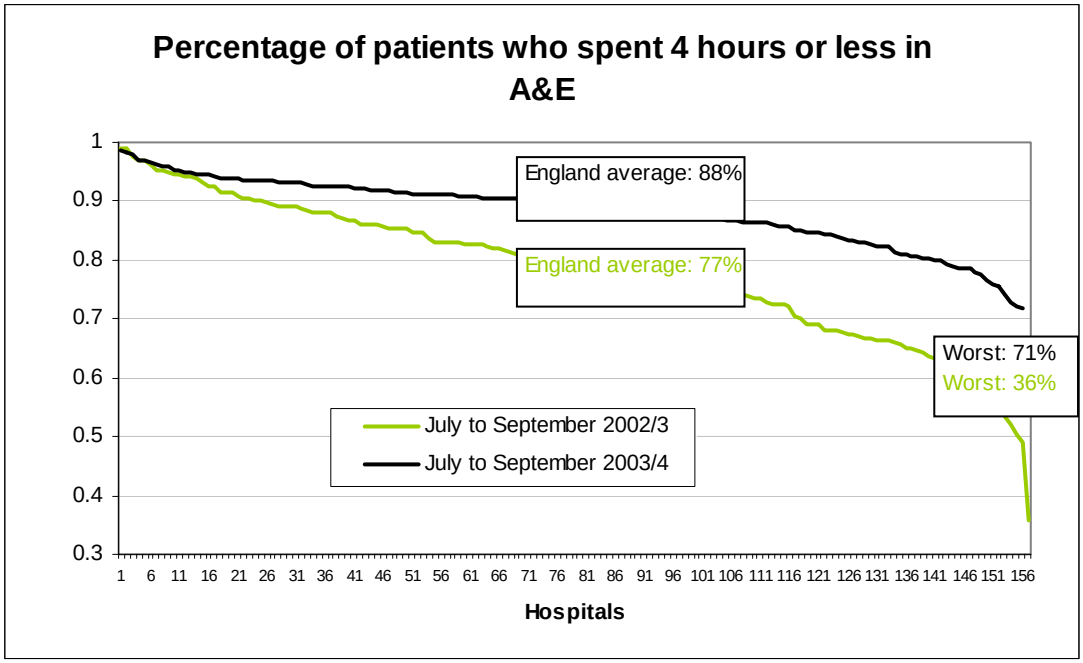
Review

Despite this improvement, there are still variations in A&E waiting times across the country – although the worst performing hospital in 2003/04 (with 71 per cent of its patients waiting four hours or less in A&E) is much better than the hospital which performed least well in 2002 (where only 36 per cent of its patients waited four hours or less).

However, a British Medical Association (BMA) survey of A&E waiting times in 2003 suggested that because the official waiting times data was collected via a pre-announced audit in one particular week, many A&E departments made special efforts to meet the target, which at that time was that 90 per cent of patients are dealt with within four hours. But the figures slipped back subsequently. The Department of Health have since changed the way this target is monitored.

The BMA survey also suggested that a third of A&E departments surveyed did not believe that the published figures for their unit were an accurate reflection of the real situation. The BMA also suggested that over half those surveyed felt that attempts to meet A&E targets had distorted clinical priorities – for example, with less urgent, but longer wait, cases being dealt with before more urgent ones.

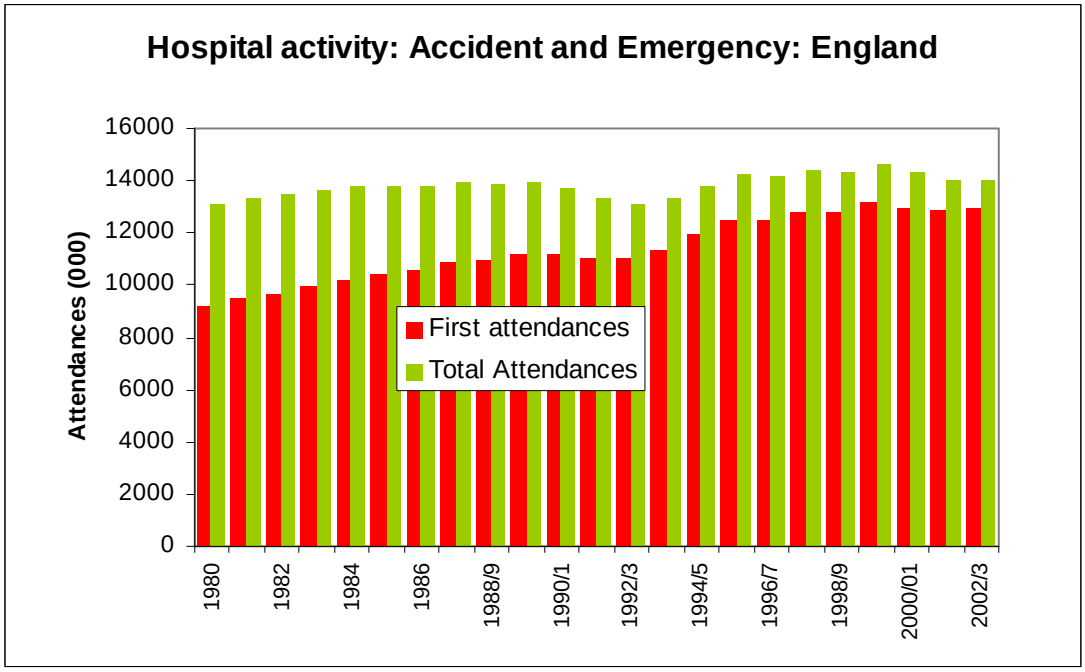
Figure 17



In its 2001 strategy to modernise A&E – *Reforming Emergency Care* – the Department of Health noted various problems that need to be overcome and set out various goals and targets:

- recruit additional 183 A&E consultants by 2004
- recruit 600 additional A&E nurses by March 2003
- reduce occupancy level in general and acute beds to 82 per cent (to relieve pressure on emergency beds)
- reduce delayed discharges to increase bed capacity
- provide 24 hour, seven days a week A&E services
- ensure all A&E departments operate two queues – one for minor and one for serious conditions
- reduce demarcation between health care professionals (for example, enabling nurses and GPs to carry out more emergency work)
- improve consistency of clinical assessments in A&E to enable patients to access the most appropriate services (including self treatment)
- all hospitals to have emergency care leads to co-ordinate local emergency care network
- Commission for Health Improvement to review emergency services on a regular basis.

Figure 18



Success or otherwise on many of these targets is hard to assess. However, a crucial goal – increasing the number of A&E consultants – does not look to be on track, with only an additional 59 consultants recruited between March 2002 and June 2003 – some 124 short of the eventual target.

However, while there are still targets in place for A&E departments, Professor Sir George Alberti has indicated that emergency care staff should concentrate on providing improved care in their departments and not just on meeting targets. The 'vision' for the future is not necessarily more of the same, but a different type of emergency service, more integrated across hospitals, GPs, NHS Direct and other organisations, so that people requiring emergency care are dealt with in the appropriate setting by the right staff.

Public priority 5: Cleaner hospitals

According to the Government - and patients - hospitals are getting cleaner. But tackling the spread of antibiotic resistant bugs is a huge problem without an obvious solution.

Department of Health statistics and surveys of patients' perceptions show that hospitals appear to be cleaner. But it is important to note that the methods used by the Department's Patient Environment Action Teams (PEATs) to assess cleanliness are only visual. They do not take swabs for microbiological analysis or inspect theatres, for example. Furthermore, while patients and staff prefer hospitals which are visually clean, this will only have a minimal impact on the spread of methicillin resistant Staphylococcus aureus (MRSA).

Dealing with the rise of MRSA has proved very difficult. Many more hospitals are now rated 'good' by the PEATs, but over the same period (2001/02 to 2002/03) rates of MRSA (0.17 per 1,000 bed days) have not changed, according to the MRSA surveillance scheme, although between 1993–2002 the number of deaths increased fifteen-fold. In Scotland, MRSA rates appear to be stabilising.

Background

The *NHS Plan* (2000) acknowledged widespread concern amongst patients and NHS staff about the cleanliness of hospitals. The Plan set out extra resources to be directed at improving the cleanliness of hospitals, targets for cleanliness to be achieved, together with unannounced visits from newly created Patient Environment Action Teams (PEATs) made up of health care professionals and patients' representatives.

Since 2000, there have been five inspections by PEATs, and it would appear that hospitals are getting cleaner. There are now no hospitals with a 'poor' rating and nearly eight out of ten now have a rating of 'good'.

In addition, two recent patient satisfaction surveys conducted on behalf of the Commission for Health Improvement (CHI) indicate that 92 per cent of patients surveyed in A&E departments in 2003 thought the departments were either very or fairly clean and 97 per cent of outpatients thought their outpatient department was either very or fairly clean.

In Scotland, a three-year cleaning programme was introduced in November 2002 together with initiatives to deal with hospital acquired infections.

Figure 19

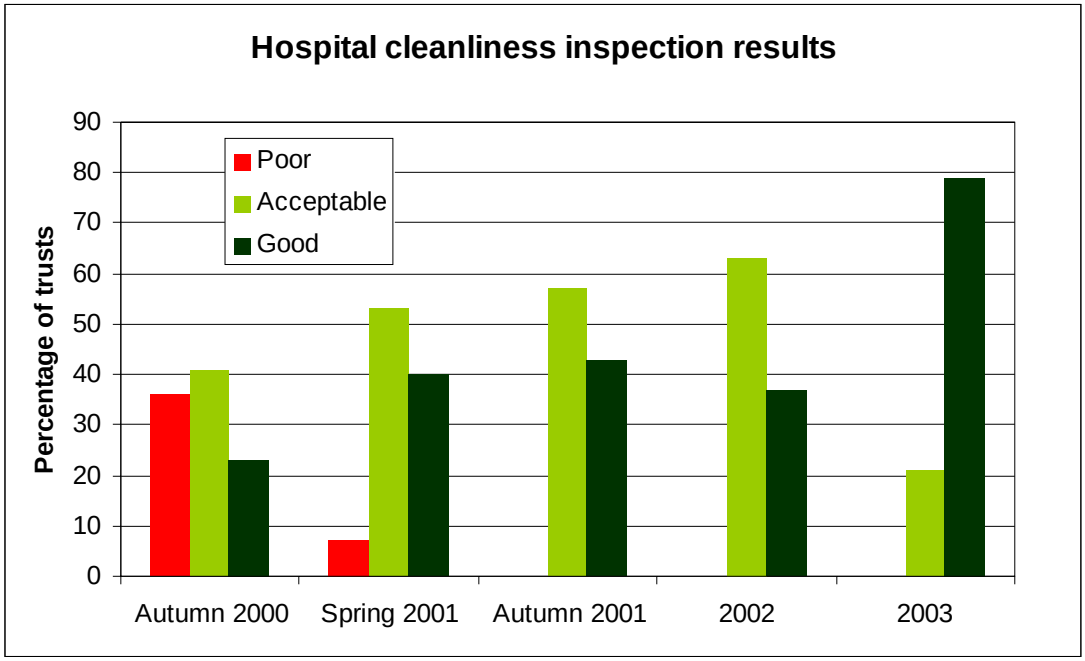


Figure 20

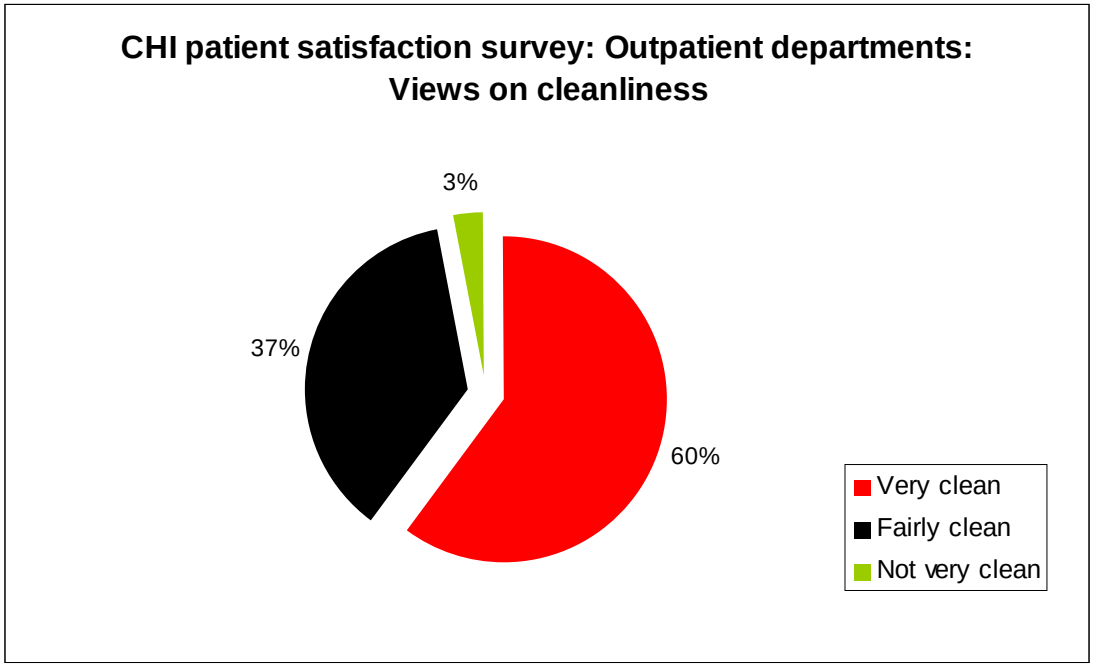
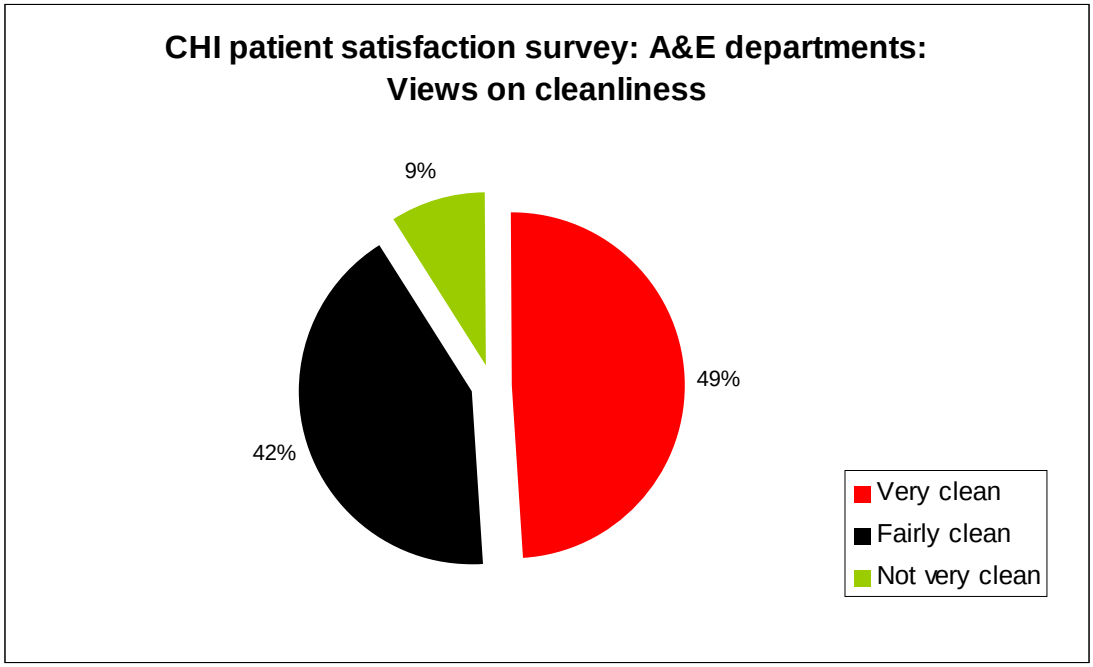


Figure 21



Review

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