Achieving the NHS Plan

Assessment of current performance, likely future progress and capacity to improve
The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, housing, health and criminal justice services.

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For further information on the work of the Commission please contact:
Sir Andrew Foster, Audit Commission, 1 Vincent Square, London SW1P 2PN Tel: 020 7828 1212
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Preface

The NHS Plan (Ref. 1), published in July 2000, set out the Government’s future vision for the health service. The Audit Commission has selected key targets from the Plan, and our appointed auditors have assessed every NHS trust in England not just on their current performance, but on their capacity to improve. Our purpose has been to assist local NHS bodies to plan improvements where necessary, rather than wait for information to appear about the previous year’s performance when it is already too late to do anything about delivering services for today’s patients. ‘League tables’ of past performance – such as the Department of Health (DH) performance indicators, or tables published by ‘Dr Foster’ – can provide patients with information about local services. By contrast the forward-looking assessments in this report will be of most use to the NHS bodies themselves, the staff within them who are trying to improve the services they provide continually, and those who support their efforts. The findings of the report will thus be of interest to:

- **The Government and the DH**: The findings will help them gauge whether their ambitious plans to improve health services are likely to succeed, identifying where and why their aims are at risk.
- **Patients’ advocates**: The findings will be of interest to the public because they are about the detailed targets set for the service – it is achievement of this type of target that should mean the delivery of a good health service.
- **Primary care trusts (PCTs)**: The information in the report could help PCTs identify where to target their commissioning effort and resources.
- **Service providers (acute, ambulance, mental health, PCTs and specialist trusts)**: The report assesses how trusts are doing across a range of key targets that they have been set and provides an independent forewarning of their capacity to achieve them in the future. It identifies factors associated with successful trusts from which others can learn.
- **Strategic health authorities (SHAs)**: The information can help SHAs carry out their duties to monitor and manage performance across their areas, indicating where they will need to provide support.

A wide range of people within trusts provided information and gave their time for interviews. Local auditors collated the information and made the judgements on which the report is based. Others made helpful comments on the report drafts. The Audit Commission is grateful to them all. As always, however, responsibility for the contents and conclusions rests solely with the Audit Commission.
Introduction

Auditors assessed the progress of every trust in England towards meeting key NHS Plan targets. They identified what constrained performance, and what helped trusts to meet targets. Auditors also reviewed each trust’s capacity to improve.

1 The NHS Plan set out the Government’s vision of a health service designed around the patient, recognising that this would require investment and step-change reform. The Plan aims to provide ‘more and better paid staff using new ways of working, reduced waiting times and high quality care centred on patients, and improvements in local hospitals and surgeries’ (Ref. 1). The NHS Plan Implementation Programme (Ref. 2), published in December 2000, provided the national framework of targets and milestones within which local action plans must be developed for implementing the Plan. Achieving those targets and milestones is a major challenge for all organisations in the NHS.

What auditors have done

2 As part of its strategy, (Ref. 3), the Audit Commission is committed to supporting and commenting on progress in implementing the NHS Plan – and for the last two years auditors1 have monitored progress by every NHS trust in England. Local auditors report their findings, and make recommendations for improvement, to local trusts and to SHAs. But in addition, auditors have submitted information in a standard way to the Audit Commission. This database of detailed information for every trust has formed the basis for the national overview reported here.

3 Auditors assessed progress on key targets between the first and second years of NHS Plan implementation, and the likelihood of achieving the key targets and milestones for 2002/03. They rated this likelihood in terms of risk – a ‘low risk’ rating was given if the target was likely to be (or had already been) achieved, and a ‘high risk’ assessment was given if the auditor judged it unlikely, on the evidence available, that the organisation concerned had made or would make sufficient progress to be able to meet the particular target or milestone. They sought to identify the constraints or success factors related to meeting each target, and assessed each organisation’s likelihood to improve performance on each target. In addition, each review included an assessment of the management capacity of each organisation, by rating 16 aspects of the financial and performance management arrangements in place to deliver the NHS Plan. The assessments were based on detailed information about patient activity and how well resources are managed, key documents and interviews with staff.IL
Auditors also collect more detailed data about a range of topics on a cyclical basis to underpin the Audit Commission’s Acute Hospital Portfolio (AHP) performance improvement tool. The tool provides comparative information that auditors are able to use to produce tailored performance assessments for each local trust. In-depth audit work may then be undertaken at some poorly performing trusts that demonstrably need it. The data for four AHP topics mesh in with the timing of the NHS Plan review reported here – those relating to outpatients, waits for elective admission, bed management and the use of operating theatres. Account has been taken of this more detailed information where relevant.1

How the report is structured

The report starts by describing how well trusts are performing against the plan, moves on to consider how well placed they are managerially and ends by linking the two to identify the actions that need to be taken now if future targets are to be met:

- Chapter 2 assesses performance – the delivery of services to patients – against Plan targets. Structured around the priorities identified in the DH’s Priorities and Planning Framework 2002/03 (Ref. 4), it focuses on targets that were due for implementation during 2002/03. It begins with clinical matters as set out in the National Service Frameworks (NSFs) designed to tackle cancer, coronary heart disease and mental health, and improve older people’s care. It then considers targets aimed at cutting waiting times and improving access to services and emergency care. Finally, it reviews what affects patients’ experiences of health services, such as the standard of cleanliness and accommodation.

- The Government has invested extra resources specifically aimed at ensuring the Plan’s success. Chapter 3 tracks the use of these new monies. In addition, it assesses the managerial capacity of trusts – are they well placed to make best use of their resources? The chapter breaks this down into several facets – financial management, human resource management aimed at strengthening frontline capacity, estate management and performance management.

- Chapter 4 examines the links between management and performance, and draws out the key lessons that must be addressed if the Plan is to be achieved. It raises difficult questions such as how to assess hospitals accurately under the ‘star’ system, and whether target-setting is the best way to achieve improvements in services.

1 Separate reports about each of the four portfolio topics will be published shortly.
Performance

Significant progress has been made towards some of the targets outlined in the NHS Plan. For example, the huge effort put into reducing waiting times for outpatient appointments and for hospital inpatient treatment has been paying off. But there are still some major challenges. The majority of mental health and primary care trusts have found it difficult to implement action plans relating to mental health and older people’s services, while few acute trusts had been able to keep waits in A&E to target levels. Management efforts to make more efficient use of resources and work in partnerships have been the key to helping some trusts meet targets.

Significant progress has been made towards some of the targets outlined in the NHS Plan, but there are still some major challenges (Box A).

Box A
The NHS Plan 2002/03 performance headlines

This box describes those targets at the extreme ends of performance. For each type of NHS trust, it lists the “top and bottom” two – the two targets most likely to be achieved (green text colour) and, by contrast, the two targets where considerable effort is needed (black text colour). The Audit Commission’s website lists all the targets selected for review.

<table>
<thead>
<tr>
<th>At high risk (%)</th>
<th>Likely to be achieved (%)</th>
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<tbody>
<tr>
<td><strong>Acute trusts</strong></td>
<td></td>
</tr>
<tr>
<td>More flexible employment conditions</td>
<td>94 6</td>
</tr>
<tr>
<td>Improved childcare provision for staff</td>
<td>92 8</td>
</tr>
<tr>
<td>90 per cent of patients to spend no more than four hours in A&amp;E</td>
<td>30 70</td>
</tr>
<tr>
<td>Increase the number of booked appointments accepted from general practice</td>
<td>23 77</td>
</tr>
<tr>
<td><strong>Specialist acute trusts</strong></td>
<td></td>
</tr>
<tr>
<td>Achieve a maximum wait of 21 weeks for all outpatients</td>
<td>100 –</td>
</tr>
<tr>
<td>Cut waiting times for coronary heart disease at all stages of the patient journey in an emergency, through maximum two week waits for rapid access chest pain clinics, and through falling waits for diagnostic angiography and for revascularization (three separate targets, each with 100 per cent performance)</td>
<td>100 –</td>
</tr>
</tbody>
</table>
**Specialist acute trusts (continued)**

<table>
<thead>
<tr>
<th>At high risk (%)</th>
<th>Likely to be achieved (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social care organisations to work together through the coronary heart disease and mental health Local Implementation Teams (two separate targets, each with 100 per cent performance)</td>
<td>100 –</td>
</tr>
<tr>
<td>Establish a Patient Advice and Liaison Service (PALS)</td>
<td>100 –</td>
</tr>
<tr>
<td>More flexible arrangements for employment</td>
<td>100 –</td>
</tr>
<tr>
<td>Recruit the required number of extra nurses</td>
<td>45 55</td>
</tr>
<tr>
<td>Clear at least a quarter of the maintenance backlog</td>
<td>42 58</td>
</tr>
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</table>

**Mental health trusts**

<table>
<thead>
<tr>
<th>At high risk (%)</th>
<th>Likely to be achieved (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve a maximum wait of 21 weeks for all outpatients</td>
<td>92 8</td>
</tr>
<tr>
<td>Abolish Nightingale wards for older people</td>
<td>89 11</td>
</tr>
<tr>
<td>Achieve financial balance</td>
<td>37 63</td>
</tr>
<tr>
<td>Recruit the required number of extra doctors</td>
<td>35 65</td>
</tr>
</tbody>
</table>

**Ambulance trusts**

<table>
<thead>
<tr>
<th>At high risk (%)</th>
<th>Likely to be achieved (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve financial balance</td>
<td>90 10</td>
</tr>
<tr>
<td>Health and social care organisations to work together through the coronary heart disease Local Implementation Team</td>
<td>86 14</td>
</tr>
<tr>
<td>Respond to 75 per cent of Category A calls within 8 minutes</td>
<td>52 48</td>
</tr>
<tr>
<td>Ensure 75 per cent of eligible patients receive thrombolysis within 20 minutes of arrival at hospital</td>
<td>43 57</td>
</tr>
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**‘Older’ PCTs***

<table>
<thead>
<tr>
<th>At high risk (%)</th>
<th>Likely to be achieved (%)</th>
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</thead>
<tbody>
<tr>
<td>Abolish Nightingale wards for older people</td>
<td>89 11</td>
</tr>
<tr>
<td>More flexible arrangements for employment</td>
<td>88 12</td>
</tr>
<tr>
<td>Significantly increase booking for outpatient appointments</td>
<td>33 67</td>
</tr>
<tr>
<td>Achieve financial balance</td>
<td>25 75</td>
</tr>
</tbody>
</table>

**‘Newer’ PCTs***

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<tr>
<th>At high risk (%)</th>
<th>Likely to be achieved (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve a maximum wait of 21 weeks for all outpatients</td>
<td>96 4</td>
</tr>
<tr>
<td>Achieve key cancer waiting time targets</td>
<td>92 8</td>
</tr>
<tr>
<td>Recruit the required number of extra nurses</td>
<td>28 72</td>
</tr>
<tr>
<td>Achieve financial balance</td>
<td>20 80</td>
</tr>
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*Except for the specialist trusts, because 100 per cent of these trusts were expected to achieve eight separate targets.

**Ambulance trusts were risk-assessed on a total of only four measures.

***The labels ‘older’ and ‘newer’ are used to differentiate between those PCTs that were established first (between October 2000 and April 2001) from those established in April 2002. The targets listed for PCTs refer to services provided by the PCT rather than services within acute and other trusts for which they have commissioning responsibilities.

**Source:** Auditors’ assessments of all trusts in England part way through 2002/03
Standards of care

Delivering healthcare using the standards set out in the National Service Frameworks (NSFs) should ensure that people receive high quality, evidence based healthcare wherever they live. Implemented successfully, the NSFs should help to improve the population’s health significantly. The frameworks have been developed by experts in their fields, using the best available evidence, and are widely respected. Auditors reviewed the four NSFs that were already operational:

- mental health, published in 1999;
- coronary heart disease (CHD – 2000);
- cancer, based on the principles of the 1995 Calman-Hine report, with detailed standards issued by the National Director for Cancer Services in 2001; and

Special reviews of NSF progress are carried out by the Commission for Health Improvement (CHI) and Audit Commission in partnership. But such reviews take time. An initial review of cancer progress has already been made (Ref. 5), and the first detailed reviews of CHD are now underway – but those for mental health and older people’s services begin next year. The assessments reported here are much less detailed than the special reviews, but provide a useful interim ‘check up’. First, auditors reviewed whether Local Implementation Teams were likely to result in the members of the health and social care community working together – a fundamental building block on which to base service development and improvement. Although commendably the majority of trusts were achieving this, there was a high risk to joint working in relation to the older people’s NSF in as many as one-third of mental health and acute trusts. And over half of mental health trusts were having difficulty implementing the action plans relating to the mental health or older people’s NSFs (Exhibit 1, overleaf). These results should act as an important ‘early warning’ exercise in advance of the future, detailed reviews.
Exhibit 1
Auditor assessments of the likelihood of achieving the NHS Plan target to implement local mental health and older people’s NSF action plans

Over half of mental health trusts were having difficulty implementing the action plans relating to the mental health or older people’s NSFs.

Target: ‘Health and social care organisations will implement the Local Modernisation Reviews’ [or other local] action plans’ (percentage of trusts with different ratings 2002/03).

In making their assessments, auditors identified what enabled some organisations to move forward, while others struggled to improve performance. Funding was the most commonly cited performance constraint – in more than half of trusts in relation to cancer, mental health and older people, and in 40 per cent in relation to CHD. Of course, difficulties or success in a whole service will always be due to a combination of factors. Some trusts were described as failing on a number of fundamental aspects. By contrast, assigning the NSF a high organisational priority was the most commonly cited precursor to success on NSF targets – once this is done, then progress can begin on a wide front (Box B).
Box B
Examples of trusts finding NSF performance difficult, contrasted with trusts making progress through partnerships

Each of these comments relates to a different example trust.

**Performance constrained...**

‘A review of Mental Health services by the PCT identified these issues: poor human resource, information, estate and general management capacities; insufficient supported housing/day care; no services to reduce admissions and speed discharge; outreach service in need of review; outstanding Strategic Outline Case for re-provision of inpatient services.’

‘The action plan resulting from the Local Modernisation Review is not incorporated into the Older People’s NSF Local Implementation Plan’s monitoring framework. High risk areas of emergency admissions, readmissions and delayed discharge are discussed at other groups and links need to be improved.’

**...Moving forward**

‘The Trust is the main site in the local health economy for cardiac rehabilitation and secondary prevention, and is working with GPs to ensure referral protocols are followed, and access to the rapid access chest pain clinic is understood. The Trust has developed closer links with Palliative Care to improve services in the community.’

‘Local Implementation Team for Older People has an assigned PCT lead for each standard in the NSF. Written, quarterly progress reports are submitted by each lead to ensure that progress is maintained and is evidenced.’

Source: local independent auditors

Below this overall level, more specific ‘tracer’ targets from the many contained within the NSFs were selected. For example, the majority of trusts were expected to achieve the targets relating to CHD waiting times (although the most at risk – achieving falling waiting times for revascularization – was judged high risk for as many as 43 per cent). However, ensuring that three-quarters of patients receive timely ‘clot-busting’ drugs (thrombolysis) was one of the most commonly cited problem targets of all, with 69 per cent of acute trusts and 57 per cent of ambulance trusts judged at high risk.

There is a ‘golden hour’ during which the administration of thrombolytic drugs can significantly boost the outcome for some people who have had a heart attack – the overall NSF aim is, therefore, to increase the percentage of eligible patients who receive the drugs within 60 minutes of calling for professional help. Ambulance services and acute trusts need to work together to achieve this – it is of little use a hospital delivering the drugs to all patients within 20 minutes of arrival (the NHS Plan target for acute trusts) if the ambulance has taken more than 40 minutes to bring the patient in (Box C, overleaf).
Box C
Partnership working and the delivery of thrombolysis to heart attack patients

Performance constrained...
‘The health community do not involve the ambulance service, which perceives that it is “ignored” – the health community do not appear to recognise the potential of ambulances to contribute.’

‘The Trust has indicated that communication with the ambulance trust is difficult.’

...Moving forward
‘In this rural area, less than 15 per cent of patients get to hospital within 30 minutes. The ambulance trust is working with the acute hospitals to introduce diagnostic telemetry services (so that the hospital can be better prepared to thrombolysed as soon as the patient arrives) or so that the patient can be thrombolysed by an ambulance crew.’

‘The ambulance trust is working closely with the CHD implementation teams, CHD Collaborative and cardiologists from the acute hospitals to ensure the proper administration of pre-hospital thrombolysis.’

Source: local independent auditors (each comment relates to a different example trust)

Capacity to treat

The NHS Plan identified waiting time for treatment as the public’s top concern about the NHS. In response, the Plan envisaged ‘the most sustained assault on waiting the NHS has ever seen’. Special funds were earmarked to expand capacity and increase activity levels, and initiatives co-ordinated by the NHS Modernisation Agency focused on identifying avoidable blockages in patients’ pathways through the system. Waiting, along with related aspects of capacity such as how often operations are cancelled, are covered here in ‘patient pathway’ order – starting with waiting times to visit a GP, to outpatient appointments and then inpatient treatment for planned care, plus key aspects of the pathway for patients in an emergency.

Waiting for primary care

Visiting a GP’s surgery is the most common form of NHS care, and is the starting point for most of those patients who need hospital or other further types of NHS care. It is therefore welcome that access to primary care is one of the NHS Plan’s priority targets. The Plan states that all patients should be able to see their GP within 48 hours, or another primary care professional within 24 hours, by 2004. This target should be achieved for 90 per cent of patients by March 2003. Auditors reported that about two-thirds of PCTs were likely to meet the two-day GP target, but that over half were at high risk of not achieving the one-day healthcare professional target.
The main constraint preventing some PCTs from achieving the targets was identified as professional staff shortages. However, some have met their targets even within current staffing levels by analysing patient flows and reorganising work and improving systems and processes. Examples include:

- rescheduling GP and nurse appointments better to meet patients flows – for example, by staggering appointment times throughout the day;
- providing appropriate types of advice over the telephone (for example, about travel);
- avoiding Mondays for follow-up appointments;
- the introduction of nurse-led clinics; and
- pre-assessment and (when appropriate) treatment by nurses.

Planned hospital care

Waiting for an outpatient appointment

An outpatient appointment is the most common route by which patients access hospital-based NHS care. It is also often an anxious time for patients. So far, waiting time performance has improved markedly. Half-way through the first year of the Plan (2001/02), auditors rated nearly two-thirds of trusts as being at high risk of missing the first milestone, which was to reduce the maximum wait to 6 months (26 weeks). Yet, after the end of that year, the DH was able to report that in fact almost all acute trusts had met the target (Ref. 6), the result of determined and imaginative effort.

The DH then set a more difficult milestone – to reduce the maximum wait to five months (21 weeks) by March 2003. And despite this tightening, auditors expected the majority of acute trusts to achieve the milestone. It is important to note that although this certainly represents a success story, there is no room for complacency – this still left a third of acute trusts where much effort was needed to achieve it (Exhibit 2, overleaf).

Many different approaches have been taken to reducing waiting times (for example, Refs. 9 and 10). However, auditors’ reports included statements questioning whether all trusts could achieve the further improvement needed to reduce outpatient waiting times to a maximum of three months (13 weeks) by the end of 2005. For example, one trust had developed a patient access policy, agreed by a Service Improvement Board that included representatives of patients, the NHS Modernisation Agency, PCT and community health council (CHC). It had a proactive activity monitoring system in place which included weekly meetings between the Director of Hospital Services and the clinical directorate managers. Despite these initiatives, physical capacity within two specialties may well prevent it meeting the 2005 target. In addition, activity levels were in excess of planned and funded volumes which increased the pressure upon access and financial targets (source: local auditor report).
Exhibit 2
Performance on outpatient waiting time targets by acute trusts

The improvements in outpatient waiting times certainly represent a success story. However, there is no room for complacency – this still left a third of acute trusts where much effort was needed to achieve the 2002/03 milestone.

Waiting for an operation

The Government has made it clear that the reduction of waiting times for treatment is one of their highest priorities for the NHS. And despite the fact that the DH has tightened the criteria, auditor assessments suggested that the majority of trusts were expected to meet the 2002/03 milestone (that by March 2003 no patient should wait longer than 12 months). In fact, progress and risk assessments were very similar to those just described for outpatient waits. This excellent performance means that most patients see a consultant and then have their treatment quicker. But although the performance of the first two years has been good, the aim of this report is to try to look forward. A number of questions then arise – can the ultimate target (that by 2005 no patient will wait more than six months for their operation) be achieved? Are the improvements sustainable into the future? At what cost can they be achieved?

Source: Auditors’ assessments of all NHS acute trusts in England

*Auditors made their assessments about whether targets would be met by March 31 approximately half-way through the financial year.
In the short term the news is good. Our findings suggest that the most serious difficulties may be restricted to a relatively small number of trusts, rather than being a general problem for the NHS. In September 2002 over three-quarters of the patients waiting beyond 12 months were found within only a quarter of trusts. And nearly a third of these patients were within only five trusts – a more detailed analysis of older data, from 1999, found a similar pattern (Ref. 11). But whether the improvements seen so far in the majority of trusts are sustainable into the longer-term future is a different matter. When the target maximum wait becomes six months (in 2005), Audit Commission analyses suggest that many trusts will require new capacity and working practices over and above the improved waiting list management and one-off initiatives commonly seen to date (Ref. 12).

Auditors suggested that the most commonly cited reason by trusts for being at high risk of failing to meet the inpatient waiting time target was a lack of resources or increasing emergency activity. But auditors’ comments also suggest that the key to improvement was better management of resources:

- **Resource capacity management**: for example, managing beds, theatres, day-case rates and lengths of inpatient stay more efficiently, thus increasing throughput and in turn reducing the numbers waiting.
- **Extra activity**: for example, funding additional theatre sessions at evenings or weekends.
- **Improved systems and processes**: for example, analysing patient flows to identify solvable blockage and delay points; ensuring that access to diagnostic facilities was efficient and did not delay subsequent inpatient treatment; ensuring that routine patients were seen in order; and trust level co-ordination for patients with the longest waits.
- **A co-ordinated approach**: one reason that inpatient targets might be hard to achieve is if improved outpatient waiting times push through extra demand pressure in terms of inpatients. But in fact only 10 per cent of trusts were rated as at low risk on the outpatient target, but high risk on the inpatient one. This suggests that the majority of trusts had been able to reduce both types of waiting lists by co-ordinated management effort.

**Cancelled operations**

Choice is a key aspect of a patient-focused service, and trusts are required to guarantee that, where a patient’s operation is cancelled on the day of surgery, the trust will arrange to admit the patient within 28 days, or offer the patient the option of treatment at a hospital of their choice. Two-thirds of acute trusts were assessed as likely to achieve the 2002/03 target, and further improvement was judged likely or possible in 90 per cent rated as at high risk. Capacity constraints and sudden emergencies were the most frequently cited reasons for cancelling operations, but again the key to success for trusts meeting the target was management attention to the systems and processes in place. Sometimes an apparent ‘capacity constraint’ had been relieved by, for example, more efficient use of the available operating theatres (Refs. 13 and 14).
Emergency hospital care

Although most patients access hospital care via the planned routes just described, others will need treatment in an emergency. Then patients need to know that they will be treated quickly and safely. Here we review two key Plan targets aimed at ensuring this is so.

Ambulance response times

Delays in treating heart attack patients cost lives – if a patient’s heart stops and there is no resuscitation for eight minutes the prognosis is poor. The introduction of priority-based dispatch means that ambulance services now classify all incoming calls, with the highest priority (Category A) including suspected heart attacks. For category A calls the 2002/03 target was that in 75 per cent of cases there should be an appropriate response within 8 minutes – the DH estimated that meeting the standard could save 1,800 lives per annum. Auditors assessed about half of ambulance trusts as likely to achieve the target, and about half as at high risk. Although trusts at risk of missing the target most commonly cited lack of resources as a reason, auditors’ comments suggest, yet again, that it is the management of resources that holds the key – for example, good data quality and the effective use of IT to make sure that responses were prioritised correctly (Box D).

Box D

Factors affecting the achievement of the ambulance ‘category A’ response target

Performance constrained...

‘The Trust currently records times for arrival at scene of accident manually. The Trust has submitted an Outline Business Case for capital to buy new technology but this has yet to be approved. Until the new system is implemented, the Trust’s data quality remains a high risk and therefore its ability to be certain that it is meeting the 75 per cent target.’

‘Since late 2001/02 the Trust has shifted the focus of its management efforts to its Patient Transport Service and has consequently not been able to introduce significant new initiatives to improve A&E performance.’

...Moving forward

‘Category A target of 75 per cent has been consistently achieved due to resources being made available, using technology and sustained staff commitment.’

‘Six teams of clinical managers to be used as first responders and focus on Category A calls. Three performance managers in post to troubleshoot between operations and control.’

Source: local independent auditors (each comment relates to a different example trust)
Waiting times in A&E

In 2001/02 nearly half of acute trusts failed to achieve the Plan target that no more than 75 per cent of patients should wait any longer than four hours in A&E (Ref. 6). For 2002/03, the target was tightened to 90 per cent of patients and was rated the second highest risk of all those assessed by the auditors of acute trusts (Exhibit 3). Few acute trusts were able to keep waits in A&E to target levels.

Long waits in A&E can be caused by a combination of factors. Some involve other parts of the hospital – for example, the wards may not have enough free beds, or there may be delays in providing x-rays and blood tests. Factors outside the hospital can also have a knock-on effect. For example, if the local area does not have enough places in residential or nursing homes, then some patients cannot be discharged when they are ready to leave the acute hospital – this means in turn that patients in A&E cannot be moved into an acute bed. The Modernisation Agency has produced a compendium of best practice that covers these diverse causes (Ref. 15).

Exhibit 3
Performance on A&E waiting time targets for acute trusts
The target was rated the second highest risk of all those assessed by the auditors of acute trusts.

<table>
<thead>
<tr>
<th>2001/02 TARGET</th>
<th>2002/03 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Half-way’ risk assessment</td>
<td>‘Half-way’ risk assessment</td>
</tr>
<tr>
<td>Likely to achieve target (low risk)</td>
<td>Likely to achieve target (low risk)</td>
</tr>
<tr>
<td>Target at high risk of not being met</td>
<td>Target at high risk of not being met</td>
</tr>
<tr>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>Not achieved</td>
<td>Not achieved</td>
</tr>
</tbody>
</table>

Source: Auditors’ assessments of all NHS acute trusts in England

"Auditors made their assessments about whether targets would be met by March 31 approximately half-way through the financial year."
Because resolving constraints that need co-ordinated action extending outside the department is a more difficult process, auditors found that improvement most commonly happened when the A&E department reviewed its own systems and processes. Examples included developing triage systems involving GPs, nurses and (for orthopaedic patients) physiotherapists, having clearer referral guidelines and revised medical staff rotas. But progress has been slow in implementing these. For example, an Audit Commission report in 1998 recommended that more hospitals should adopt the practice seen in a few where emergency nurse practitioners diagnosed, treated and discharged or referred on patients within agreed protocols (Ref. 16). About 60 per cent of patients attending A&E are not classified as urgent, and a large number could be safely treated and discharged by nurse practitioners. However, a follow-up Audit Commission study found that very few departments took advantage of this method of reducing waiting times – almost all patients had to wait and see a doctor (Ref. 17). An adapted form of this concept has however now been introduced in some hospitals by the Modernisation Agency Emergency Services Collaborative, where it is termed ‘see and treat’.

Will waiting time improvements be sustained?

A consistent message in this section of the report has been that performance measures relating to patients’ access to services can only be properly interpreted by looking at the interaction between a number of factors. The Audit Commission is reporting separately on waiting times for admission, and that report explores the links between the demand for services, the resources trusts have available (such as the number of beds and staff) and their efficiency in managing them (Ref. 12). Trusts have worked hard to hit waiting time targets. Sometimes this has been by improving systems – for example, making more efficient use of available operating theatres, or eliminating administrative blockages that were delaying patients’ progress. And sometimes capacity has been permanently increased – for example, by recruiting extra consultants, or investing in new beds. Such achievements should have a lasting effect, provided that recurrent funding is made available to make use of them year after year. But some of the means used may not stand the test of time – will trusts that achieved targets by special measures such as paying consultants to do extra sessions, or paying private providers, be able to repeat this year after year? Auditors frequently raised questions about the sustainability of such achievements, especially when future targets stretch trusts even more – and when so many are at risk financially, a point picked up in Chapter 3.
The patient’s experience

26 The NHS Plan outlined that care has to be shaped around the convenience and concern of patients. Patients’ first impressions of the NHS can be formed by how easy it is to make contact with the right service. Their next impression will be of the courtesy and consideration they are given by staff, and the buildings and the environment in which their care is provided. Patients should have more say about these things, and someone to turn to for independent advice if they want it.

How easy is it to get the service you want?

NHS Direct

27 The Government aims to use NHS Direct as a way of simplifying access to services for patients, reducing the confusion they might experience if they do not know which organisation to contact for which type of care, and to reduce the fragmentation of services that can confront someone – “A single phone call to NHS Direct will provide a one-stop gateway to healthcare” (Ref. 1). This will take some time to achieve, and so in the first two years of the Plan, PCTs were required to confirm that there was telephone access to specific types of service via NHS Direct – that some of the building blocks necessary to create an integrated service were being put into place. For example, by March 2003, all PCTs were required to have implementation plans for single phone-call access to GP out-of-hours care – three-quarters of the longer-established PCTs were expected to achieve this, but nearly half of the newer PCTs were judged to be at high risk.1 As in the previous sections of this chapter, PCTs tended to cite lack of resources as the key constraint, but auditors most frequently commented that reconfiguring systems and processes via management attention had brought improvements.

Booked appointments

28 By introducing pre-booking, the NHS is beginning to treat patients at a time that suits them, and in accordance with their medical need. A number of targets have been set – for example, the Plan envisages the use of electronic booking by the end of 2005, enabling patients to choose, with the support of their GP, who they want to treat them and when. However, large numbers of acute trusts were assessed as at risk of not achieving the 2002/03 milestones (Exhibit 4, overleaf). The variable development of IT and other management systems were the dominant reasons given for success or failure (Box E, overleaf).

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1 In addition, 40 per cent of PCTs were to have operational systems in place – and auditors indeed judged 40 per cent of PCTs as likely to achieve this.
Large numbers of acute trusts were assessed as at risk of not achieving the targets.

Source: Auditors’ assessments of all NHS acute trusts in England

*Auditors made their assessments about whether targets would be met by 31 March approximately half-way through the financial year.
Box E
Factors affecting the achievement of patient-booking targets

Performance constrained...
‘GPs are not in support of the current systems. IT links are not in place to make GP booking easy.’

‘The Trust has no targets for booking from and within general practice.’

...Moving forward
‘A booked admissions manager leads on behalf of the community. A call centre is being developed in order to manage calls from patients and the amalgamation of the acute hospitals’ patient administration systems (PAS – a computer system) is planned in order to fully book referrals into the PAS system.’

‘Patients are able to ring the day after the GP has faxed a referral to obtain an appointment – 20 per cent of practices referring to the Trust now use this system.’

Source: local independent auditors (each comment relates to a different example trust)

Aspects of hospital experience

The NHS Plan includes targets intended to improve patients’ experiences. The key targets are to provide:

• a clean hospital;
• single-sex ward accommodation;
• wards that offer better privacy and quiet than old-style large, open plan, ‘Nightingale’ wards, while still allowing nursing staff to monitor the patients in their care;
• a Patient Advice and Liaison Service (PALS), to offer patients a contact within their local hospital to address any concerns or from whom they can seek information (the contact should be independent and have the power to negotiate solutions with the hospital); and
• a feedback mechanism – acute trusts are expected to carry out surveys, because the quality of patients’ experiences can only be assessed by asking them.

Commendably, much progress has been made – these were among the least at risk targets during 2002/03. For example, there has been almost universal establishment of PALS in the acute trusts, widespread improvements in cleanliness, and most acute trusts are on course to abolish ‘Nightingale’ wards by the target deadline of April 2004. However, significant problems remain in some trusts – for example, one-third of mental health trusts were assessed as at high risk on the issue of PALS, despite mental health patients potentially being in particular need of a source of independent advice.
Managerial capacity

The majority of trusts were finding it difficult to balance their books – some used new money, intended to boost services, to meet underlying financial problems. The majority of trusts were finding it hard to recruit enough extra doctors and nurses. Trusts that have faced the most organisational change recently – the PCTs and mental health trusts – not surprisingly had the most managerial difficulties.

Chapter 2 has shown that NHS organisations face considerable challenges to meet all of the performance targets set by the NHS Plan. Some of the wide-ranging performance constraints and success factors that auditors identified were to do with issues that impact on trusts from the outside. But an emerging theme was that trusts’ own internal management capacity will be fundamental to determining how well placed they will be to respond to the Plan’s future challenges. The change agenda is so extensive that, despite a widely-shared dedication to the targets set out in the NHS Plan and great efforts on the part of committed and hard-working individuals, even well-established organisations are finding their management resources thinly spread. This chapter focuses on the different aspects of managerial ability, and auditors’ assessments of strengths and weaknesses.

Financial management

All NHS organisations are required to achieve financial balance as a firm financial footing is essential if the NHS is to implement the modernisation agenda. Most trusts were assessed to be adequate at the key aspects of financial management – with the exception of the newer PCTs and mental health trusts which are still establishing some aspects of their managerial arrangements. Despite this, the majority were judged to be at high risk of not achieving financial balance. The level of resources – or issues outside the control of an individual trust such as allocation arrangements or commissioning patterns – therefore appeared to be at issue, and not simply trusts’ ability to manage them (Box F). Two aspects give cause for future concern:

- of those trusts that achieved financial balance in 2001/02, the majority did so by making use of non-recurrent, ‘one-off’ funding to cover what would in fact be ongoing commitments in future years – an approach which makes longer-term planning more difficult; and
- of those trusts that were in deficit when assessed part-way through 2002/03, auditors judged that one-third of recovery plans were inadequate to correct the trust’s overall financial situation.
Box F
Factors affecting the achievement of financial balance and future financial footing

Performance constrained...
‘Delays in agreeing 2002/03 Service and Financial Framework (SaFF) led to delays in finalising savings programme. As a consequence the Trust is having to identify non-recurrent savings to underpin the savings programme.’

‘It may be possible to balance financially this year using local brokerage. But it is difficult to see how this achieves real advantage other than buying limited time to find more sustainable solutions.’

‘The service level agreement with the PCT’s principal acute service provider remains unsigned due to disagreement over the activity to be undertaken to meet NHS performance targets and its value, and ownership of cost pressures which have emerged in 2002/03.’

Moving forward
‘A balanced budget has been set and the financial pressures from 2001/02 have been addressed. The mid-November 2002 position is that the PCT is forecasting that it needs £0.4 million of brokerage to achieve financial balance, the funding of which it has identified locally. It is developing plans to identify a further £0.25 million of in-year savings as a contribution to health economy financial pressures. Therefore, while pressures remain, financial balance is achievable.’

‘The actions taken to arrest the overspend include a freeze on vacancies and on use of agency staff, two directors with assigned responsibility for tackling the prescribing issues, and increased controls over non-pay expenditure. It is evident that the PCT management team is determined to manage the position.’

‘There is a history in the local economy of recovery plans not being adhered to or achieved. Since its recent inception the Strategic Health Authority has intervened and demanded a more robust recovery plan.’

Source: local independent auditors (each comment relates to a different example trust)

How new money has been used
33 Extra funds have been made available that were intended to help trusts meet specific NHS Plan targets. These are known as ‘hypothesised’ or ‘earmarked’ funds – meaning that, for example, funding made available for cancer should actually have been spent on improving cancer services. The DH does not require trusts to record in a standard way how the money was spent – and auditors found considerable variation in the arrangements for controlling and keeping track of this money. It would not be a cost-effective use of staff time to identify this type of expenditure in a separate budget entry at department level. However, a trust acting prudently should have kept records of what the money was spent on. In half of PCTs and mental health trusts, and in nearly two-thirds of acute trusts, auditors were satisfied that adequate arrangements
were in place to ensure that growth monies were used for their intended purposes. But auditors found a stark contrast between those trusts that had taken reasonable steps to ensure money was spent on its intended purposes (Case study 1), and those where poor records had been kept or the money had been used on other things – most frequently, to fund deficits (Box G). It was not always the hospital trust actually spending the money that was at fault for not tracking its use – sometimes the extra funding was not separately identified by the health authorities and PCTs. As a result funding may not have been applied to the intended priority area because the hospital trust would not have known which area it was intended for.

Case study 1
New monies used as intended, and reasonable records kept by the trust to demonstrate this

In 2001/02 the Trust received ‘earmarked’ funds for these priority areas:

<table>
<thead>
<tr>
<th>Priority area</th>
<th>Amount</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Booked admissions</td>
<td>£117,000</td>
<td>Specific project that can be clearly tracked through to budgets.</td>
</tr>
<tr>
<td>IT</td>
<td>£240,000</td>
<td>Specific project that can be clearly tracked through to budgets.</td>
</tr>
<tr>
<td>Reducing inpatient waiting times</td>
<td>£69,000</td>
<td>Less easy to track – but, since the targets to be achieved through the use of this money are part of the core functions of the Trust, they impact on most direct and indirect budgets, and would be unlikely to be given a separate ‘line’ in each budget. Interviews with frontline staff made it clear that additional funds had been made available to increase theatre and bed capacity, and waiting time targets had been achieved.</td>
</tr>
<tr>
<td>Cleaning</td>
<td>£50,000</td>
<td>Not clearly identifiable, but the cleaning specification had been enhanced, and better cleanliness standards than previously had been achieved.</td>
</tr>
</tbody>
</table>

The auditor concluded that there was no evidence to suggest that hypothecated monies had been used for anything other than the purpose for which they were intended. The funds were received late in the year and it is questionable whether it would have been a valuable use of staff time filtering the funds through to individual budgets. However, there was scope for the trust to co-ordinate better the way in which it reports and records bids for additional money, and to ensure the trust has a mechanism in place for seeking prompt feedback on whether or not a bid has been successful.

Further earmarked funding of £465,000 had been received in 2002/03 (for projects including further work on booked admissions and patient choice). These bids were better structured, with the areas of expenditure to be incurred made clear in the bid documentation. This should enable the trust to pass additional funds through to direct budgets.

Source: Local auditor report
Box G
New growth monies: use of funds for other purposes and poor record keeping

Each of these comments by an auditor refers to a different trust

Funds used for other purposes...
‘Based on the area’s financial constraints, it is highly likely that growth monies will have been invested in funding the deficit. Furthermore, we identified during our review that 50 per cent of Information Management and Technology funding (£500k) has not been fully invested in this area.’

‘Our work shows that funds were used to support the recovery programme.’

‘Our review showed that of £567k hypothecated funding allocated to the PCT for its own provider services, only £207k (37 per cent) was spent on provider services within the specific NHS Plan area. The remainder was diverted towards NHS Plan areas within commissioning and achieving financial balance.’

‘Performance fund monies have been used in recent years to support the Trust’s underlying financial position, with the full agreement and understanding of the commissioners.’

‘The local health economy is projecting a deficit of some £13m for 2002/03. The Annual Development Plan assumed that growth monies would be used to fund deficits by delaying project starts until near the year end.’

‘The Trust used some NHS growth monies for spending in line with NHS Plan criteria (£75,000 for CHD, £42,000 for Cancer and £24,000 for Mental Health). However, 64 per cent of all money received (£12,000 for increasing capacity, £146,000 for primary care and £97,000 for Information Management and Technology) has been spent on trying to achieve financial balance in 2002/2003.’

Poor record-keeping...
‘Monitoring across the Trust is not “joined up” – for example, project managers will have specific money allocated to them to reduce waiting times, but they do not report to the Corporate team to enable the Trust to demonstrate effective, efficient and economic use of the new NHS Plan monies.’

‘The Trust receives limited information from Commissioners regarding funding streams. Therefore it is unable to accurately segregate hypothecated funds from Commissioners’ main allocations.’

Source: local independent auditors (each comment relates to a different example trust)

With increasing amounts of funding being made available for the NHS it will be important to be able to account for how this additional funding has been used and identify the improvements that have been achieved as a result of it. There needs to be greater clarity for commissioners and providers of services on how the funding which is allocated to them is to be used. If it is intended that NHS bodies have flexibility locally to determine how funding should be applied, then this also needs to be made
clear. Funding has often being used to ensure that NHS Plan targets were met, sometimes with relatively short-term solutions. With changes to the way in which funds flow through the NHS (Ref. 18), there will be a greater focus on financial management and in particular on linking financial and activity information.

People management

The NHS Plan set out specific targets and milestones aimed at increasing staff numbers and developing the NHS workforce. The DH and other organisations have a large number of initiatives in place designed to make the necessary gains in frontline capacity – nevertheless, large numbers of NHS trusts were rated as at high risk of not achieving the required increases in frontline staff numbers (Box H). By contrast, few trusts were rated as at high risk of failing to offer more flexible employment opportunities or offering improved childcare arrangements. Though an essential building block, simply recruiting extra staff is not the sole solution – there are other human resource challenges that will have to be met if the Plan’s service aims are to be achieved. For example:

- We recently reported considerable variations in GP staffing levels and in the range and quality of services provided by practices (Ref. 19). A more detailed update is due for publication later this year.
- There is scope for managing hospital staff more efficiently to maximise their contributions (Ref. 20).
- Comments by auditors made it clear that there was still considerable work needed to ensure that the local organisations’ human resource planning integrates well with the Workforce Development Confederations.
- Recent contract negotiations with hospital consultants and GPs suggest that there are deep-seated difficulties in the relationship between frontline staff, managers and central government that need resolution (Ref. 21).

Box H
Factors affecting the strengthening of frontline capacity

Performance constrained...

‘National lack of required skills and lack of trust management effort to recruit and retain doctors and nurses. The Trust will have to scale down/consolidate its activities due to the fact that it cannot recruit nurses. Budget constraints mean they are unlikely to receive funding approval to recruit.’

‘There is currently no workforce plan in place in the Trust either by locality or overall. There is no evidence that workforce planning is linked to capacity planning, service developments and NSF milestones. As the Trust was only formed on 1 April 2002, there has been pressure on the HR department as regards integrating new staff, policies, procedures, pay and conditions therefore Trust-wide workforce planning for the new organisation has yet to take place. There have been no recruitment targets set either externally or internally.’
‘High vacancy rates and severe workforce shortages. Lack of money for newly created posts.’

...Moving forward

‘A 5-year workforce plan has been produced which feeds into the Workforce Development Confederation (WDC) but structures and links with the WDC have yet to be agreed. Nursing vacancies are monitored and a recruitment and retention strategy and action plan has been produced.’

‘Long-term strategic plans have been developed which include risk assessment, monitoring supply rates and market trends. The annual planning cycle risk assessments feed into the capacity planning process. Working Time Directives have affected this area and analysis is undertaken to ensure that there is compliance with these.’

‘The Trust is continuing to develop relationships with the Workforce Development Confederation (WDC). The Trust plans to recruit an extra 42.5wte doctors over the next four years. The Trust has developed a three-year action plan for recruitment and retention which includes a number of initiatives aimed at increasing the numbers of nurses applying to the Trust, developing skills in-house through rotational programmes and encouraging the Return to Practice initiative.’

Source: Local independent auditors (each comment relates to a different example trust)

Estate management

The NHS has one of the largest property portfolios in Europe with a current use value of about £23billion and a significantly greater replacement value. New buildings will need to be continuously developed over the ten-year lifespan of the NHS Plan to meet service and patient needs. Due to significant under-investment over a long period the NHS currently has a maintenance backlog which will need to be addressed to offer the quality facilities that patients expect (Box 1, overleaf). A majority of trusts were rated as at high risk of failing to significantly reduce the maintenance backlog – it was one of the highest rated of all risk factors. For some trusts, planned large-scale building projects will eliminate some of the maintenance backlog, but they will not be completed within NHS Plan target timeframes.
Box I
Factors affecting the ability to reduce the maintenance backlog

Performance constrained...
‘A survey was carried out 3 years ago and this is currently held and updated electronically. The Trust states that £18.4 million will be required over the next 10 years to maintain the physical condition and meet fire, health and safety requirements. This level of expenditure would exhaust the Trust’s entire minor capital allocation and it is clear that large parts of this backlog will have to be addressed through new buildings targeted at improving services.’

...Moving forward
‘Issues regarding maintenance backlog are incorporated within the Estates Strategy. An investment plan prioritises developments. Users’ views concerning environment and buildings are identified.’

‘Spending to reduce the maintenance backlog is sufficient to meet the NHS Plan target. Investment to address backlog maintenance is linked to the Trust’s estates strategy and is seen as a priority by the Trust Board.’

Source: local independent auditors (each comment relates to a different example trust)

Performance management

Auditors identified management capacity issues of ‘high risk’ concern in nearly two-thirds of mental health and primary care trusts. This is partly explained by their relative newness as organisations, a theme picked up in Chapter 4. Auditors then assessed the adequacy of six broad features of trusts’ performance management arrangements. Although such measures can ‘take the temperature’ of a trust’s management arrangements, we do not seek to over-emphasise their status – managing performance is not just about having a system, but also harder to measure factors like leadership and a performance culture (for example, Ref. 22). However, comments by auditors also suggested an apparent shortage of experienced managers (Box J).
Box J
The availability of good managers

Performance constrained...
‘Because the management structure is so new, and not yet fully recruited to, it will take time to become embedded and new managers will need significant support to become effective. The Trust urgently needs to agree its overall strategy so that managers can develop plans to meet key targets.’

‘There are difficulties with lower tier managers within the Trust. Although there are exceptions, the gap between the Business Managers and Directorate leads and the Executive team is immense. This leads to the Executive team continuing to be involved in the day-to-day management of the Trust.’

...Moving forward
‘Considered approach to recruitment ensuring individuals with appropriate skills and competencies are recruited to the organisation.’

‘The Trust has put a number of posts in place to take the modernisation agenda forward including a Head of Modernisation. There are also a number of project managers in post to take forward key elements of the NHS Plan including booked admissions, reforming emergency care and cancelled operations.’

Source: local independent auditors (each comment relates to a different example trust)
Achieving the Plan

Trusts varied greatly in their overall performance and managerial capacity. Some succeed on all fronts – a few by contrast could be considered to be failing. Some are managerially good but external factors limited their Plan performance – conversely, others have performed well against the Plan milestones to date, but managerial weaknesses may mean that their performance will not be sustained.

Chapters 2 and 3 have shown that current and likely future performance, and management capacity, both vary. This chapter brings the two together to highlight the main successes, but also where significant challenges remain at local levels. But performance limitations may not be due only to management weaknesses or external factors, such as limited resources. Systems of central target setting inevitably have limitations. The chapter ends, therefore, by considering these wider questions about what are the best mechanisms by which to improve health services for tomorrow’s patients.

Managerial capacity and performance

The overall picture, both in terms of performance and management capacity, is one of optimism amidst outstanding challenges (Table 1). Mental health trusts show the highest number of weaknesses in both performance and capacity across the board, while the PCTs stand out as weakest in management capacity. The better performance of the acute, specialist acute and ambulance trusts may reflect a longer period of stability within these types of organisation. By contrast, the mental health trusts and PCTs have been subject to more recent reorganisation and may take time to settle down.
Table 1
Average performance and capacity measures, as assessed by auditors in late 2002

<table>
<thead>
<tr>
<th>Type of Trust</th>
<th>(a) Percentage of 2001 targets on which performance improved since assessed in 2001</th>
<th>(b) Percentage of 2002/03 targets judged to be low risk (i.e., likely to be achieved)</th>
<th>(c) Percentage of measures where improvement likely</th>
<th>(d) Percentage of measures where improvement possible or likely</th>
<th>(e) Percentage of managerial capacity judged very good or adequate</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>81</td>
<td>63</td>
<td>43</td>
<td>(93)</td>
<td>71</td>
<td>165</td>
</tr>
<tr>
<td>Specialist acute</td>
<td>88</td>
<td>79</td>
<td>56</td>
<td>(90)</td>
<td>80</td>
<td>14</td>
</tr>
<tr>
<td>Mental health</td>
<td>79</td>
<td>64</td>
<td>37</td>
<td>(92)</td>
<td>62</td>
<td>64</td>
</tr>
<tr>
<td>Ambulance</td>
<td>n/a</td>
<td>69</td>
<td>28</td>
<td>(85)</td>
<td>80</td>
<td>26</td>
</tr>
<tr>
<td>Newer PCTs</td>
<td>n/a</td>
<td>67</td>
<td>38</td>
<td>(95)</td>
<td>43</td>
<td>141</td>
</tr>
<tr>
<td>Older PCTs</td>
<td>81</td>
<td>68</td>
<td>35</td>
<td>(94)</td>
<td>58</td>
<td>156</td>
</tr>
</tbody>
</table>

Notes: The percentages on which each column is based varies by type of trust:
(a) Improvement is based on 16 targets for acute and specialist trusts, 11 for older PCTs and 8 for mental health trusts (figures for ambulance trusts and newer PCTs are omitted, because there was only 1 relevant target).
(b) Auditors assessed 42 targets for acute and specialist trusts, up to 31 for older PCTs, up to 29 for newer PCTs, up to 23 for mental health trusts and up to 4 for ambulance trusts.
(c and d) Potential to improve was measured across 22 target areas for acute and specialist trusts, up to 22 for PCTs, 17 for mental health trusts and 3 for ambulance trusts.
(e) There were 16 measures of managerial adequacy for all types of trust.

Source: Auditors assessments of all local NHS organisations in England, late 2002

But what are the relationships between these factors? In particular, is performance dependent upon trusts’ managerial capacity? On average, the results from auditors’ work suggests that there is indeed a statistically significant relationship between managerial adequacy and performance – the organisations facing the largest number of performance challenges tend to be least likely to have the management capacity to address them (Exhibit 5, overleaf).1

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1 The relationship between managerial adequacy and NHS Plan performance existed for all types of trust, but only that for acute trusts is depicted in the exhibit.
The relationship between performance, managerial adequacy and DH stars for acute trusts

There is a statistically significant relationship between performance and managerial adequacy. The number of DH stars awarded is only weakly related to either.

But there is very substantial variability within this overall relationship. Not only are there extremes in performance and capacity, but there are also trusts inhabiting each quadrant of the exhibits – we can characterise trusts as belonging to one of four basic types:

- **Succeeding trusts:** Only a small number of trusts were rated as likely to achieve a 100 per cent NHS Plan performance, and as adequate or very good on all managerial measures. But, commendably, the majority of acute and specialist acute trusts fall into this ‘succeeding’ quadrant – they performed well on the majority of targets and were rated as adequate or better on the majority of the managerial measures (Case study 2).

- **Something is limiting performance:** A small number of trusts were rated as managerially competent, but performance was poor. One reason for this can be limited resources compared to others, but this was rarely the only reason (Case study 3, overleaf).
• **Is performance sustainable?** Many PCTs and mental health trusts were performing well, but were rated as weaker managerially. They may not be able to maintain high performance into the future where it is not underpinned by sound management (**Case study 4, overleaf**).

• **Needing support:** A few trusts did poorly on the majority of both performance and management measures. Within this set we can distinguish between two types. First, there are those trusts which score low on managerial adequacy and performance, but where auditors have identified a capacity to improve. These include recently merged trusts, or those with a recent change of top management where things are settling down (**Case study 5, overleaf**). But then there are those who score badly on the two axes but where the auditor has not identified sufficient signs of improvement potential. These could be considered failing trusts, where more radical action may be called for (**Case study 6, overleaf**).

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**Case study 2**  
**A succeeding hospital Trust**

This Specialist Acute Trust achieved most NHS Plan targets, and was rated as "very good" on the majority of measures of financial and performance management. The Trust was awarded two stars by the DH.

**NHS Plan performance:** Examples of progress included reducing the wait for revascularisation of heart disease patients to 12 months during 2001/02, and then to six months during 2002/03. This was achieved mainly by extra funding and the willingness of staff to carry out additional theatre lists, coupled with ward level staff coping with the extra throughput. The Trust’s managers expected progress to continue, although demand continued to exceed capacity and there were difficulties recruiting extra staff in some specialist areas.

Building maintenance was the only NHS Plan target at high risk – rather than the required significant progress towards clearing its maintenance backlog, the backlog had in fact increased over the last few years to £14 million (with ‘essential works’ of about £5 million). The Trust had carried out a detailed building condition survey and bid for significant sums, but received only about one-tenth of the identified backlog amount.

**Managerial capacity:** The auditor commented that ‘The Trust has been proactive in ensuring that it has the staff in place to implement the NHS Plan.’ There was a comprehensive performance management system in place, based on a clear statement of core objectives. This was used to ensure that personal objectives were aligned to those of the directorates and the organisation as a whole. The Trust had considered the ability of key members of staff to manage devolved budgets and devolved them appropriately – where a need for training in budget management was identified, this was provided. The Trust had implemented a rolling programme of process improvement groups to ensure that performance was continually challenged and service improvements achieved. However, the Trust did have some break-even challenges to resolve.

*Source:* Local auditor comments
Case study 3
A PCT where ‘something is limiting achievement’

This PCT was established in April 2001. It received a good rating on managerial capacity, but was rated as at high risk on half of its NHS Plan targets. Factors constraining performance included:

- The PCT was in deficit when reviewed, largely due to prescribing budget pressures and health economy wide deficits. Given the newness of the organisation, it could not reasonably be held responsible for past poor financial performance, but must now begin to manage the situation, improve efficiency and redirect resources towards meeting key targets.

- The Trust was finding it difficult to meet targets related to seeing an NHS professional the next day, and a GP within 48 hours, partly due to a high proportion of small practices making target achievement vulnerable to illness. An action plan was in place to review whether practices could link with the local ‘walk-in’ centre.

- The PCT is responsible for an old hospital – although its redevelopment is being planned, in the meantime ‘Nightingale’ wards will persist and it cannot clear the maintenance backlog.

- The mental health Local Implementation Team was ‘well established, with clear vision and action plans for the delivery of the NSF. However, there are significant constraints in respect of staffing shortages in mental health services, and funding to support service developments.’ Similarly, funding and recruitment difficulties were limiting the development of stroke services under the older people’s NSF.

Source: Local auditor comments

Case study 4
A Mental Health Trust where performance may not be sustainable

This Mental Health Trust performed well on most of the assessed NHS Plan targets and was awarded two stars by the DH. However, it was rated as managerially ‘adequate’ or ‘very good’ on only 13 per cent of measures.

The auditor identified resource constraints that might limit future performance. For example, ‘there are concerns that financial constraints will mean that crisis resolution and early intervention teams will not be implemented in full or at the scale required.’ However, the auditor noted that the future risk to services was not just a question of inadequate resources, but due to shortcomings in the way resources were being managed. For example:

- management capacity had deteriorated, with a reduction in management posts coupled with the imminent departure of the Acting Director of Finance and Chief Executive;

- the human resource management function was split between several individuals, and staffing information was poor with the only source being payroll;
there was no strategy in place to devolve resources to frontline staff, and no training programme related to budget management;

the Trust recorded a deficit in 2001/02 and was at high risk of doing so in 2002/03, for reasons that included a shortfall in funding for the cost of patients treated on the trust’s behalf by other trusts, overtime and agency nursing costs, under-achievement of the Cost Improvement Programme and outstanding non-domestic rating arrears dating back to 1993.

The auditor commented that ‘The Trust continues to make progress on the way it manages its overall performance, although there is considerable scope for further improvement and concerns about management capacity to fully implement the changes necessary to restore recurring balance.’

**Case study 5**

**A poorly performing Acute Trust, but showing signs of improving managerially**

This Acute Trust performed poorly in relation to NHS Plan targets, and was rated as poor managerially, including high staff sickness and turnover rates. A ‘data quality’ check revealed inaccuracies in waiting list information and waiting times in A&E. The Trust was awarded two stars by the DH.

However, a new chief executive has now been appointed and the auditor has noticed encouraging signs of potential improvement, including:

- To improve inpatient waiting times, the Trust had begun to use management information to identify the underlying reasons for low productivity, with a project manager in post to review theatre utilisation, and work planned with GPs to identify any scope to reduce high bed occupancy rates by reviewing the appropriateness of referrals.
- Performance on the NSFs had been poor but, for example, ‘New staff are in post and taking a proactive lead in Cancer services. The Cancer Network is well established and has various sub-groups for site specific cancers. Leads have now been identified in an action plan to ensure delivery of cancer plan targets.’
- To improve A&E waiting times the trust is ‘looking to streamline the system, working with the ambulance service to plan emergency bookings and working with the Bed Manager to identify likely bed availability. Will try to triage ambulance arrivals on a 2, 4 and 6 hour basis.’
- ‘The management and reporting regime has recently been changed and managers are now being supported and involved more in strategic decisions. A number of project managers have been appointed, some working with the Modernisation Agency, to lead on key NHS plan target areas.’
- ‘New Chief Executive putting in measures designed to address root causes of financial problems. Recovery Plan appears to be robust and soundly based, but is dependent on a number of uncertain events, for example, receipt of significant...’
brokerage, additional funding from PCTs.’ In addition, Cost Improvement Programme targets were not met throughout the year.

- ‘Currently developing and improving monthly monitoring reports to Trust Board. All Directors now attend board meetings and have the opportunity to be involved in delivering continuous service improvement. Four group managers also meeting monthly with commissioners.’

Source: Local auditor comments

Case study 6
A hospital Trust needing radical improvement

This Acute Trust has performed poorly in relation to NHS Plan targets, and the auditor noted significant financial management failings, without identifying any substantial signs of imminent improvement. The Trust was awarded two stars by the DH.

Examples of difficulties included:

- Both outpatient and inpatient waiting time targets for March 2002 were met by special initiatives. But waiting time performance deteriorated. The most notable problem was in ophthalmology outpatients where as many as six additional clinics were estimated to be needed to meet the 2003 target. Although an additional consultant started in January 2003, the auditor noted ‘PCTs not taking sufficient responsibility in helping to manage targets. [The hospital] Trust focus is on inpatients not on outpatients.’

- A wide range of challenges related to the four NSFs. For example, ‘Linked with four cancer networks and three SHAs and workforce confederations. Complex patient flows.’ ‘Mental health not viewed as a priority for the Trust. No protocols in A&E for liaison with the Mental Health Services.’ ‘Delayed discharges and growth in emergency admissions affecting achievement of targets in older persons NSF.’

- A history of financial difficulties. The Trust was not on course to achieve the current three-year recovery plan for a range of reasons. A main cause was a large agency nursing overspend. Poor controls meant that the Trust did not identify this early enough to correct it within the financial year (for example, nurse managers delayed signing off bills, compounded by shortages in creditor payments staff further delaying processing).

- The Trust is one of the most expensive of the large acute trusts, and needed to carry out an analysis of reference cost data to identify where and why they have increased in costs. The auditor provided the Trust with a report identifying areas which needed further investigation.

- The Trust had developed service areas to meet some NHS Plan targets by using non-recurrent funding. These had now become recurrent services, but the Trust had yet to resolve with its commissioners how these would be funded in the future.

- The recovery plan expected clinical efficiency savings, based on the assumption that extra activity could be carried out at a full charge to commissioners, while only incurring marginal extra costs to the Trust. However, the auditor questioned whether the Trust would have the capacity to do the extra work, and whether the PCTs would be in a position to pay for the extra activity.

Source: Local auditor comments
Measuring performance

The Government has set out its intention to attach considerable consequences to performance against the NHS Plan, making it essential that the criteria used to judge performance are accurate at identifying the ‘real’ best and worst trusts. There was a statistically significant relationship between the number of stars awarded to trusts by the DH, and their performance on the NHS Plan priority targets as assessed by auditors. However, there was considerable variation. Some trusts which, because they were given three stars, may be eligible to apply for freedoms as NHS Foundation Trusts, were judged by auditors to be performing poorly and as having management shortcomings (Exhibit 5, above). The case studies given above illustrate the starkly differing performance and management capacities of four trusts which were each given two stars. The function of developing performance assessment measures and publishing performance indicators and star ratings recently transferred to CHI (and will, in turn, transfer to the Commission for Healthcare Audit and Inspection, CHAI). A wider set of performance and management measures should be consulted on and used – for example, by making use of the type of information reported here and of the service level performance frameworks developed as part of the Audit Commission’s Acute Hospital Portfolio work.

Giving support

The DH and others (for example, the Modernisation Agency) have supported trusts in many specific ways to boost performance (for example, Ref. 10) and the Audit Commission continues to do so through its Acute Hospital Portfolio work. But this will be an ongoing task and continuing work will be needed to identify and spread good practice. The SHAs have a key role here, and local auditor reports will help them to identify priorities. The size and nature of SHAs’ performance management tasks varies – there were significant differences between both the performance and management capacity of trusts within different SHAs (Exhibit 6, overleaf). The SHAs will need to identify the characteristics of succeeding trusts. What could others emulate? In some cases it will be something specific, such as resources in a particular clinical area, or experienced managers. In others it might be something less tangible – a cultural change that has led to a performance breakthrough (Ref. 22). Perhaps such trusts could be paired with failing trusts within an SHA in a management mentoring arrangement – in the case of service providers, this could become one of the responsibilities of NHS Foundation Trusts.

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Averages: 3 stars: 69 per cent of targets rated by auditors as likely to be achieved; 2 stars: 66 per cent; 1 star: 57 per cent; 0 stars: 52 per cent. 1-way analysis of variance: \( p < 0.001 \).
Exhibit 6
The varying support task faced by different SHAs
The size and nature of SHAs’ performance management tasks varies – there were significant differences between the management capacity of trusts within different SHAs.

The percentage of 16 measures of managerial adequacy assessed by the auditor of each PCT as ‘very good’ or ‘adequate’. Similar variations were found for other types of trust.

The diamonds plot the average percentage for the trusts within each SHA. The vertical bars show the variability about these averages (the 95 per cent confidence interval). If the bars for two SHAs do not overlap, then the PCTs within one SHA were assessed to be better managerially and the difference is unlikely to be due to chance.

Source: Local auditor assessments of all trusts in England

Target setting as a way to improve performance
Setting national standards and developing action plans are powerful tools for improving services to patients and holding organisations to account for their performance. A strength of the NHS Plan is its attempt to pair a vision of an improved health service with measurable targets and milestones by which progress can be tracked. And the importance placed on Plan targets has ensured that local trusts must take them very seriously. For example, a senior A&E nurse recently stated that ‘There is an incredible change happening. Things that have been talked about endlessly are coming to fruition. The reason is that the government’s targets are very stringent, and everyone in the hospital is working towards meeting them. From a shop floor perspective, everyone is focused on the same things, we have a whole systems
approach and the money is coming through’ (Ref. 23). Thus NHS Plan targets can play their part in improving performance within trusts provided there is:

- an understanding that targets are the means not the end – tools which will trigger the change that achieves improvement;
- focus on the leadership, systems and culture that lead to improved services, as well as on the current performance of services;
- local ownership of the problems and the need to change; and
- effort to make the changes sustainable and permanent – building change management into the fabric of everyday management.

However, the process does have limitations and pitfalls to avoid:

- The idea should not be to come up with a comprehensive set of performance indicators which covers everything under the sun – too many targets and indicators risk obscuring where the real priorities lie. Achieving a number of key successes in targeted priority areas can create a culture, a management mechanism which boosts further improvements at all levels of the organisation. The DH’s new Priorities and Planning Framework (Ref. 4) has reduced the total number of targets to 62. A further refinement could be to highlight the key outcome standards that trusts must achieve (such as fewer deaths from breast cancer), and then provide guidance, rather than impose targets, on the type of detailed process steps that might help achieve the standards (such as reducing waiting times).
- Targets that frontline clinicians and managers perceive to be unrealistic, inappropriate or not the real priorities can become obstacles to change. Rather than becoming an integrated part of day-to-day management, such targets risk being seen as an irritating distraction. Managers then develop parallel information systems: one to monitor and deliver the service, and another to report on it. For example, some doctors have questioned whether clinical priorities are being distorted by the focus on waiting times (by making patients who are clinically more in need wait for their treatment because a relatively non-urgent patient is approaching the NHS Plan target maximum wait). Clearly some clinicians feel this is the case – however, auditors did not investigate this possible consequence.
- Local managers must want to improve patient care via meeting targets – not manipulate things to theoretically meet targets without real gain. For example, practices such as offering appointments at short notice and restarting waiting times if patients cannot attend comply with DH guidelines, and allow some trusts to achieve targets, but would not be considered fair by patients (Ref. 8). Similarly, cancelling high numbers of operations the afternoon before the due date means that the commitment to rearrange within 28 days does not apply, and the Plan target can be met – but again, this is not acting in a way that patients would think fair (Ref. 12). Such trusts have lost sight of the real priorities, which are about improving the NHS for patients, not just meeting Government targets.
• Targets must be relevant to underlying strategic goals (Ref. 24). However, some NHS Plan targets are probably too superficial. For example, the target of ‘20,000 extra nurses’ by 2005 has already been met – but this is measured by a ‘headcount’. Auditors encountered examples where apparently significant gains in nursing staff amounted to only a few shifts per week because most of the recruits were part-time nurses each working a small number of weekly hours. Given that the alternative measure of whole time equivalents could be easily implemented by trusts, it is disappointing that the new target in the Priorities and Planning Framework continues to use a headcount as the measure of progress.

Is the Plan on course?

The positive message from this study is that the majority of trusts were assessed to be performing well, and to be managerially adequate, on the majority of facets by which they were judged. Not only has performance improved in the majority of trusts on the majority of targets, but this improvement has come while overall NHS workloads and activity continued to increase. However, the Government has made it clear that it intends to ensure that all trusts achieve all of the NHS Plan’s targets – a 100 per cent performance is required if the ‘postcode lottery’ is to be avoided and every patient is to be assured that they will receive a good service wherever they live. From that viewpoint, the message is less positive – there is a great deal of work to do and only a few trusts were judged likely to achieve all of the Plan’s targets. Indeed, given the variability inherent in such a large and complex organisation like the NHS, it is questionable whether 100 per cent performance will ever be achieved. And, in any case, the Plan inevitably covers only what the DH sees as the main, general, priorities – for an individual patient, a good quality experience will be made up of everything that happens in their journey through the care system, all the details of which cannot be covered by a general plan.

But there are concerns about the sustainability of this progress. To continue to deliver on some targets (for example, those relating to pre-booking of appointments) requires fundamental system redesign, involving considerable cross-departmental work involving large numbers of different clinicians and managers. This will be difficult where there are shortages of frontline staff, weaknesses in managerial capacity or continuing financial pressures. In relation to the comprehensive performance assessment (CPA) of local authorities, we said that councils should be assessed not so much on the circumstances they find themselves in, but on the way that they respond to those circumstances (Ref. 25). We believe that this principle should apply equally to NHS bodies working towards achievement of the NHS Plan. There are circumstances where even a well-managed trust might fail to achieve a target. Their capacity to improve matters as much, if not more than, their current performance. There is a case for arguing that the focus should shift more towards the development of managerial capacity and the other factors that promote achievement.
Recommendations

The Department of Health should:

1. Take account of the ‘early warning’ given by auditors of widespread risk to achieving targets related to the mental health and older people’s NSFs. Plan action that could be taken now, since detailed joint CHI/Audit Commission review findings for these NSFs are not due for some time.

2. Ensure that the SHAs make use of the local trust action plans supplied by auditors to help in the performance management of their local health economies.

3. Review how the management needs of mental health trusts and PCTs can be met.

4. Provide guidelines on how trusts should demonstrate and record that new money has been spent to boost the services for which it was intended. If it is intended that NHS bodies have flexibility locally to determine how funding should be applied, then this also needs to be made clear.

5. Investigate further the conditions necessary to sustain progress on Plan targets such as waiting times, and if necessary refine Plan targets.

6. Focus the closest attention on a smaller number of priority targets.

The strategic health authorities should:

7. Use auditors’ judgements to supplement the DH star awards, to ensure that trusts true strengths and weaknesses are correctly identified, allowing the SHA to provide the necessary support.

8. Promote work to ensure that local trusts’ human resource planning integrates well with the Workforce Development Confederations.

9. Review the robustness of trusts’ financial recovery plans – in particular those of trusts that have used new monies, intended by the Government to boost specific services, to offset underlying deficits.

10. Pair poorly performing trusts with successful ones in a management mentoring arrangement; this could become one of the responsibilities of NHS Foundation Trusts.
Local NHS trusts should:

11. Look beyond a ‘lack of resources’ as the excuse for poor performance, and concentrate on achieving efficiency improvements, using resources such as the Modernisation Agency’s programmes and advice, involvement with the Collaboratives, and the action plans delivered by local auditors.

When operational, the new Commission for Healthcare Audit and Inspection should:

12. In consultation with the DH, consider what use could be made of auditors’ assessments to help ensure that their revision of the trust ‘star’ system produces an accurate way of categorising trusts.

In playing its part, the Audit Commission will:

13. Continue to support and comment on progress in implementing the NHS Plan, by carrying out a further review during 2003/04.

14. In the period before the Commission for Healthcare Audit and Inspection becomes operational, ensure that we work effectively with the Commission for Health Improvement during joint NSF reviews.
Appendix 1: how auditors carried out their local reviews

A full list of the NHS Plan targets selected for review, and the measures of managerial adequacy employed, can be found on the Audit Commission’s website (www.audit-commission.gov.uk), together with extra details of the results.

The assessments described in the report (‘low’ or ‘high’ risk, etc) were based on detailed information about current performance, how well resources are managed, key documents and interviews with staff. For example, for the targets relating to waiting times, auditors were asked to review monthly monitoring information, DH performance indicator information and any activity modelling results. Where available, they linked waiting time peaks to other local factors, for example, delayed discharges, emergency admissions, cancelled operations, cancelled theatre sessions, day case rates and length of stay. They reviewed any available action plans aimed at reducing cancellations (for example, capacity plans, workforce plans, local health community waiting times strategy and action plans resulting from Local Modernisation Reviews). They interviewed key trust staff (for example, Director of Operations, Head of Performance Management).

Approximately halfway through the financial year, auditors judged whether sufficient progress had been made locally to deliver against the NHS Plan target or milestone. If such progress had been made – or there was evidence that suggested sufficient progress would be made by the target date – then the auditor recorded the trust to be at ‘low risk’. If the evidence suggested that insufficient progress had been – or would be – made, then a ‘high risk’ assessment was recorded.

Next, the auditor assessed the organisation’s strategic capacity to improve. If there was no recognition of any need for improvement despite obvious shortcomings, no record of responding positively to external challenge such as quality and inspection reports and no evidence of ability in terms of people, systems and resources to make the arrangements necessary to achieve change, then the auditor recorded a judgement of ‘unlikely to improve’. That change might ‘possibly’ occur was recorded if the trust demonstrated acceptance that there was scope for improvement; clear recognition of the need for change; evidence of change in the right direction but with a realisation that there is still more to be achieved; focused plans for improvements were in place; or where there was a track record of responding positively to external challenge such as audit and inspection reports. A ‘likely to improve’ judgement was made if there was a proven capacity for improvement (ie, the authority could show what had happened, who had achieved it and that plans and resources for further improvement were in place), and a track record of responding
positively to external challenge such as audit and inspection reports. The judgements made were not based on the same level of detailed evidence as those made under the Commission’s comprehensive performance assessment (CPA) framework for local government authorities. They will, however, have been based on the auditors’ detailed knowledge of the organisation’s past performance and the barriers that have and may still exist which may prevent future improvement.

Finally, auditors assessed the adequacy of trusts’ financial, resource and performance management systems. For example, when assessing the monitoring of financial systems, auditors recorded whether arrangements were:

- ‘inadequate’ – management did not monitor the operation of the financial systems;
- ‘adequate overall, but some weaknesses identified’ – management monitored the operation of the financial systems through a small number of key controls and took corrective action where necessary.
- ‘adequate’ – management monitored the operation of the financial systems through key controls and key indicators and took corrective action where necessary; or
- ‘very good’ – management monitored the operation of financial systems through: key controls, key indicators, validation of information and took corrective action where necessary.

Arrangements were made to promote and test consistency of judgements between different auditors.
References


Outpatients: Acute Hospital Portfolio review 12

More patients attend hospital as outpatients than in any other acute setting of the NHS, so performance in outpatient departments has a big impact on public perceptions of the NHS. This review looks at patient experiences and whether outpatient departments are well managed by trusts.


Waiting for Elective Admission: Acute Hospital Portfolio review 11

This review examines the causes of long waiting times and high numbers of cancelled admissions. It recommends improvements in the way that waiting times are measured to better reflect patients’ perceptions and ways in which NHS trusts can manage their waiting lists more equitably and efficiently.


Operating Theatres: Acute Hospital Portfolio review 10

Operating theatres are a very complex and resource-intensive part of the NHS. This review considers whether they are being managed effectively and safely; in particular, the efficient use of scheduled theatre time, space and staff. It recommends a number of specific targets and actions for improvement.


Bed Management: Acute Hospital Portfolio review 9

It is essential that beds are managed well and used efficiently. This review looks at the outcomes for patients of good bed management and considers trusts’ capacities to meet the demands made upon them. It will help trusts to understand and improve their performance.

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