



*Chief Executive's Report
to the NHS*

May 2004

*Chief Executive's Report
to the NHS*

May 2004

Gateway reference 3209

© Crown copyright 2004

First published May 20004

Produced by the Department of Health
CHLORINE FREE PAPER

The text of this document may be reproduced without formal permission or charge for personal or in-house use.

Contents

Preface from the NHS Chief Executive	1
1. The Changing NHS: local treatment, redesigned services, choice and reform	4
2. Faster Services and Improved Outcomes	16
3. Greater Capacity: staff, facilities and equipment	31
4. Funding the Improvement: quality and productivity	34

Preface from the NHS Chief Executive

This report describes activity and performance in the NHS over the last financial year and since the publication of the *NHS Plan* in July 2000.

It is clear that something really significant is happening in the NHS. We have a dramatic fall in waiting times coupled with very big changes in how services are delivered in communities and in hospitals. The NHS is using its new funding to good effect, with improvements in quality and productivity.

These successes have been achieved by the hard work, commitment and creativity of hundreds of thousands of people. This is just the start and there is much more to do before we have the services that we all want; but progress is being made quickly and visibly.

The headlines are:

- **improvements are coming quicker**
 - waiting times have fallen faster and further this year than ever before
 - premature death rates from the major killer diseases are falling quickly
 - more staff have been recruited and more buildings and equipment brought into use
- **the NHS is working more effectively and more efficiently:** with measurable improvements in productivity throughout the NHS
 - many more treatments are being provided outside hospitals, more quickly and more conveniently for patients
 - individual services have been redesigned to be more efficient and effective, with staff taking on new roles and responsibilities
 - patients are beginning to be offered more choice and more influence over services
- **there is more to do:** these changes have been won through hard work and through changing the way we work. In building on this good progress we must:
 - continue to learn from each other and our partners and spread good practice
 - give local staff more scope to develop local services, with more support from IT and new facilities
 - improve the whole patient experience, listening to them and the public wherever possible

Improvements are coming quicker

This report shows that waiting times are falling across the board and, crucially, that these falls are sustained and accelerating. Compared to a year ago, patients are now:

- being seen more quickly by GPs and primary care staff: 98% can see a primary care practitioner within 24 hours
- seen and treated faster in A&E: 94% within 4 hours
- given outpatient appointments within an average of 7.1 weeks and a maximum of 17 weeks, down from 21 weeks a year ago
- admitted to hospital within an average of 10.2 weeks and a maximum of 9 months, down from 12 months a year ago
- less likely to face delay in discharge from hospital: improved by 30% in the year

Progress in these areas is on target and accelerating. In the last 12 months, we have seen a reduction of nearly two thirds in people waiting more than 13 weeks for an outpatient appointment and about a 60% reduction in those waiting more than 6 months for admission to hospital.

The total number of people waiting for hospital admission has fallen significantly this year from 992,000 to 906,000. In 2000, the numbers on the waiting list were the equivalent of 10.8 weeks of hospital activity; now they are down to 8.5 weeks which is an improvement of 22% in NHS performance.

Similarly, the report shows that premature death rates from cancer and circulatory disease, and suicide rates, are falling at or better than target trajectory.

These improvements have been achieved with the help of a big increase in staffing – the vast majority of whom have a direct hands on role in patient care – and by the improvements in facilities and equipment being brought into use throughout the NHS.

The NHS is working more effectively and more efficiently

However, these improvements are not just due to the extra capacity in staffing and facilities. Big changes are underway as the NHS reforms and modernises:

- more treatments which were once only done in hospital are now being done in the community
- more drug treatments are keeping people out of hospital
- GPs, ambulance staff and community staff – from the NHS and social care – are finding new and better ways of looking after people

These changes have delivered improved services for patients in the community. They have also helped deliver the big falls in hospital waiting and, equally importantly, contributed to the successful management of winter pressures this year.

The report shows that many services have been redesigned to improve quality and be more effective and efficient with, for example, Treatment Centres providing planned surgery or 'one stop shops' streamlining services. In many cases staff roles have also been redesigned to support these changes.

Patient involvement and greater patient choice have in their turn helped to accelerate these changes and provide more responsive and higher quality services.

The effect of all this is improved quality of services and improved use of resources. The current debate about how to measure productivity in the NHS obscures how hard people are working and how successfully they are delivering improvements in quality and reducing pain and suffering, alongside productivity gains.

Whilst we do not yet have an adequate way of measuring the overall productivity of the NHS:

- we have measurable improvements in productivity in individual services, such as ambulance services and cardiology
- there are quantifiable improvements in results, such as in mortality and access
- health promotion measures, such as flu injections, give value for money
- overheads and wastage is controlled with, for example, lower management costs than other organisations.

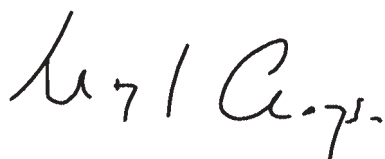
There is more to do

We have seen sustained and accelerating progress over the last four years. However, this is only the start and there is still more to do to make sure that every service is improved and that we can offer every patient the sort of experience we and they would want. We need to:

- continue to learn and implement best practice in all areas – in health promotion and chronic disease management, as well as in acute and primary care services – and make sure we do so in partnership with Local Authorities and the voluntary and private sectors
- use the forthcoming planning round to give local staff and organisations more control of resources and support them with both IT and facilities
- increasingly place patients and the public at the centre of the whole system: giving them as much choice and control as possible, tailoring services to their requirements and listening to their concerns

There is a sustained turnaround happening in the NHS. These figures demonstrate it. It is encouraging to see that external commentators – such as the Nuffield Trust and the King's Fund – are commenting on our improvements such as the significant improvement in waiting times.¹

The improvements recorded in this report have been achieved by the hard work, determination and creativity of hundreds of thousands of people working in and with the NHS. I know that everyone involved has had the very difficult task of making improvements for the future whilst running today's services. We all owe them a great deal. Their effort and their leadership locally will ensure success.



Sir Nigel Crisp
NHS Chief Executive

7 May 2004

1 *The quest for quality in the NHS*, S. Leatherman and K. Sutherland, December 2003.
Has the Government Met the Public Priorities for the NHS?, King's Fund, March 2004,
<http://www.kingsfund.org.uk/pdf/NHSDay.pdf>

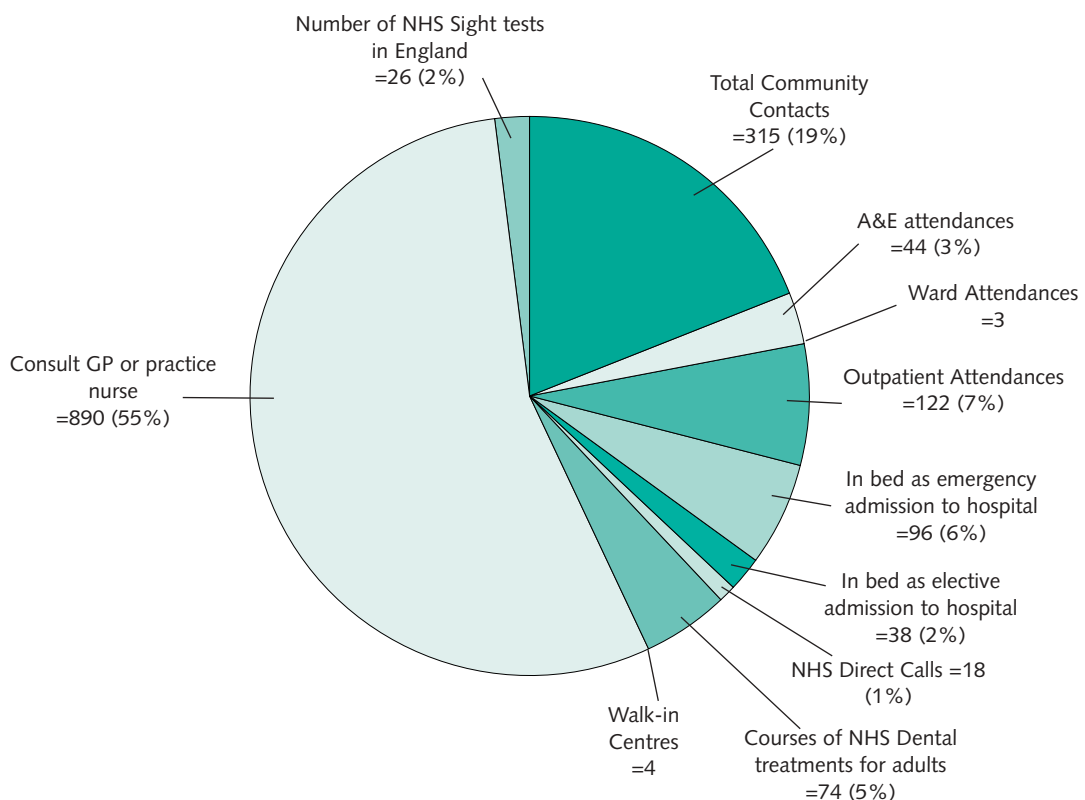
1. The Changing NHS: local treatment, redesigned services, choice and reform

The NHS is changing fast.

- Many more services and treatments are available in the community. Last year
 - there were 325 million consultations with GPs or nurses in primary care
 - 6.4 million calls were made to NHS Direct and there were 6.5 million hits on NHS Direct Online
 - more than one and a half million people used walk-in centres
 - treatments once only available in hospitals were being provided in the community.
- Services are being redesigned to be more effective and efficient and staff roles are changing accordingly.
- Patients are becoming more empowered, with more choice and control.

Most contacts between patients and the health service take place outside hospital, as the following chart shows.

Pie Chart A: Contacts with the NHS per day (thousands)



In order to improve the quality of services, as well as their efficiency and effectiveness, we are making fundamental changes in how the NHS delivers its services. These changes concentrate on:

- providing more care, more conveniently for more patients closer to home
- redesigning services to incorporate good practice
- giving patients more control and influence

This chapter describes how services are changing

- in primary and community care
- for acute emergencies
- for planned or elective treatments

It goes on to describe

- how individual services are being redesigned locally
- how patients are becoming more empowered with more choice and control

Primary and community care

There is a wide range of national and local initiatives in primary and community care, which are improving the quality of services and bringing them closer to the patients and the public. The main ones are:

- changes in primary care itself
 - the introduction of GPs with special interests (GPwSIs) – there are now more than 1300 in the country – who can provide more specialist services in their surgeries
 - the freedom and flexibilities provided through the new General Medical Services (GMS) contract, which will allow practices to develop new services and deploy their staff differently
 - the investment in new health premises, suited to providing a wider range of services, through NHS Lift, as well as more traditional means
 - support from the National Primary Care Development Team in improving practices' performance and from the NHS Modernisation Agency's National Primary and Care Trust Development Team (NatPaCT) in supporting and developing Primary Care Trusts (PCTs).
- new services
 - NHS Direct, the confidential telephone advisory service, now supplemented by the Internet service NHS Direct Online
 - Walk-in centres where patients can find advice and treatment without an appointment or registering

- greater collaboration between health and social care
 - with more shared services, joint appointments and pooled budgets
 - increases in the amount of home care and intensive home care provided by social services
 - rapid reductions in delayed discharges from hospitals
- implementation of the standards in the National Service Frameworks for coronary heart disease, older people and mental health leading to
 - big increases in the prescription of statins and in prescribing more generally
 - improved community mental health services with more outreach and crisis teams
- development of local schemes to promote greater primary and community care as a better way to provide for many patients. These include schemes described below which
 - introduce referral services and provide more local services
 - provide active case management for patients with long term conditions or chronic diseases who can be best cared for out of hospital.

In some areas of the country, community-wide schemes have been introduced to develop primary and community care and ensure that patients get as high quality, fast and convenient a service as possible. In these schemes, GPs will typically refer to a referral centre or to another community provider and only where absolutely necessary directly to an acute hospital. Two examples, from Greater Manchester and from Somerset, are described below:

The 14 PCTs in **Greater Manchester Strategic Health Authority** (SHA) have successfully introduced a system-wide scheme, called **Tier 2**, to deliver more effective primary and secondary care services. The scheme uses a variety of approaches to offer diagnostic assessment and treatment from GPs with a specialist interest, specialist nurses or other practitioners. Many patients who would formerly have been referred to hospital are now treated in primary care. Tier 2 services allow more patients to be seen sooner and this rapid assessment can lead to the earlier detection of serious illness. It also involves more contact with the patient and this improves the quality of the process.

Somerset Coast PCT provides a **Referral Management Centre** (RMC), which helps patients to make informed choices with their GP about where they should be referred. It is a simple system in which GPs send all their scheduled referrals through the RMC. This in turn feeds information back to GP practices to facilitate the process of patient choice. The result has been a significant increase in the number of patients choosing to see a specialised GP in the community, which is often more convenient for them than hospital admission. Patients also have shorter waiting times through being able to choose the fastest treatment route if they wish. In addition, information collected from referrals passing through the RMC allows trusts to understand, with a greater degree of clarity, the health needs and choices of their community and they can commission and develop services to match.

There are also now a number of schemes around the country – some of these supported by learning from other countries and organisations such as United Healthcare from the USA – which have identified those patients with long term conditions or chronic diseases who have most need of care and support. In many cases they are introducing case managers who will provide that support proactively at home, rather than subject the patient to repeated hospital visits and admissions.

9 PCTs across the country are implementing United Healthcare's **Evercare** approach for managing care for vulnerable, elderly patients. Each of the PCTs has put in place a team of nurses with enhanced clinical skills to provide co-ordinated care and increased support to a caseload of vulnerable, elderly patients. These nurses are working with the wider primary healthcare team and bringing the different parts of the health and social care systems together to help these patients stay healthy and out of hospital. Patients and their families have felt real benefits from being supported and treated at home when previously they would have gone into hospital.

The example below from Essex shows how patients are being helped to manage diabetes closer to home so reducing the need to attend hospital.

When diabetes patients in Canvey Island in Essex have a problem with their medication or are suffering a bad episode, they can turn to specialist nurse Alexis Hodgkins. She runs two nurse-led clinics each month and a weekly drop-in clinic at a local health centre, offering patients help and advice and, where necessary, adjusting their medication so they can regain control of their condition. Alexis is one of four nurses with a special interest (NwSI) in diabetes who are employed by **Castle Point and Rochford PCT**. The outreach clinics give patients fast and easy access to care and treatment. They also free up the time of Southend Hospital's two diabetes consultants by providing follow-up care, which would otherwise be handled in their outpatient clinics. "The services we offer are very patient-centred," said Alexis. "Our clinics are local, easy to access and give patients the confidence of knowing they can see someone they know who has time to spend with them."

The impact of these changes can be seen in some of the figures relating to activity levels nationally shown in the following table. In every case there is growth in community based activity. There is a corresponding slowing down in GP referrals to consultants.

Table A: Increased activity in community and primary care

	In 1999/2000	In 2003/2004	Increase during– 2003/2004	Increase since NHS plan ¹
Patient access				
Calls to NHS Direct	1,650,000	6,411,000	92,000 (1.5%)	4,761,000 (289%)
Visits to NHS Direct Online	n/a	6,542,000	2,570,000 (65%)	n/a
Patient visits to walk-in centres	0	1,582,000	209,000 (15%)	1,582,000
Prescribing				
Number of prescriptions in the community	540.7 million ²	649.7 million ³	32.7million (5.3%)	109 million (20%)
Cost of drugs prescribed (£ millions)	£5547.4 ² million	£7510.1 ³ million	£663.4 million (9.7%)	£1962.7 million (35%)
Mental health				
Assertive Outreach (number of teams)	130 ⁴	251 ⁴	54 (27%)	121 (93%)
Crisis Resolution (number of teams)	n/a	137 ⁴	75 (121%)	85 ⁵ (163%) ⁵
Early Intervention (number of teams)	n/a	36 ⁴	14 (64%)	20 ⁵ (125%) ⁵
Social care				
Number of contact hours of home care provided ⁶	2,684,000	3,113,000	130,000 (4.4%)	429,000 (16%)
Number of households receiving intensive ⁷ home care ⁶	68,700	87,000	5,600 (6.9%)	18,300 (27%)
Elective procedures				
Procedures in Primary Care	n/a	725,000 ¹³	16,000 ¹³ (2.2%)	n/a
Referrals to consultants				
Number of GP referrals made to outpatients ⁸	8,961,000 ⁹	9,328,000 ¹⁰	12,000 (0.1%) ¹¹	367,000 ¹² (4.1%)

1 In all tables, change since the NHS Plan takes as a baseline the last annual figure before July 2000. This is usually for 1999/2000 although some figures are published on different dates and these are indicated.

2 Figures are on a year to June basis.

3 Figures are on a January to December basis i.e. calendar year 2003.

4 Data is collected annually in the autumn.

5 Increase between Autumn 2001 and Autumn 2003.

6 During a survey week in September.

7 Defined as more than 10 contact hours and 6 or more visits during the week.

8 Figures for referrals based on 2003/4 definitions.

9 Figures are for the financial year.

10 Figures are for calendar year because Quarter 4 figures are not yet available.

11 Increase from calendar year 2002 to calendar year 2003.

12 Change from 1999/2000 baseline to 2003 figure.

13 Estimated.

The results of these changes can be seen throughout the country in many examples of improved services for individual patients. In addition, as reported in the next chapter, they are contributing to falls in waiting times for appointments in primary care.

As importantly, the increased activity in primary care is helping shorten waiting times in hospitals. The average annual growth over the last five years in GP referrals to consultants has been 1.5%, but this year has reduced to almost zero for the first time. Halting the increase in GP referrals to consultants has undoubtedly contributed to the fall in waiting times for admission and for consultation. Other improvements and interventions have similarly helped reduce the pressure in A&E.

Emergency care

The ways in which emergency care is being provided is also changing rapidly. More and more care is being provided through emergency care networks which co-ordinate the activities of the ambulance service, NHS Direct, primary care, acute hospitals, and community and social care.

By 2006, primary care out of hours (OOH) services should be fully integrated with other emergency care services, to offer people an appropriate response to their unscheduled care needs. This is already happening in some parts of the country. Out of hours providers, NHS Direct and local PCTs have been developing such integrated approaches at 34 exemplar sites covering 10 million patients.

In Nottingham, for example, it has long been recognised that the pressures of emergency and unplanned care affect the whole of the health and social care system. Their local solution is to adopt an inter-agency approach to meet patients' needs, as pressure at any particular point can have an impact on the health and social system as a whole.

Nottingham Emergency Medical Services (NEMS) is a local out of hours co-operative. It has agreed referral protocols with its local ambulance service to help prevent patients going unnecessarily to A&E departments. It has also established care pathways so that patients who attend an A&E department or an NHS Walk-in Centre can be referred directly to the out of hours primary care centre if that is the more appropriate place for them to receive treatment.

In the example from Coventry below, the PCT has recently introduced an integrated out of hours service.

Coventry Teaching Primary Care Trust's new out of hours service went live in April 2004. Designed as a truly integrated service, the PCT is directly employing a range of staff to work out of hours, including nurses and a number of local GPs. The new General Medical Services contract has allowed the PCT to plan and deliver a much more comprehensive out of hours service for the people of Coventry, utilising the skills of a whole range of staff, emphasised by a recent doubling of the nursing staff. The new service allows pressure to be taken off Coventry GPs. They benefit from being able to work in a service which is an important part of the local emergency care network, and patients benefit from a wide ranging, modern and integrated service designed to make sure they get the right treatment from the right clinician efficiently and effectively.

Improvements are being made in all parts of the emergency care system.

- Ambulance services are transporting patients to hospitals more quickly but are also introducing schemes, such as that from the London Ambulance Service in Croydon described below, where ambulance staff are able to treat some patients in their own homes or take them to facilities other than acute hospitals.

- A&E services throughout the country have introduced new ways of working, most notably 'see and treat' which have helped them to see patients more quickly and achieve the access targets described in the next chapter.
- Alternative sources of care are being promoted through, for example, the 'get the right treatment' campaign which highlights the role of pharmacies, as well as hospitals and surgeries.
- Uptake of vaccination for flu in those aged 65 and over increased to 71%, up from 65% three years ago.

As part of the work to identify and improve the different staff skills and competencies available within the emergency care system, the NHS Modernisation Agency's Changing Workforce Programme is piloting the new role of Emergency Care Practitioner (ECP). An ECP is an advanced healthcare practitioner who has undertaken specific training so that they can practice independently in a variety of settings. There are 17 pilot sites across England looking at an expanded role for paramedics and emergency care nurses working in A&E, pre-hospital areas, such as minor injury units and walk-in centres, and primary care, as well as in more traditional ambulance settings.

As a result, patients benefit by receiving the most appropriate care in the most appropriate place by the most appropriate healthcare professional, often negating the need for them to attend hospital. There is increasing evidence from the pilot sites that ECPs have led to a reduction in unnecessary waits for emergency care, reduction in attendances of A&E and improved patient experience.

For example, London Ambulance Service NHS Trust has 24 ECPs. They provide a 10am-10pm service in Croydon and Wandsworth managing mainly category C cases (those that are not life threatening but need assistance and/or advice). Of these cases, 83% are dealt with by a single ECP. This model has the potential of being 30% cheaper for the ambulance service as more emergencies can be dealt with by a single practitioner. In addition, as many people are treated by the GP or taken to another facility, the patient gets a faster and better service and pressure is taken off hospitals.

The active management of emergency care throughout the country has meant that, despite the fact that there has been increased demand, waiting time targets have been met and emergency pressures over winter have been very well managed. The following table shows the activity levels.

Table B: There is continuing growth in emergency activity

	In 1999/2000 ¹	In 2003/2004	Increase during– 2003/2004	Increase since NHS plan ¹
New A&E attendances	13,167,000	13,891,000 ²	786,000 ³ (6.0%)	723,000 ⁴ (5.5%)
Total emergency admissions	3,876,000	4,252,000 ⁷	245,000 (6.1%)	376,000 (9.7%)
Ambulance emergency journeys	2,850,000	3,178,000 ⁵	n/a ⁵	328,000 ⁶ (11.5%)

1 Figures are for financial year.

2 Figures are for calendar year 2003, financial year data for 2003/04 is not yet available.

3 Increase from calendar year 2002 to calendar year 2003.

4 Increase from 1999/2000 baseline to 2003 figure (figures in table are rounded).

5 Most recent data for ambulance emergency journeys is for 2002/03.

6 Increase from 1999/2000 to 2002/03.

7 Provisional figure.

Elective or planned care

Major changes are also underway in the provision of elective treatment. The main changes are:

- The way, described earlier, that more treatments are being carried out in primary and community care that were once only offered in hospitals.
- Improvements in the way that hospitals operate with new, more streamlined services allowing faster and more convenient access for patients. As part of this, more treatments that once required admission are being done in outpatients.
- Increasingly integrated and strategic elective/emergency bed management is making the most efficient use of beds in hospitals. This is helping to ensure that elective operations can go ahead alongside the improvements to emergency waiting times.
- New Treatment Centres are being developed which separate elective care from emergency care and make planning of treatment more efficient.

The following table illustrates these changes and shows that 364,000 more procedures were carried out this year than last.

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

	In 1999/2000	In 2003/2004 ²	Increase during– 2003/2004	Increase since NHS plan ¹
Elective Hospital Admissions ¹	4,942,000	5,454,000	167,000 (3.2%)	512,000 (10.4%)
Procedures in Outpatients	n/a	1,916,000 ³	181,000 ³ (10.0%)	n/a
Procedures in Primary Care	n/a	725,000 ³	16,000 ³ (2.2%)	n/a
Total procedures	n/a	8,095,000	364,000 (4.7%)	n/a

1 All NHS funded patients, including those treated in both NHS and private hospitals.

2 Provisional figures.

3 Estimated.

Table D: Outpatient activity

	In 1999/2000 ¹	In 2003 ²	Increase during 2003 ³	Increase since NHS plan ⁴
Number of new outpatient attendances with a consultant ⁵	12,136,000	13,299,000	469,000 (3.7%)	1,163,000 (9.6%)

1 Figures are for the financial year

2 Figures are for calendar year because Quarter 4 figures are not yet available

3 Increase from calendar year 2002 to calendar year 2003

4 Change from 1999/2000 baseline to 2003 figure

5 Figures from NHS trusts, since commissioner-based information is not yet available

Redesigning services

The improvements described in this report involve redesign of the way services are delivered and the way staff members work, of which there are now thousands of examples around the country. This section describes two major national initiatives: the introduction of Treatment Centres and the support work of the NHS Modernisation Agency. It also recognises that there are many individual examples of service improvement which have been initiated and led locally.

Treatment Centres

Treatment Centres provide safe, fast, pre-booked surgery and diagnostic tests by separating scheduled treatment from emergencies. They provide a wide range of surgical procedures and diagnostic tests, but concentrate on those specialities where there are bottlenecks, such as ophthalmology and orthopaedics. By the end of 2005, we expect 80 Treatment Centres to be open, providing up to 250,000 additional operations a year.

There are 26 NHS-run Treatment Centres already open and a further 20 in development. We anticipate that these 46 NHS-run Centres will be treating an additional 144,000 patients a year when fully operational by the end of 2005.

In addition, the NHS has turned to the independent sector to provide extra capacity quickly, through the independent sector Treatment Centre Programme. It will utilise the talents of some of the world's leading independent healthcare companies to deliver high quality care for NHS patients. This programme represents an investment of £2.3 billion over five years. The providers are being asked to provide innovative solutions, which can include mobile units, modular facilities and the use of refurbished NHS facilities.

There are two independent sector Treatment Centres now open and a further 32 are in development. The work of mobile ophthalmology units is described below.

At the rate of 100 procedures a week, each of the two **Independent Sector Treatment Centre mobile units** are helping to cut waiting lists for cataract operations. Since taking to the road on 1st February, they have operated on approximately 2,500 people and have visited a total of 10 different sites. They spend anything from two days to two weeks in each location. In the north of England, once the immediate waiting lists have been dealt with appropriately, the units will travel on an 11 week rotation. The units in use are completely self contained. All of the clinical staff who work in the mobile units are additional to the NHS and represent a clear increase in the services provided to patients. Netcare (UK) Ltd has a five-year contract with the NHS, during which time they shall complete over 40,000 cataract removal procedures.

Modernisation: service improvement and redesign

The NHS Modernisation Agency (MA) was established in April 2001, as a result of the *NHS Plan*, to help local clinicians and managers redesign services around the needs and convenience of patients. In its three years, the MA has worked collaboratively with over 150,000 NHS staff, which has brought great benefits to patients on many thousands of projects. A few examples from many are:

- through the work of the Agency's Coronary Heart Disease Collaborative waiting times for all types of diagnostic tests have fallen
- redesigned services for cancer patients, supported by the Agency's Cancer Services Collaborative, mean that patients who are urgently referred by their GP with suspected cancer see specialists more quickly
- the work that the Agency has done on radiology has improved the treatment of 977,000 patients by reducing waiting time from referral to examination on average by 32 days

Mayday University Hospital in Croydon has reduced its waiting times in radiology by 80%, partly with the help of a dedicated radiology service improvement manager. Vanessa Wood, Chief Executive for the trust said: "The service improvement project in radiology has provided an excellent example of redesigning services to improve patient care. Identifying and reacting to bottlenecks in the process has meant that, with little investment, the benefits of major change have been felt across the trust. The success of the project owes much to the way the redesign principles have been embraced by all members of the clinical team, so much so that it is now seen as an essential part of the 'day job!'"

These changes and local modernisation often depend on staff taking on different roles. The example below shows how paramedics at the Westcountry Ambulance Service have improved treatment for heart attack patients and saved lives.

In February 2003, the **Westcountry Ambulance Service NHS Trust** launched a training programme for paramedics that led to an average reduction of approximately one hour in treatment delay for those with acute myocardial infarction. This followed publication of the National Service Framework for Coronary Heart Disease and was based on lessons learned from pilot studies in Cornwall and South Devon. By April 2004, 520 paramedics had been trained in electrocardiogram (ECG) analysis and thrombolysis. Patients will benefit from the new programme, which will significantly reduce mortality and complications, such as heart failure.

Patients becoming more empowered through more choice and control

The way patients relate to the NHS is being changed and strengthened. This involves:

- recognising that patients with long term conditions are often more knowledgeable about them than individual doctors. The 'Expert Patient Programme' is designed to help such patients contribute to the planning and organisation of services
- the introduction of greater choice for patients, with early pilots being successful
- the creation of patients forums which allow local people to have direct influence on their local services

Choice

The public wants services that are responsive and that can accommodate the needs of the individual. The Department of Health has recently conducted an extensive consultation on what would most improve the experience of healthcare for patients. Drawing out the main themes of the public consultation, the Government published *Building on the Best: Choice, Responsiveness and Equity in the NHS*, which set out how we need to make the NHS more responsive by offering choice across the spectrum of healthcare.

Offering choice is not an end in itself; it is a means to improving the patient experience by empowering them and professionals to make shared decisions. In extending choice in the NHS, we are mindful of the need to offer the right level of information so that patients are making informed choices and have the professional support they feel they need to do so.

There is already much good practice locally and many schemes where service users are becoming more involved in their care. A national initiative offering choice of hospital is already being implemented for those waiting over six months for elective surgery and from December 2005 choice of hospital will be offered at the point of referral by a GP. From December 2005, it is expected that nine million patients a year will be offered choice.

Local communities are making their NHS services more responsive to meet patients' needs. The examples below, from the London Patient Choice Project, show how individuals are being given more choice in where and when they have the treatment that they need.

Malcolm had an accident at work that shattered his knee and triggered rheumatoid arthritis: "I had to go up and see the surgeon every six months for an examination on the knee and every time I went up there it was getting worse so he said I would definitely need a knee replacement. Sitting indoors one day I got a phone call saying they were London Patient Choice and would I go to another hospital to have the knee done. I was in a lot of pain and my local hospital said that I'd have to wait even further on the waiting list so I said 'yes'." Malcolm was offered a date to go for a consultation at University College Hospital. He had the operation a week later.

Hilda's eyesight had deteriorated in both eyes to the point that she had double vision and she couldn't see a person's face across the road. Hilda was put on the waiting list for cataract surgery at her local hospital: "They told me I would be on a waiting list for quite a while. Then I heard from London Patient Choice in February. They offered me four choices within the London area. I accepted a March appointment at King's College Hospital. I jumped at the chance of going and getting this done within a matter of weeks at King's." Hilda and her husband Stanley were taken up to King's for the first operation on one eye and then again six weeks later for the operation on the second eye. "All the staff there were first class. And now, well it's great to have your sight virtually back again as it nearly was before. I'm all for giving patients more choice and going somewhere else for your treatment if it's going to be quicker."

Patient 'voice' is also very important in allowing people to influence their local services. During this year, 4,800 people have been recruited on to the new patient forums, one of which is associated with each NHS provider unit, whether they are NHS Trusts or PCTs. These forums are new bodies but already, as described in the example of Bromley below, they are beginning to become fully engaged in their local services.

The Bromley Patient and Public Involvement (PPI) Forum has been actively working with its NHS Trust to take forward its primary role of monitoring and reviewing the local NHS. The eight member Forum has split into three groups and has just completed an inspection of the Trust. Group one is working to improve air conditioning, signage, telephones, food and cleaning. Group two is working to review bed shortages, water basins, showers, discharge coordination, ward observation and dementia training. Finally, group three is working with the minor injury unit to monitor waiting times. It is improving access to interpreters and is providing literature in a number of languages spoken by people in the community. Once collected, the findings of each of the working groups will be shared with other members of the forum at one of their public meetings.

The future

The changes described in this chapter have come about from the initiative and hard work of literally thousands of people. They are making improvements for patients and the public throughout England. They also provide an excellent foundation for future improvements. We need to make sure that:

- the whole NHS is able to learn and adopt best practice in all areas with the support of national agencies, such as the NHS Modernisation Agency and its successor, as well as the National Primary Care Development Team;
- the forthcoming planning round gives more control of resources to local staff and organisations to focus on local issues
- the introduction of new staff contracts and the IT system support these changes and give local leaders the tools with which to make progress; and
- we continue to listen to and involve patients and the public, and give them more influence and control over their own treatments and their local services.

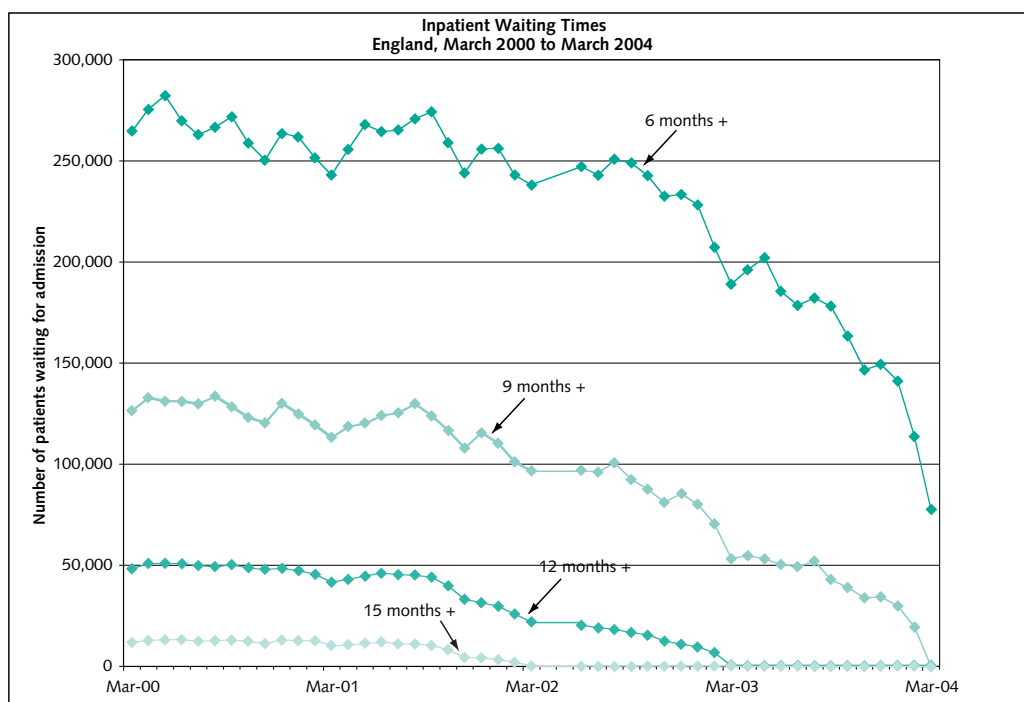
2. Faster services and improved outcomes

Waiting times throughout the healthcare system are falling and challenging targets to reduce waiting are being met thanks to the concerted effort of people in all parts of the NHS and social care.

- Long waits for inpatient treatment have been cut so that hardly anyone now has to wait more than 9 months and the average wait is far lower at 10.2 weeks. The numbers waiting more than 6 months have fallen by about 60%.
- Similarly, we are successfully tackling long waits for outpatient appointments so that hardly anyone waits over 17 weeks and the average wait is far lower at 7.1 weeks. The number waiting more than 13 weeks has fallen by nearly two thirds.
- 97% of patients are able to see a GP within 2 days and 98% can see a primary care professional within one day.
- 94% of patients are seen and treated in A&E within 4 hours.
- The number of people delayed in their discharge from hospital is falling sharply.

Graph A shows that the number of long waiters for inpatient treatment has been falling steadily since the publication of the *NHS Plan*. Thanks to the efforts of people throughout the NHS, we have achieved the target of a 9 month maximum wait by March 2004. This means we are well placed to reduce the maximum wait to 6 months by December 2005.

Graph A: Maximum inpatient waiting times



Note: Figures for April and May 2002 were not available following the abolition of Health Authorities.

Not only does Graph A show successful reductions in long waits, but it also shows that the downward trends have been more consistent month by month in the last year than in the previous three. This indicates that the NHS is getting better at managing capacity and demand so that it is more able to cope with seasonal variations and does not face such a rush towards the end of the year to meet its targets.

The following table shows how much progress has been made in the last year and since the publication of the *NHS Plan* in three time categories. It shows that twelve month waits have now been virtually eradicated and, as of the end of last year, hardly anyone now waits for more than nine months for inpatient treatment.

Table E: Inpatient waiting times at the end of March 2004

	March ¹ 2000	March ¹ 2003	March ¹ 2004	Reduction in last 12 months	Reduction since NHS Plan
Number of people who had been waiting over 9 months	126,388	53,183	48 (34 ²)	53,135	126,340
Number of people who had been waiting over 6 months	264,370	189,054	77,587	111,467	186,783

1 Figures are cumulative so, for example, the 264,370 patients who were waiting more than 6 months in March 2000 includes those waiting more than 9 months (126,388) and those waiting more than 12 months (48,145).

2 Of the 48 people who have been waiting over 9 months, 34 patients are waiting for admission to English trusts and 14 are waiting for Welsh hospitals.

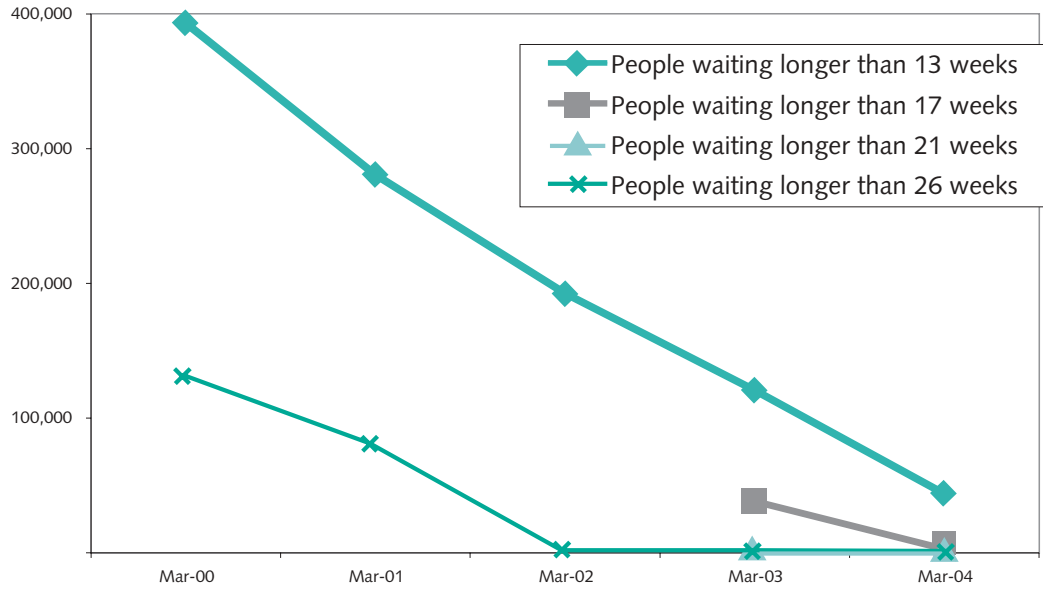
The following table and graph show similarly positive trends in outpatients. Hardly anyone now waits more than 17 weeks for their outpatient appointment and the number of patients waiting more than 13 weeks is dropping quickly.

Table F: Outpatient waiting times at the end of March 2004

	March 2000	March 2003	March 2004	Reduction in last 12 months	Reduction since NHS Plan
Number of people who had been waiting over 17 weeks	n/a	38,011	18	37,993	n/a
Number of people who had been waiting over 13 weeks	393,027	120,259	43,848	76,411	357,760

Note: The number waiting over 17 weeks were not collected until April 2002.

Graph B: Outpatient waiting times in England



Note: The number waiting over 17 weeks and 21 weeks were not collected until April 2002.

Although there was a slight increase in the number of people waiting for admission to hospital in the two years after the publication of the *NHS Plan*, numbers are now falling significantly. The downward trend is firmly established and the total number of people waiting for admission to hospital fell to 906,000 at 31 March 2004, the lowest number for over fifteen years.

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

	March 2000	March 2003	March 2004	Reduction in last 12 months	Reduction since NHS Plan
Total waiting list	1,037,000	992,000	906,000	86,000	131,000

In 2000, the total waiting list of 1.037 million people was equivalent to 10.8 weeks of activity at the then activity rates. Today the total list is equivalent to 8.5 weeks of activity at current rates – a major improvement in NHS performance of 22%.

Whilst the NHS has made considerable efforts to tackle the longest waits, it must be remembered that the majority of patients receive treatment far more quickly than these maximum time measurements. The median waiting time of those waiting for admission is now only 10.2 weeks. This is the most recent figure which is a reduction from the previous year.

There are other ways to calculate averages. The above figures are based on the *Körner* statistics that record the time that patients on the waiting list have been waiting. Another measure – the time between decision to admit and admission to hospital for patients admitted in the previous year – can be produced from *Hospital Episode Statistics*. The latter measure will not be available until the autumn.

The reduction in waiting times for both inpatients and outpatients is attributable to the hard work of frontline staff and extra capacity that allows them to carry out more procedures. Improvements have also been made possible through new ways of working such as the following initiative in Sheffield.

A seven person, nurse-led clinic service set up at the colo-rectal unit of the **Northern General Hospital in Sheffield** has enhanced patient care, halving waiting times for patient assessment following GP referrals. The colo-rectal unit now treats almost twice as many patients as it did three years ago. Instead of the team of consultants managing the bi-weekly clinics, skilled nurse practitioners now hold the clinics so that the consultants can concentrate on acute treatment and major surgery. The nurse practitioners offer preliminary endoscopy services and provide personal care plans, including dietary and supportive advice.

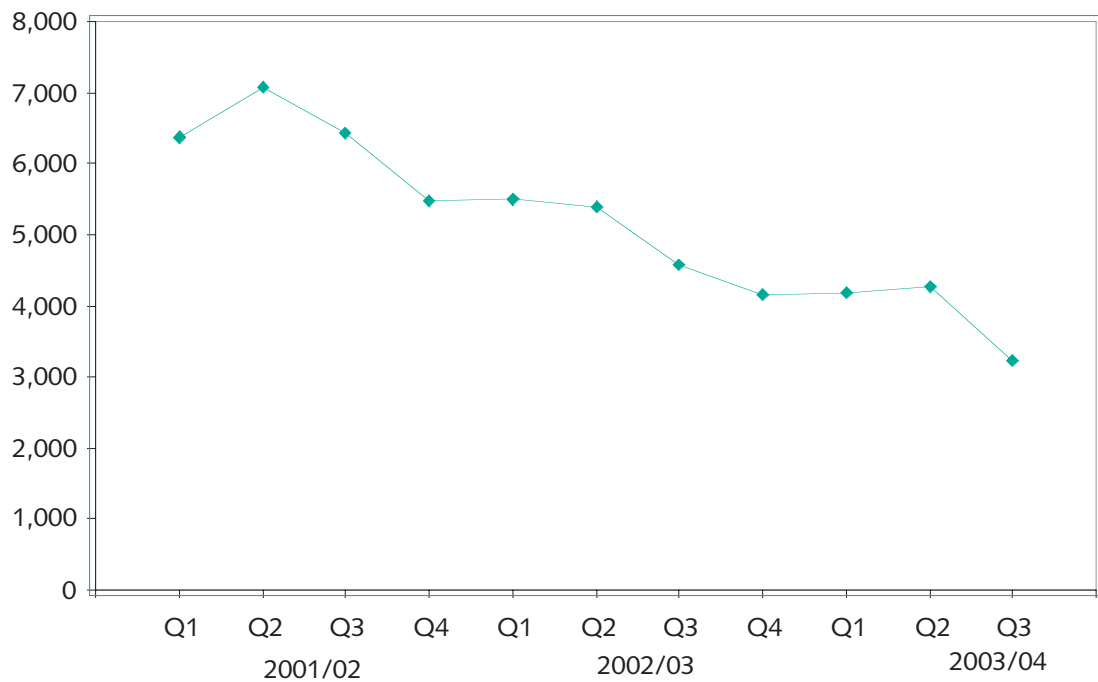
Delayed discharges

It has been due to good work by social care services, in tandem with the NHS, that the number of delayed discharges from hospitals has continued to fall. There was a particularly significant fall towards the end of 2003 following the commencement of the shadow period for the Community Care (Delayed Discharges) Act 2003, which introduced financial reimbursement for delayed discharges from January 2004. The long-term trend of improvement and the recent sharp drop in delayed discharges is shown in the table and graph below. An example of the practical ways that an NHS Trust in Cambridge is tackling delayed discharges, in partnership with social care and community health, follows the graph.

Table H: There was a big reduction in delayed discharges in 2003/04

	March 2000	December 2002	December 2003	Reduction December 2002 to December 2003	Reduction since NHS Plan
Number of patients of all ages occupying an acute hospital bed with delayed discharge	n/a	4,586	3,220	1,366 (29.8%)	n/a
Number of patients over 75 occupying an acute hospital bed with delayed discharge	5,431	3,502	2,406	1,096 (31.2%)	3,025 (55.7%)

Graph C: Numbers of patients of all ages occupying an acute hospital bed with Delayed Discharge



Improving discharge procedures, so that a patient's discharge is not delayed through poor communication or organisation, is one way of increasing a hospital's capacity to admit patients. **Addenbrooke's Hospital in Cambridge** has introduced a risk assessment on admission to identify those patients who might have complex needs following discharge and are therefore at risk of being delayed. This means that their discharge can be properly planned, involving colleagues from community health and social services early in the process, to avoid duplication and to ensure that the right services are in place when the patient needs them.

Waiting in primary care

Now 97.5% of patients can see a primary care professional within one working day and 97.4% can see a GP within two working days, if they choose. The following table shows the dramatic improvements that have been made in the last two years.

Table I: GP and Primary Care Professional appointment availability

	March 2002	March 2003	March 2004	Increase during 2003/04
GP within 2 days	74.6%	88.2%	97.4%	9.2%
Primary Care Professional within 1 day	71.7%	90.5%	97.5%	7.0%

Much of this progress has been made possible by new ways of working and by designing services around the needs of patients, which is more convenient for them and reduces delays that can be caused by providing services in isolation from each other.

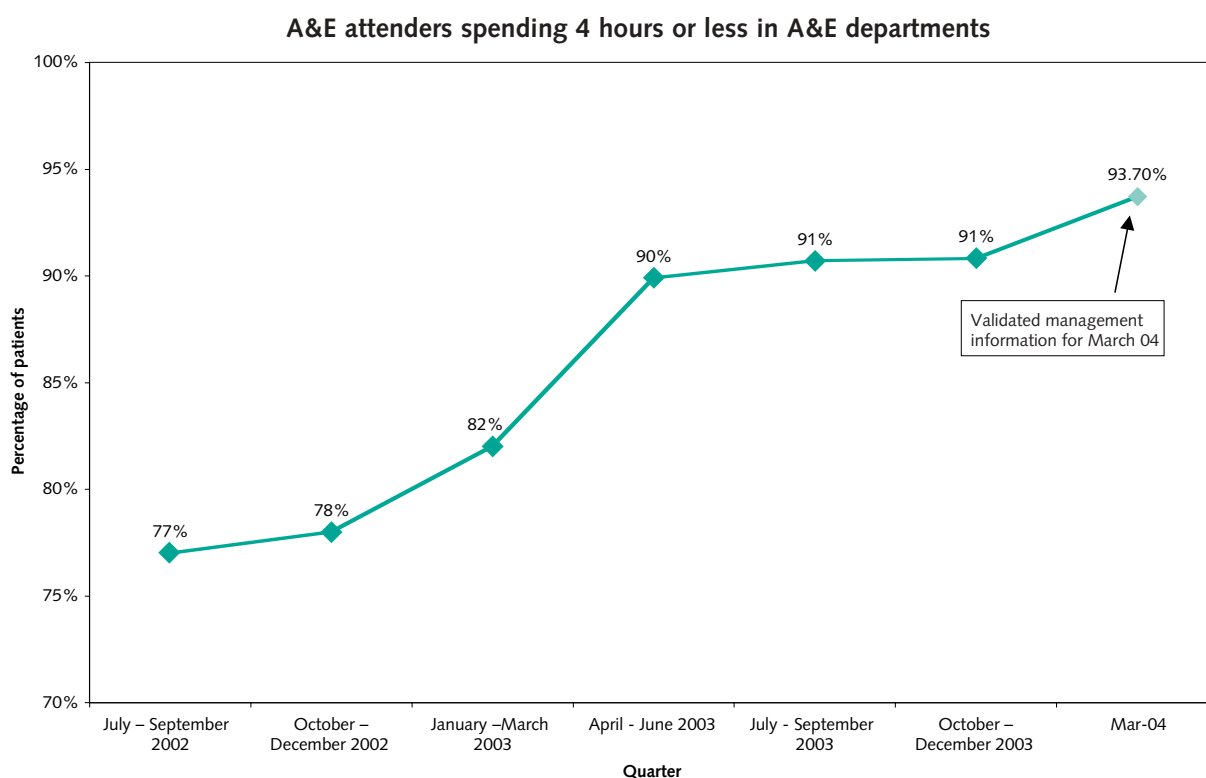
Appleton Primary Care, a Personal Medical Services practice in Warrington, has developed a whole-team approach based on the needs of the patient so that they can act as a 'one-stop shop'. This integrated approach cuts down on bottlenecks and bureaucracy, which can delay patient treatment. Nurse clinicians now care for patients' straightforward injuries and minor illnesses, leaving the GP more time to concentrate on complex cases. All patient information is stored in a single record, which means there is less confusion and risk of error. Patients are also given copies of their records so that they are involved in a working partnership with the clinician. With this approach, for example, a new mother will now be given a single post-natal consultation to see a primary care nurse or nurse clinician with health visiting skills, as well as a GP who will carry out some of the baby's physical examination. This avoids the inconvenience of repeated visits to different healthcare professionals.

At new out of hours NHS Walk-in Centres in **Southampton**, the multi-skilled nursing staff assess patients and carry out procedures traditionally referred to doctors and specialists. This includes administering drugs, requesting x-rays according to a series of protocols and admitting people to hospital. With more staff available to manage minor injuries and illnesses and offer advice, waiting times for patients have been significantly cut to less than one hour and GPs are more available to provide a better service in the community.

Faster treatment in A&E

Patients are also being seen and treated more quickly in A&E. The graph below shows that more and more people who attend A&E spend no more than four hours there in total. Performance has now been maintained at 90% or above for the 9 months from March-December 2003. Further progress is steadily being made. 87 of the 155 trusts with a major A&E department achieved 94% or above in March 2004, compared to 24 by December 2003. The NHS is well on track to deliver the minimum standard of 98% by December 2004.

Graph D: Waiting times in A&E



Note: Up to January - March 2003, percentage is for major A&E departments. From April - June 2003, percentage is for all A&E departments, as data for all began to be collected from that quarter.

Progress has been made with extra capacity and redesigned services as in the following examples.

Hinchingbrooke Hospital A&E unit, run by **Hinchingbrooke Healthcare NHS Trust**, now treats over 96% of its patients in less than four hours. This is attributed to new ways of working, involving almost every part of the hospital and including the appointment of East Anglia's first A&E nurse consultant, and streaming into minor and major injuries and 'see and treat' techniques. Minor injuries are not only triaged by nursing staff but immediately treated by them too, which has led to many patients being seen, treated and discharged in a very short timescale.

Streaming of patients, with the introduction of nurse-led diagnostic testing at the A&E unit of the £155 million **Princess Royal University Hospital in Farnborough**, has reduced waiting times and accelerated treatment time by an average of one hour. Three streams have been introduced: children's, minor injuries and majors, each with dedicated staffing. Along with a nurse-led triage system, this has led to a calmer, more nurturing environment for patients. The total time minor injuries patients spend in A&E, from arrival to discharge, has reduced from three hours to between one and a half and two hours.

Clinical priority areas of cancer, heart disease and mental health

There have been continued improvements in services and outcomes for patients in these three clinical priority areas over the last year and since the publication of the *NHS Plan*.

Cancer

Thanks to the hard work of those working in the NHS, we are already making real progress in implementing the NHS Cancer Plan. The Plan is being supported by unprecedented resources; by March 2003 an extra £406 million per annum was being spent compared with 2000-01. It is anticipated that we will have been spending an extra £570 million on cancer services compared with 2000-01, when figures for March 2004 are available. Patients are benefiting from improvements across all aspects of cancer care, such as shortened waiting times to see a specialist, access to new drugs and the most modern equipment to diagnose and treat cancer. The National Audit Office recently concluded that England's position on cancer mortality is improving relative to other comparable countries.¹

Key progress includes:

- Nearly 99% of people with suspected cancer are now seen by a specialist within two weeks of being referred urgently by their GP; 97% of women referred urgently with breast cancer are being treated within two months of GP referral.
- Over 1,000 extra cancer consultants have been appointed since 1997.
- Cancer patients can now benefit from 15 of the newest cancer drugs appraised by the National Institute for Clinical Excellence.
- The number of cancer patients entering clinical trials for the latest drugs and treatments has doubled in the last three years.

¹ <http://www.nao.org.uk/>, *Tackling Cancer in England: Saving more lives*, (March 2004).

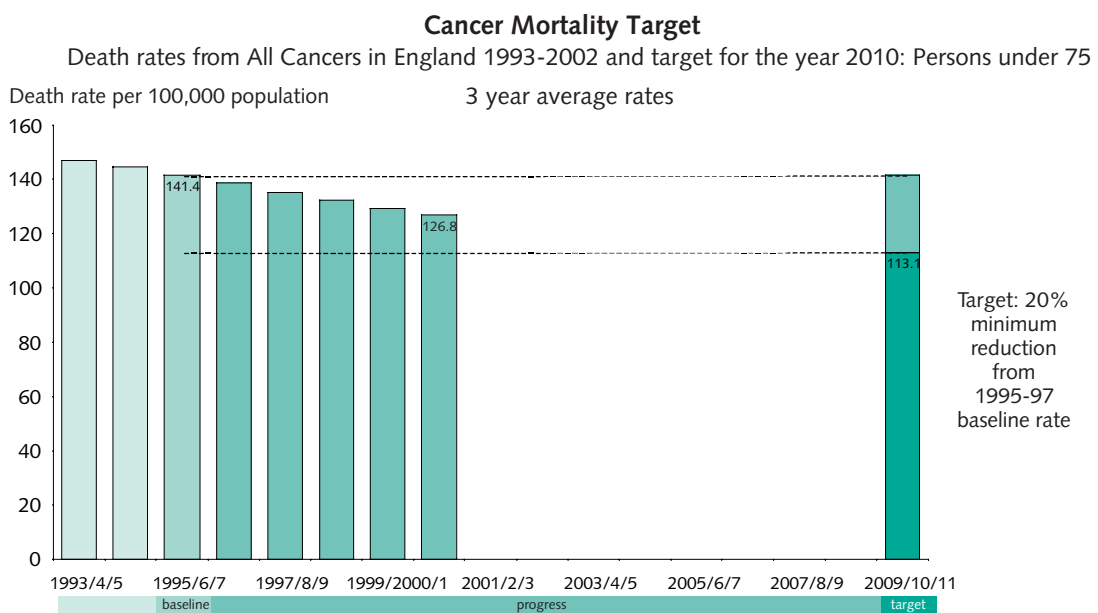
- Over 1,000 items of the most modern equipment to diagnose and treat cancer have been delivered since April 2000.
- Since April 2001 an additional 200,000 women have been invited to be screened as a result of the expansion of the breast screening service to include women aged 65-70 years.

The following example of good practice from Newcastle helps to alleviate the anxiety of women with suspected breast cancer.

Seven minutes is all it takes from a GP making a referral for breast cancer screening to an appointment being made for specialist assessment in one of fourteen practices in **Newcastle upon Tyne**, where they are piloting end-to-end electronic booking for patients with suspected breast cancer. The immediacy of the service means that the appointment for specialist assessment can be confirmed to the patient while they are in the GP surgery. As well as being convenient and responsive, this helps to alleviate some of the anxiety that a patient experiences at this time.

Implementation of the Cancer Plan has continued the reduction in premature mortality rates, demonstrated in the graph below.

Graph E: There have been sustained reductions in premature death rates from cancer



Rates are calculated using population estimates on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure. ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards. Source: ONS (ICD9 140-209; ICD 10 C00-C97).

Coronary heart disease

The NHS has also delivered substantial improvements in outcomes for patients with coronary heart disease, guided by the Coronary Heart Disease National Service Framework. The recent report, *Winning the war on heart disease: Coronary Heart Disease National Service Framework progress report 2004*, sets out details of the progress that has been made, including:

- The number of statins (a key drug in preventing and treating coronary heart disease, by lowering the level of harmful fats in the bloodstream) prescribed continues to rise by around 30% a year.
- 681 defibrillators have been installed in public places in 110 sites across the country.
- In emergency care, there is steady improvement in the time taken for heart attack patients to receive 'clot busting' therapy.
- The National School Fruit Scheme provides a free piece of fruit each school day to over a million children.

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

	In 1999/2000	In 2003	Increase – 2003	Increase since NHS Plan
CHD revascularisations	46,000 ¹	60,300 ^{1,2}	2,489 ³ (6%)	31%
Lipid Regulating drug prescriptions items ⁵	9.0 million ⁴	22.7 million	29% ⁵	150%
Time to thrombolysis (% treated within 60 minutes of call) ⁶	24% ⁷	46% ⁹	9% ⁸	22% ^{7,8}

1 Figures include non-England residents and private patients treated in NHS hospitals.

2 Figure for 2002/03.

3 In the first nine months of 2003/04 compared to the same period last year.

4 Year to June 2000. Figure was wrongly cited as 9.1 million in the December 03 publication. This has now been corrected.

5 Lipid regulating drugs refers to section 2.12 of the British National Formulary. These drugs, of which more than 90% are statins, regulate the concentration of cholesterol (refers to table 2.4.2 in Statistical supplement).

6 Data is on a calendar year basis.

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

8 Percentage point change.

9 Percentage is the aggregated national average for the whole of 2003.

Table K: Long waits have come right down

	April 2002	March 2003	March 2004
Number of patients waiting over 6 months for a heart operation ¹ (revascularisation)	2,788	732	1

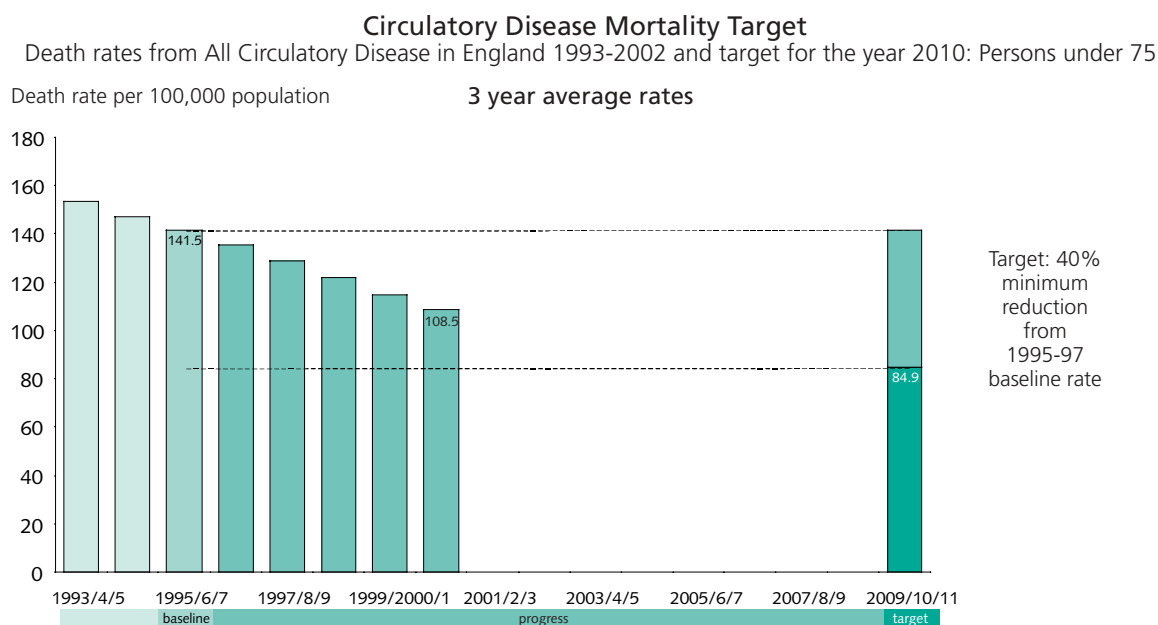
1 Data collection started in April 2002.

Reorganisation of services to provide timely intervention is having a real impact in reducing mortality rates, as in the following examples from Norwich and Hammersmith.

Norfolk and Norwich University Hospital has achieved one of the highest rates in the country for thrombolysing patients within 30 minutes of arrival. Dr Tony Page, Clinical Director for Cardiology, explains: "Our door to needle times have indeed improved dramatically over the last year. The development of nurse led thrombolysis has helped, as well as the introduction of electrocardiogram (ECG) telemetry from the ambulance paramedics. By far the most important factor, however, has been the close co-operation between the thrombolysis nurses on our Coronary Care Unit and the staff in the A&E department, which is where the majority of patients with myocardial infarction arrive. Thanks to this co-operation and the enthusiasm of A&E staff, there is now a general awareness that seconds saved here and there all add up."

The Hammersmith Hospital, in conjunction with the **London Ambulance Service**, is the first centre in the UK to set up a comprehensive, 24-hour angioplasty service for the treatment of acute myocardial infarction. This new treatment means that many patients now spend considerably less time in hospital (three to five days for angioplasty patients compared with seven to more than thirty days in patients treated with drugs) and are able to return to work earlier. With the newly developed angioplasty service, the ambulance service identifies heart attack patients at the point of initial contact and transfers them to the specialist unit at the Hammersmith Hospital rather than to their local hospital.

Graph F: There continues to be a sustained reduction in premature death rates from heart disease.



Rates are calculated using population estimates on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure. ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards. Source: ONS (ICD9 390-495CD10 I00-C199).

Smoking

It will help our aim to tackle the long-term causes of cancer and heart disease that we are also seeing more people stopping smoking year on year. However, there is still more to do, in this and other key indicators, to improve public health, which will be a key objective in the years to come. The forthcoming Public Health White Paper will guide those efforts.

Table L: More people are stopping smoking

	In 2000/2001 ¹	In 2003 ²	Increase during 2003 ³	Increase since NHS plan ⁴
Number of people who had successfully stopped smoking at 4 week follow up ⁵	64,600	155,100	33,600 (28%)	90,500 (140%)

1 Earliest year for which figures available for England.

2 Figure is for calendar year 2003 because quarter four figures for 2003/04 are not yet available.

3 Increase from calendar year 2002 to calendar year 2003.

4 Increase shown is from 2000/2001 to 2003.

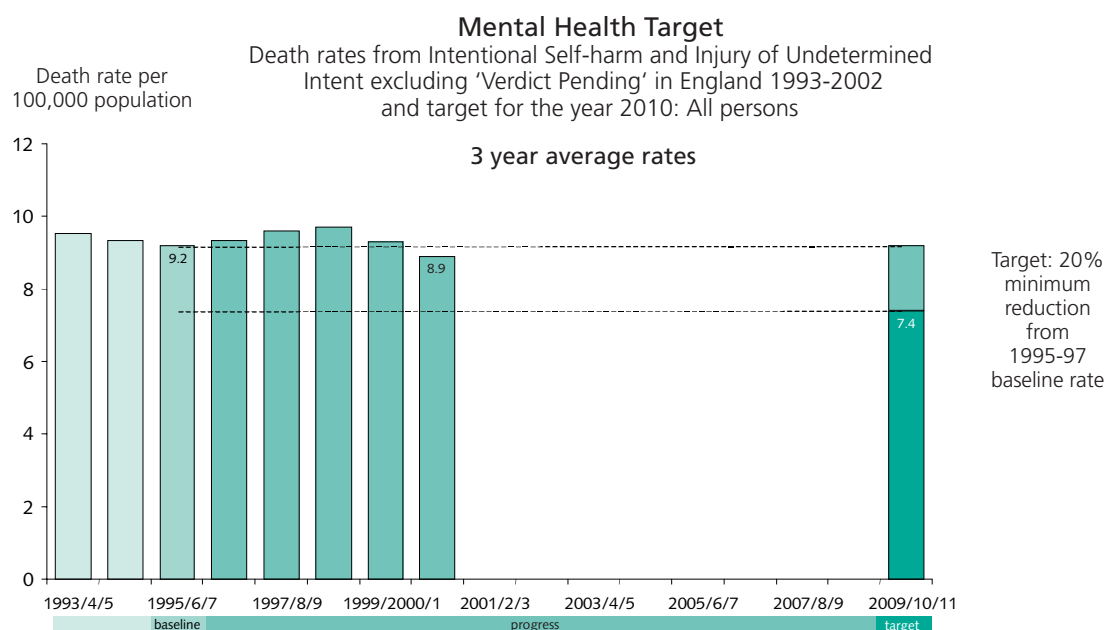
5 Source is NHS Stop Smoking Services monitoring returns – number of people who had successfully quit at 4 week follow up (self report).

The **Knowsley Children and Young Person's Smoking Cessation and Prevention Initiative** has had extremely encouraging results. Of those who used the service, 85% were successful in either quitting smoking after six weeks (29%) or cutting down significantly (56%). Dedicated Smoking Cessation Advisors, working directly with young smokers and using resource packs developed in partnership with young people, are responsible for the programme's success. Advisors hold awareness raising sessions in assemblies, form groups and Personal, Health and Social Education (PHSE) classes, and then invite pupils to self-refer into group sessions on smoking. The initiative has helped to build supportive relationships amongst young smokers who want to quit.

Mental health

As in the other priority areas of cancer and heart disease, mental health services are getting better and death rates from suicide have been falling: *the current suicide rate in England is the lowest ever recorded*. The graph below shows that the suicide rate has fluctuated in recent years but has fallen consistently since the publication of the *NHS Plan*.

Graph G: The suicide rate has fallen markedly in two consecutive periods



Rates are calculated using population estimates on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure. 1993 to 1998 and 2000 have been coded using ICD9; 1999 and 2001 onwards are coded using ICD10. Source: ONS (ICD9 E950-E959, plus E980-E989, excluding E988.8 (inquest adjourned); ICD10 X60-X84, Y10e X34 Y 33.9 (verdict pending)).

As well as this notable reduction in the suicide rate, the overall quality of mental health services is also improving in more subtle ways, for instance, by offering more holistic care as with this example from North London.

Antenna Outreach in North London, run by **Barnet, Enfield and Haringey Mental Health NHS Trust**, works with African and Caribbean service users aged 16-25 who have complex mental health problems. It aims to help them participate in their chosen community and to turn their hopes into realities. The emphasis is on helping them to develop social roles and explore the potential for independence, rather than simple symptom reduction. A service is offered 24 hours a day every day of the year. Clients are visited mainly between 9am-5pm weekdays, but there is provision to see those who need extra social support at weekends. Client opportunities range from work placements, personal training, home tuition and short break holidays to supported access to recording studios and sports facilities.

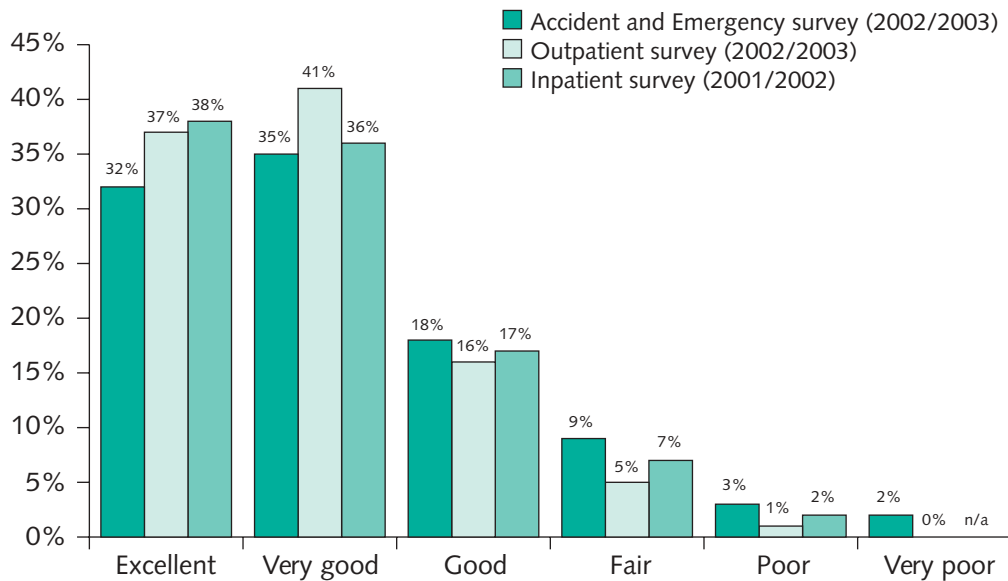
Improving the patient experience

Central to the modernisation of the NHS described in this Report, is the delivery of patient focused care; we are aiming to continuously improve patients' experiences of the NHS. While there is still much to do, the NHS is making better use of the valuable patient survey evidence, which helps us to understand the preferences of patients and the public, and to respond appropriately.

Patients have been surveyed on a range of experiences that are important to them such as: whether they had enough information and explanation about medicines; whether test results were explained well enough; and whether they were treated with respect and dignity. In all these areas, and more, patient surveys show high degrees of satisfaction and this is praise for the efforts of frontline staff.

The Commission for Health Improvement was responsible for the most recent round of patient surveys for, outpatients and those attending A&E and the Department of Health was responsible for the most recent survey of inpatients. These surveys demonstrated that the majority of patients are satisfied with their care; 86% A&E attendees, 91% inpatients and 94% outpatients rated their overall care as either good, very good or excellent. The following graph illustrates these high levels of patient satisfaction, but also that there is further scope for improvement.

Graph H: Patients in inpatients, outpatients and A&E were asked, "Overall, how would you rate the care you received?"



Source:
 CHI – Patient Survey – A&E (2002/2003) (figures are rounded to nearest whole number).
 CHI – Patient Survey – Outpatients (2002/2003).
 Dept of Health – Patient Survey – Acute Inpatients (2001/2002).
 Notes: 1. The Acute Inpatient survey did not include a response category of very poor.
 2. Percentages have been rounded to the nearest whole number. As a result, the total responses on A&E appear in the table as 99%.
 The total of the top three categories of response on the A&E survey appear in the table to add up to 85%, but, in fact account for 86% of responses as set out in the text in the paragraph above the chart.

The drive to improve the experiences of NHS patients is helped by learning about what works well and spreading good practice, such as the following examples.

Jayne Norbury, A&E matron at **Southport and Formby District General Hospital and Ormskirk and District General Hospital**, has introduced an innovative patient paging system. The system is reducing congestion in waiting areas and eliminating conflict. Jayne said, "The pager system was introduced following a patient survey and a meeting with A&E staff to give patients the flexibility to leave the department whilst waiting for results or speciality consultations without compromising their care."

Paul Reeves, a matron at the **Heart Hospital, University College Hospitals, London**, has managed a benchmarking exercise on privacy and dignity. He said: "We've made small but meaningful changes that improve the patient experience, such as getting pyjamas and night-dresses added to our linen contract. We've also emphasised the need for privacy and dignity in our ward philosophies – things like knocking on doors, or asking patients if you can pull back a curtain. These are practical issues that can really improve the patient experience."

Winter

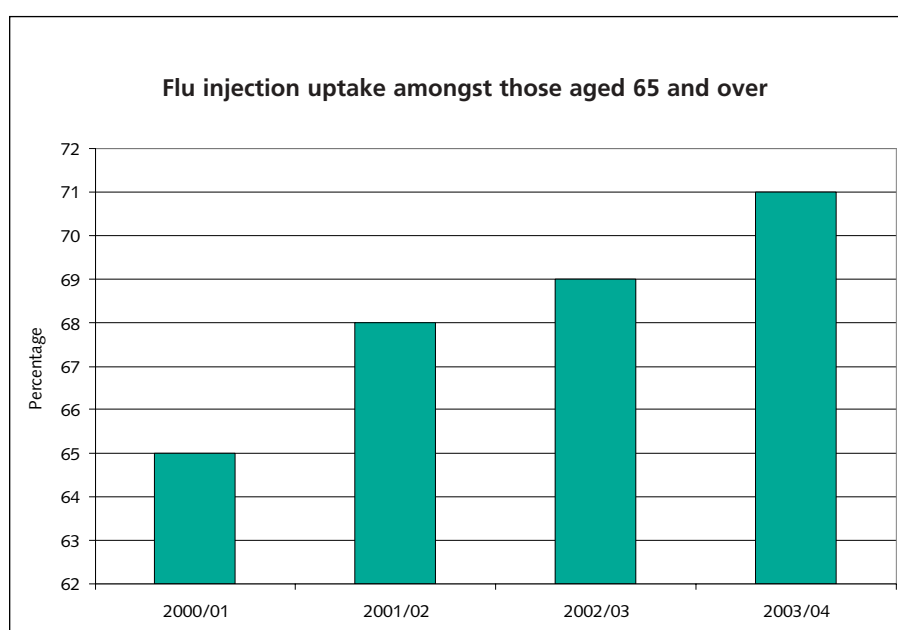
Winter has traditionally been the season when the NHS is under the greatest pressure from increases in respiratory ailments, influenza-like illnesses and accidents due to adverse weather. This can lead to a rise in hospital admissions, especially among the elderly, putting pressure on hospital capacity. However, winter 2003-04 was a success for the NHS. Strong performance was sustained or increased across a range of indicators, such as the percentage of patients treated within four hours of attending A&E.

Two aspects of the NHS's handling of this winter are particularly noteworthy. Firstly, there is now better management of capacity than ever before. Trusts plan elective activity further in advance, taking into account the expected demand for beds from emergency patients. This means that more elective operations are done during the summer months, when fewer beds are required for emergency admissions.

King's College Hospital NHS Trust has managed the balance between elective and emergency activity by doing more elective operations early in the year. Deirdre Barr, General Manager for the Clinical Site Team at King's, said: "This allows us to support the increase in emergency activity during winter. We also put in place a complete bed plan to manage the extended holiday period over Christmas and New Year, ensuring that beds, which are shut down in elective specialities, can be reopened in a planned, staggered fashion at short notice if there is an increase in demand. This plan also allowed the hospital to start elective activity early in the New Year, minimising any disruption to elective work." This approach reduces the likelihood of cancelling elective operations because staff are dealing with emergency admissions.

A second notable aspect of this winter was the improvement made in flu immunisation amongst those aged 65 and over. Those most severely affected by influenza are the elderly and people who already have a chronic medical condition, such as heart or chest disease. Immunisation gives substantial protection against influenza. Since 2000, the Department of Health has run an active flu immunisation programme, supported by a high-profile advertising campaign, to encourage those who are most at risk from flu to get a free flu jab. This year's programme was the most successful ever, as demonstrated in the following graph.

Graph I: There has been an increase in the flu injection uptake



The effect of elective planning, locally agreed escalation procedures and flu immunisation is to reduce the impact that winter has on the NHS. We are moving from a situation in which winter was a 'special event', to one in which it is handled smoothly as part of the NHS's routine business. For patients, this means that they are now more likely to have the same experience whether they enter hospital in December or June.

3. Greater capacity: staff, facilities and equipment

NHS capacity has expanded considerably over the last 4 years. More staff, working in new ways, with increased investment in facilities and equipment, have improved outcomes for patients and allowed them to be treated more quickly. The latest staff census shows that the total NHS workforce now stands at nearly 1.3 million people, having had a record increase of 59,000 from the previous year. 84% of the total number of staff have a direct hands on role with patients. As well as greater staff numbers, there have also been improvements in the numbers of hospital beds and in hospital redevelopment and building. Since the NHS Plan there are:

- 56,700 more nurses
- 15,000 more doctors
- a 52% increase in the medical school intake
- an increase of 33% in nursing and midwifery students
- more than double the number of intermediate care beds
- a third more critical care beds

There have been sustained increases in the NHS workforce since the publication of the NHS Plan. In 2003, patients across England benefited from the largest ever increases in numbers of nurses, GPs and consultants, so that the NHS workforce has grown to a new, all time high of 1,282,900 people. Almost exactly half of these staff are fully qualified clinical staff, whilst 84% – 1,083,100 people – are involved directly in patient care, the remaining 16% – 199,800 people – provide the infrastructure support which keeps our hospitals, clinics and organisations running effectively.

Table M: Number of doctors and nurses

	In 1999	In 2003	Increase during 2003	Increase since NHS Plan
Doctors	93,980	108,990	5,640 (5.5%)	15,010 (16.0%)
Total Qualified Nursing, Midwifery (including practice nurses) and Health Visiting Staff	329,640	386,360	18,840 (5.1%)	56,720 (17.2%)

Note: data from annual workforce censuses of 30 September each year.

To ensure that increases in staff numbers are sustainable, we are investing in the future of our workforce. The table below shows that there were large increases in the number of training places for doctors and nurses in England last year.

Table N: Numbers of training places for doctors and nurses

	In 1999/2000	In 2003/2004	Increase during 2003/2004	Increase since NHS Plan
Medical School Intake	3,972	6,030	753 (14.3%)	2,058 (51.8%)
Nursing and Midwifery Training Commissions	18,707	24,806 ¹	1,850 (8%)	6,099 (33%)

¹ 2003/04 figure is an estimate based on April to December 2003 data.

Hospital beds

The following table shows there has been growth in hospital beds since publication of the NHS Plan. This demonstrates how additional resources have been used to make up accumulated capacity deficits and ensure that the NHS is able to build appropriate capacity.

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

	In 1999/2000	In 2003/2004	Increase since NHS Plan
Total number of general and acute beds	135,080	136,679 ⁴	1,599 (1.2%)
Total number of intermediate care beds	4,242	8,748	4,506 (106%)
Total number of open and staffed critical care beds (at January)	2,362 ¹	3,143 ²	781 (33%)

¹ Figure as at January 2000.

² Figure as at January 2004.

³ January 2004 compared to January 2003.

⁴ Figure for 2002/03.

Investing in facilities and equipment

Continued investment in buildings, equipment and facilities, alongside the increases in staff numbers, are helping to provide better services for NHS patients. Below is just a sample of how facilities and equipment are improving:

- 12 hospital schemes opened in 2003-04 (4 of them major) with a capital value of nearly £400 million.
- 5 medium sized schemes were completed, worth in excess of £70 million.
- There are 42 NHS Local Improvement Finance Trust (LIFT) schemes – the initiative designed to invest over £1bn into primary and social care facilities – of which 6 reached financial close during 2003-04.
- Work has begun on 12 of the new LIFT buildings, the first of which, in East London, is expected to open to patients in September 2004.

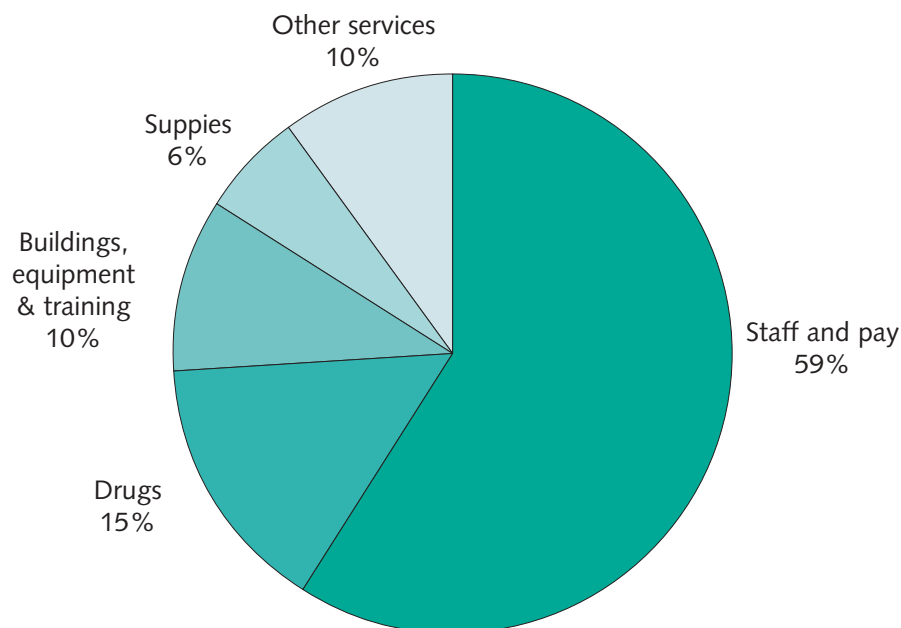
- There has been expansion and modernisation of services for Coronary Heart Disease patients worth £103 million in 2003-04.
- Initiatives put into place to increase the capacity of diagnostic services are taking effect. About 130 CT scanners and over 40 MRI scanners were delivered to the NHS between 2000 and 2003 as a result of new investment. These meant that 30% more CT scans and 34% more MRI scans were conducted in 2002-03 than in 1999-2000.

4. Funding the improvement: quality and productivity

In 2003-04, NHS spending will have reached almost £63.7 billion, an increase of £5.9 billion or 7.3 per cent in real terms over 2002-03. This unprecedented level of investment will be sustained over the 5 year period from 2003-04 to 2007-08 with an average annual real terms increase of 7.3 per cent and NHS spend exceeding £90 billion by 2007-08.

Total NHS expenditure

Pie Chart B: Breakdown of NHS expenditure in 2003-04 (total £63.7bn)

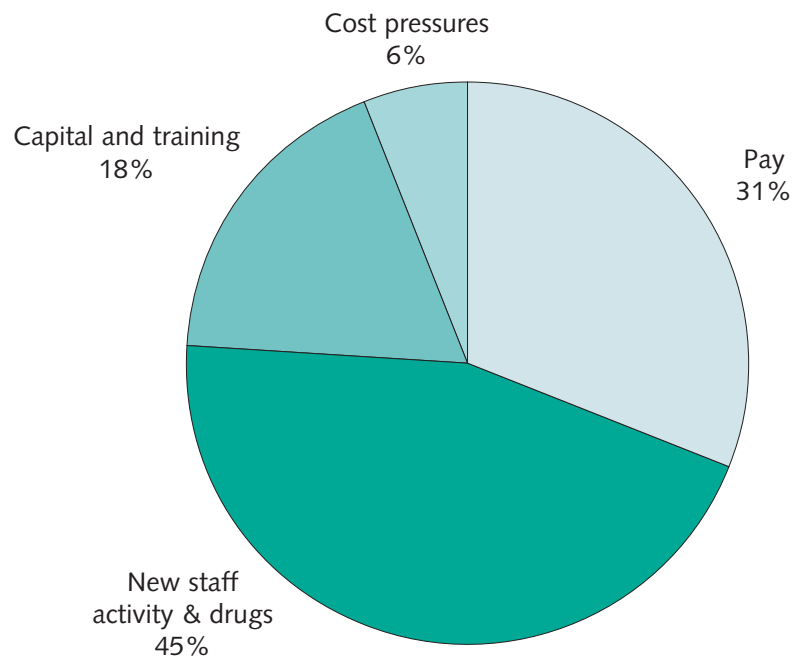


Pie Chart B provides a high level breakdown of NHS expenditure last year. By the nature of the service it delivers, the NHS is a labour intensive organisation, employing nearly 1.3 million staff. This means that around 59% of total expenditure is accounted for by staff costs. The next largest single element of cost is prescribing, with drug costs taking up around 15% of spend. Investment for the future in buildings, infrastructure, training and research accounts for 10% of spend, with other services (mainly utilities) accounting for 10%. The balance is made up of expenditure on general and medical supplies and services, such as medical equipment, bandages, catering and cleaning.

Extra investment in 2003-04³

The breakdown of the extra investment in 2003-04 is given in Pie Chart C.

Pie Chart C: Breakdown of additional spend in 2003-04 (total £5.9bn)



Of this £5.9 billion additional expenditure:

- 45% went on improving quality and access through additional staff, increased prescribing and more goods and services. This has led to the improvements described above, including:
 - An increase in elective hospital admissions of 167,000
 - An increase in the number of procedures carried out in primary care and outpatients of 197,000
 - Inpatient and outpatient waits continue to fall
 - Primary care access is improving so that 97% of patients are able to see a GP within 2 days and 98% can see a primary care professional within 1 day
 - Faster treatment in A&E even with increased emergency activity so that 94% of people are seen and treated within 4 hours
 - An increase in the number of drugs prescribed by 32.7 million prescriptions
 - Improved outcomes for patients in the clinical priority areas of cancer, heart disease and mental health so that premature mortality rates are falling quickly in these areas

³ Estimates based on plans and in-year monitoring of spend. Audited accounts will be available in the autumn of 2004.

- 31% went on pay for staff that reflects the contribution they make to delivering improved services and that help to retain existing staff and attract new workers into the NHS. This continues to have a direct impact on NHS staff numbers and has helped with the record increases during the last year of 59,000 staff including:
 - 18,840 more nurses and midwives
 - 5640 more doctors
- 18% was invested in the future of the NHS through increased training and investment in capital
 - 18,850 more nurses and midwives in training
 - 753 more doctors in training

NHS productivity

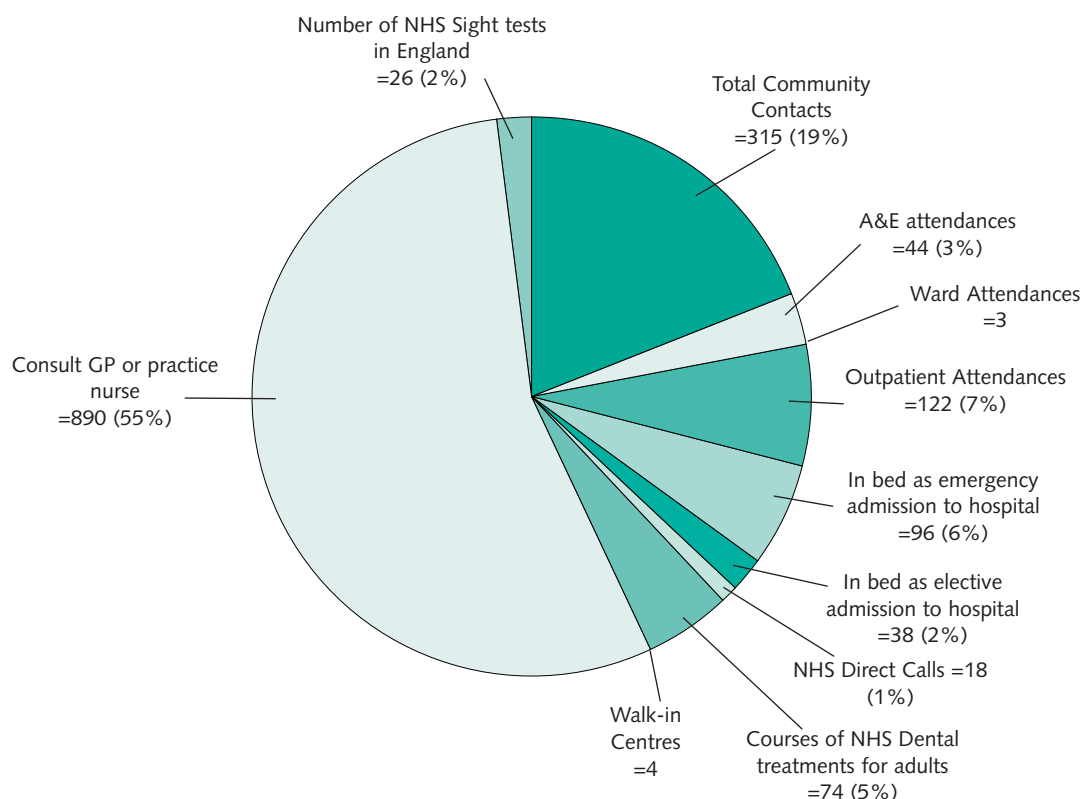
Ensuring that the public receives good value for every pound spent in the NHS is a responsibility of everyone working in the service. Using the new money as effectively and efficiently as possible will bring real dividends.

The only current measure of NHS productivity is flawed in how it measures the output deriving from the increased funding of the NHS. It defines outputs giving undue prominence to hospital activity. As the chart below shows, this is only a small percentage of NHS activity. Even more importantly, it ignores the fact that for many patients the NHS is providing better quality, more convenient care locally and attempting to **reduce** hospital admissions. On this measure, this improvement in services leads to a fall in productivity!

In particular, the current flawed measure:

- ignores the extra activity in primary care that would previously have been carried out in hospital, such as specialist procedures now performed by GPs and described in chapter 1;
- ignores new drug treatments offered either by GPs or hospital specialists;
- ignores important improvements in quality, such as modern scanners that do not break down, shorter waiting times, or single sex wards;
- defines new services that prevent emergency hospital admissions as a productivity decrease, such as better community nursing or cholesterol lowering medicine; and
- defines investment for the future, such as new hospitals instead of Victorian Infirmaries and training places for new doctors, as a productivity *decrease*.

Pie Chart D: Contacts with the NHS per day (thousands)



The NHS needs a new measure of productivity and is working with the Office for National Statistics and the Atkinson Review to develop one. This is a difficult task – capturing the many and diverse strands of care within the NHS – and one which has not yet been solved in any country. However, we can produce a better version and indeed owe this to staff whose efforts are undervalued by the current measure and the current debate.

NHS staff: improving quality and productivity

Anyone visiting NHS facilities can see staff working hard and introducing new approaches and treatments that improve quality and productivity. Whilst there is no overall measure of productivity, there are:

- measurable improvements in productivity in individual sectors as shown in the examples from the ambulance service and cardiology below
- quantifiable improvements in results – in both outcomes and outputs – with improvements in premature mortality from CHD, cancer and suicide and faster access and treatment throughout the NHS
- health promotion measures such as flu injections, which provide value for money
- control of overheads and wastage with, for example, lower management costs than other organisations, improved procurement and project management and control of bureaucracy as shown below

Improvements in quality and productivity: cardiology, examples include

- attendance at rapid access chest pain clinics up 67% since the beginning of 2002/03 – offering earlier diagnosis and treatment
- extra spending of £21m on ACE inhibitors resulting in 600 lives saved and 450 admissions avoided for high risk patients and 1700 lives prolonged and 20,000 admissions avoided for patients with heart failure
- a reduction in premature mortality from circulatory disease of 23% from 1995/6/7.

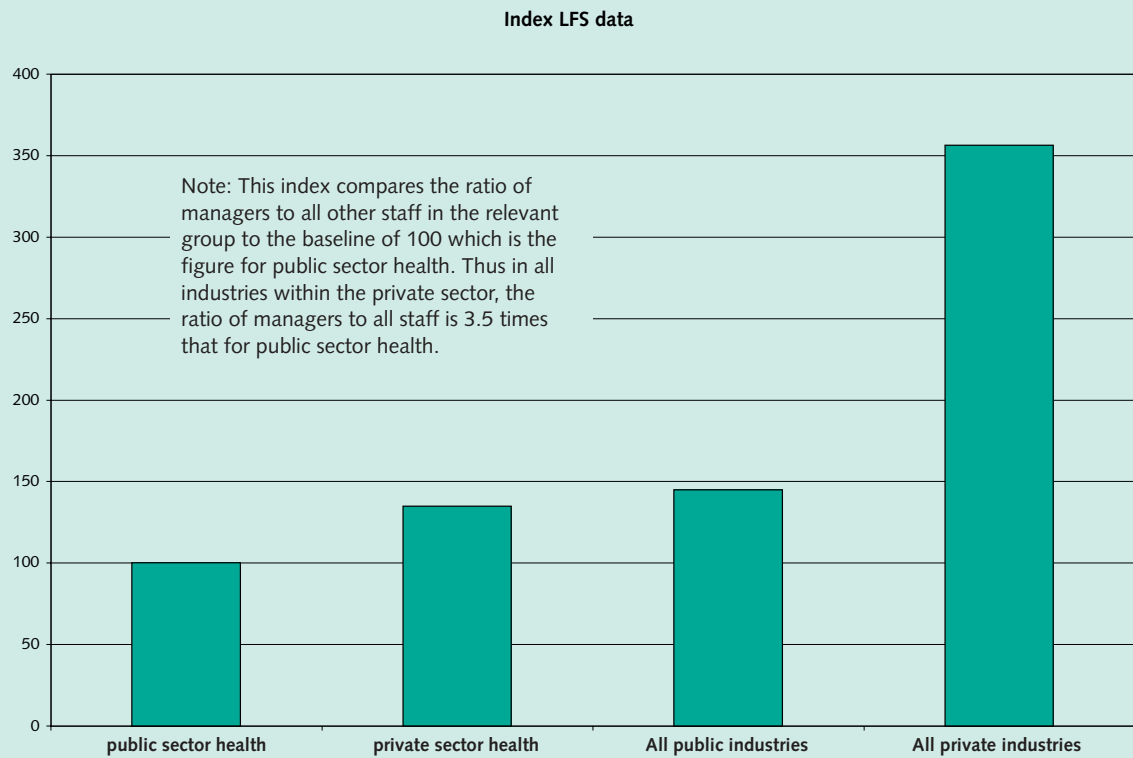
Improvements in quality and productivity: ambulance services, examples include

- more patients transported for no additional cost
- improvements in speed of transfer – with an increase for the most urgent patient category A from 71% seen in 8 minutes in 2001/02 to nearly 75% in 2002/03, when most recent figures are available
- improvements in service design – like these two examples from the London Ambulance Service (LAS):
 - The LAS have introduced Emergency Care Practitioners in Wandsworth, Croydon and Havering. These staff are able to respond to the same number of calls in a single shift as an ambulance and cost 30% less than a traditional ambulance. In addition only 45% of patients attended by ECPs are transported to accident and emergency departments (17% by ambulance and 28% by the ECPs themselves) compared with 75% transported when an ambulance attends. This saves the whole NHS money and is a more effective and efficient use of precious resources.
 - The LAS also has clinical telephone advisors in its communications centres which helps save 50 unnecessary ambulance responses a day. Again a better use of resources and more appropriate care for patients. Our effectiveness measure has shown that this is twice as effective as a traditional ambulance response.

Control of overheads and waste:

- a lower proportion of managers to other staff in the NHS than elsewhere

Graph J: Index of proportion of managers to all staff compared with other sectors



Source: ONS Labour Force Survey – Spring (March-May) 2003.

Note: People in employment by occupation in main job and industry in public and private sector in England. LFS relies on self classification of occupation. The relevant group for managers is "managers and senior officials" and will include some clinical staff and staff in other categories. Health is "human health related activities".

- removal of regional structure and two thirds of health authorities in 2001 to decentralise authority to local PCTs. In 2003-04, 75% of funding went directly to PCTs, allowing them to focus their resources to deliver on local priorities.
- reduction on Department of Health staffing by 38%
- development of project management e.g. for IT and creation of central commercial directorate to manage procurement: with savings beginning to accrue
- through creation of the Counter Fraud Service, we have made a very positive start since 1999 on the ten year programme to ensure NHS resources intended for improved patient care and services are not lost to fraud or corruption – with an overall positive financial impact of more than £475 million achieved, representing a 13:1 return on the budgetary investment in this work.
- with the introduction of DH Gateway controls, the volume of documents being issued to the service has been slashed by a third. Reduction in central targets by 46 since 2001-2, and Health Service Circulars from 37 in 2000 to 12 in 2003 with further reductions planned as autonomy and control transfers more locally. The DH Information Review in 2003 reduced the number of central information requests by 11%, with further reductions expected. In 2002 the Department made 170 regulations. In 2003, that was down to 98.



© Crown Copyright
Produced by the Department of Health
40123 1p 1k May 04 (CWP)
CHLORINE FREE PAPER

The text of this document may be reproduced without formal permission or charge for personal in-house use.

If you require further copies of this publication quote *40123/Chief Executive's Report to the NHS* and contact:

Department of Health Publications
PO Box 777
London SE1 6XH
Tel: 08701 555 455
Fax: 01623 724524
Email doh@prolog.uk.com



08700 102870 – Textphone (for minicom users) for the hard of hearing
8am-6pm Monday to Friday

40123/Chief Executive's Report to the NHS can also be made available in braille, on audio cassette tape, on disk, in large print, and in other languages on request.

www.dh.gov.uk/