improving value for money in the NHS

a compendium of good practice from Audit Commission reports
The Audit Commission promotes the best use of public money by ensuring the proper stewardship of public finances and by helping those responsible for public services to achieve economy, efficiency and effectiveness.

The Commission was established in 1983 to appoint and regulate the external auditors of local authorities in England and Wales. In 1990 its role was extended to include the NHS. Today its remit covers more than 13,000 bodies which between them spend nearly £100 billion of public money annually. The Commission operates independently and derives most of its income from the fees charged to audited bodies.

Auditors are appointed from District Audit and private accountancy firms to monitor public expenditure. Auditors were first appointed in the 1840s to inspect the accounts of authorities administering the Poor Law. Audits ensured that safeguards were in place against fraud and corruption and that local rates were being used for the purposes intended. These founding principles remain as relevant today as they were 150 years ago.

Public funds need to be used wisely as well as in accordance with the law, so today’s auditors have to assess expenditure not just for probity and regularity, but also for value for money. The Commission’s value-for-money studies examine public services objectively, often from the users’ perspective. Its findings and recommendations are communicated through a wide range of publications and events.

For more information on the work of the Commission, please contact:
Andrew Foster, Controller, The Audit Commission,
1 Vincent Square, London SW1P 2PN, Tel: 0171 828 1212
Website: www.audit-commission.gov.uk
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Introduction

The Audit Commission’s role in promoting value for money in the NHS

1. The National Health Service (NHS) spends about £32 billion of public money each year and the public needs to know that this money is being used to best effect. Since 1990, the Audit Commission has helped to provide this assurance by undertaking the external audit of NHS bodies in England and Wales. It has also carried out more than 30 national value-for-money (VFM) studies in health, each of which has resulted in a national report and a programme of local VFM audits. It has also produced a range of management papers relevant to health service management.

2. Audit Commission national reports and management papers have examined existing arrangements for service management and delivery and have sought to define good practice. They have focused on areas of significant spend where real improvements can be made and have been undertaken in consultation with a wide range of stakeholders. And for some of the value-for-money studies, a number of key indicators have also been identified and collected, both at the time of the main audit and again when the study has been followed up. The results of these follow-ups are reported in value-for-money indicator (VFMI) update reports.

Who this compendium is for

3. Improving Value for Money in the NHS: A Compendium of Good Practice from Audit Commission Reports is a collection of at-a-glance summaries that distil the key issues and messages of the Audit Commission’s value-for-money health reports, relevant management papers and VFMI update reports. It is aimed primarily at NHS trusts that provide acute and community services, and commissioning bodies. But in some cases the summaries also have recommendations that will be relevant to mental health trusts, ambulance trusts, GP practices and local authority social services departments. Some of the summaries also contain recommendations for the NHS Executive (Department of Health) and the Welsh Office, now the NHS Directorate for Wales (National Assembly for Wales). There are no specific recommendations for primary care groups, local health groups or primary care trusts because when the reports in this compendium were published they did not exist. However, these new bodies will be interested in many of the recommendations addressed to health authorities and GPs and are also likely to be interested in some of the recommendations for NHS trusts, especially those providing community-based services.
The changing face of the NHS

4. The past ten years have seen significant changes in the NHS. The NHS and Community Care Act 1990 led to the development of an internal market that separated the purchase and provision of healthcare. There was a steady growth in the number of trusts and the role of the health authority changed to focus more on overall strategy, health needs assessment, commissioning of healthcare and the balancing of budgets. Separate family health service authorities (FHSAs) were responsible for primary care until their functions were merged with a reduced number of health authorities under the Health Authorities Act 1995. Under the same legislation, regional health authorities in England were abolished in favour of an enhanced role for the regional offices of the NHS Executive.

5. The NHS and Community Care Act 1990 also provided for a growing number of general practices to become GP fundholders, responsible for managing their own budgets. Some GP practices banded together, pooling their budgets, as multifunds. And in certain localities, non-fundholding practices also banded together as commissioning groups to advise health authorities on local priorities.


7. More recently, the Government declared the internal market structure to have failed. In the White Papers, The New NHS: Modern, Dependable (1997, England) and NHS Wales: Putting Patients First (1998, Wales), the Government signalled its intention to establish a new set of relationships, roles and responsibilities in the NHS with the aim of improving the efficiency, quality and consistency of healthcare provision. The proposals set out in these White Papers have been drawn up in the Health Act 1999.

8. The Health Act 1999 provides for the abolition of GP fundholding. Instead, GPs, primary care professionals and other local stakeholders will work together in primary care groups (England) or local health groups (Wales) to promote the health of local people, to develop primary care services locally and to commission local healthcare, all within a budget devolved by the local health authority. Potentially, over time, health authorities in England will relinquish commissioning responsibility altogether and instead fund and oversee freestanding primary care trusts. There will be separate arrangements for commissioning specialist services. In Wales local health groups may also, in the future, be able to obtain trust status subject to secondary legislation being introduced by the National Assembly for Wales.
9. Under the new arrangements, there is also to be a system of new national standards and guidelines. These include the establishment of the National Institute for Clinical Excellence and an independent statutory body, the Commission for Health Improvement, which will support and oversee the quality of clinical services locally. In addition, the NHS Executive (Department of Health) and the NHS Directorate for Wales (National Assembly for Wales) will work together, in consultation with the clinical professions, to develop national service frameworks. These will bring together evidence of clinical and cost-effectiveness with the views of service-users to determine how best to provide specific services or services for specific client groups. It is intended that these measures will help to ensure consistency of care across England and Wales.

10. The new arrangements place an increased emphasis on the quality of healthcare delivered by NHS trusts, both existing acute and community trusts and the new primary care trusts. There will be a duty on all NHS trusts to ensure that there are appropriate arrangements in place to monitor and improve the healthcare that they provide and quality standards will be central to new local service agreements between health authorities, primary care groups or local health groups, and NHS trusts.

11. A new statutory duty of partnership is also introduced, requiring NHS bodies to work with local authorities in pursuit of common goals. Health authorities will work, in consultation with local authorities, NHS trusts and primary care groups or local health groups, to develop health improvement programmes. These will identify local needs and the services needed to meet them. This will set the framework within which commissioning bodies and healthcare providers will operate locally.

12. The National Assembly for Wales assumed responsibility for the management and oversight of the NHS in Wales as from July 1999. Although the NHS will remain a unified service, the National Assembly for Wales will have a wide range of powers to determine separate NHS policy in Wales.

The new arrangements place an increased emphasis on the quality of healthcare delivered by NHS trusts.
The changing face of the Audit Commission

13. The Audit Commission acts on behalf of citizens, both as users of public services and as taxpayers who bear the cost. Its work, and that of the local auditors it appoints, helps those who commission and provide public services both to minimise costs and to maximise the quality and effectiveness of services delivered. During a period of change, both in the policy framework for the delivery of health services and constitutional change in Wales, it is all the more important that there is a focus on delivering services economically, efficiently and effectively. Despite the degree of change that has taken place over the last decade, and the changes that are currently being implemented, many of the issues and recommendations identified in past Audit Commission reports and management papers continue to be relevant.

14. The Audit Commission believes that the value of its work to date has been underpinned by five key features of its regime.

- Firstly, the Audit Commission is an independent body and is, and is widely seen to be, impartial in its dealings with both central government and audited bodies.
- Secondly, its work is firmly based on evidence, collected through independent and comprehensive research and frequent follow-up work.
- Thirdly, the width of its remit in the public sector means that it is uniquely placed to promote joint working across organisational boundaries.
- Fourthly, the combination of local audit with national co-ordination is a powerful one. It allows local auditors to draw upon the Audit Commission's national research capacity. Equally, the Audit Commission's central functions can draw upon a large pool of expertise in local audit, bringing together audit findings to ensure that implications of national importance are drawn from the evidence and communicated appropriately.
- Finally, the Audit Commission's commitment to widespread consultation enables it to test its evidence, its conclusions and its own performance before publishing its findings.
15. These factors remain important as external developments take place and will continue to characterise the Audit Commission's work. However, in Changing Picture, Sharper Focus: Strategy 1999–2002, the Audit Commission recognises that it needs to review its own structures and ways of working so that it can work effectively alongside the Commission for Health Improvement as it comes into being, and respond fully to the NHS quality agenda and constitutional change in Wales. In particular, it will support modern and innovative audit approaches, building on the strengths of its regularity regime and previous initiatives such as the 'managed audit' (which encouraged closer working with internal audit). It will also aim to develop further its partnerships with other public sector auditors. And to support the delivery of audit locally as effectively as possible, the Audit Commission has recently brought together its audit appointment, regulation and support functions. The Audit Commission is also undertaking a comprehensive review of its public service research processes, bringing together its local government and NHS work into a single directorate. This will help it to develop further its existing cross-sectoral approach, emphasising what works and helping to spread innovation and good practice. The Audit Commission has also established an office in Cardiff and a Wales forum to develop and implement an integrated response to legislative and other changes in Wales. These initiatives are set out in detail in Changing Picture, Sharper Focus: Strategy 1999–2002.

How this compendium is structured

16. Each summary in this compendium is primarily an aide-memoire to NHS managers of the good practice that the Audit Commission has promoted over the last ten years. However, care has been taken to ensure that recommendations are still relevant and that the summaries are placed in a current context with reference made to any significant changes that have taken place since the original report was published.

17. The compendium is divided into two sections. The first section, Getting the basics right, contains summaries of Audit Commission reports that are relevant to the overall management of NHS bodies. The second section, Delivering value for money, contains summaries that set out the good practice from value-for-money studies in specific areas of service delivery.

18. The summaries in the first section are arranged under four headings: general management, IT and information management, staff management and support services. The summaries are grouped under these subject headings in alphabetical order. In the second section, the summaries are listed in alphabetical order.

19. Where appropriate, related reports have been brought together into one summary. The table at the beginning of the compendium sets out which reports are of relevance to which service bodies in order to help managers to identify those of most interest to them.

Finally ...

20. Contact should be made with the local audit manager to follow up issues raised in the compendium. Auditors can assist health bodies in identifying further opportunities to improve value for money in their services.
There are no specific recommendations for primary care groups, local health groups or primary care trusts because when the reports in this compendium were published they did not exist. However, they will be interested in many of the recommendations that are addressed to health authorities and GPs and are likely to be interested in some of the recommendations for NHS trusts, especially those providing community-based services.

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* Health authorities and primary care groups/local health groups or trusts with commissioning responsibility.
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Section 1: Getting the basics right

The Audit Commission is responsible for the external audit of NHS bodies in England and Wales. As part of this function, the Audit Commission’s appointed auditors are required, by law, to examine local management arrangements for securing economy, efficiency and effectiveness. The Audit Commission also produces occasional management papers that provide practical guidance on public management issues. This is in addition to conducting value-for-money studies in specific areas of health service management, such as information management. A robust management framework is essential for ensuring value for money in all aspects of health service provision. For this reason, the summaries covering overall management issues are gathered together in this section under four separate headings: general management, IT and information management, staff management and support services. The summaries in this section provide a context for all of the good practice summarised in Section 2, Delivering value for money.
General management

Financial management

Refer to:
See also:
Trusting in the Future: Towards an Audit Agenda for NHS Providers (1994) 0118861042, £5

Background

The NHS faces rising demand for healthcare from an ageing population, developments in medical technology that are leading to the availability of new treatments, and a more questioning and informed attitude from service users. These growing demands and expectations must be balanced against the resources available to meet them. The Audit Commission published A Healthy Balance to help trusts and commissioning bodies to meet this challenge successfully.

A Healthy Balance drew upon information gathered from a survey of all health authorities and trusts in England and Wales, in-depth fieldwork in 20 NHS bodies, and interviews with a range of chief executives and directors of finance across England and Wales.

Key messages

• Maintaining good financial health is the result of successfully managing many conflicting pressures and of understanding and managing the main risks and uncertainties.

• Four key conditions are important in achieving financial balance:
  – instilling a culture of strong financial awareness;
  – creating good financial and business planning and budget-setting processes;
  – maintaining a clear framework of financial control; and
  – establishing effective monitoring and management information systems.

  These are elaborated upon below.

Instilling a culture of strong financial awareness

• Good financial management is not the sole preserve of the finance function. It is a corporate responsibility that is shared by all staff throughout the whole organisation.

• The members of a trust or commissioning body perform an important leadership role in securing effective financial management.

• A cornerstone of many financially well-run organisations is a strong working relationship between the chief executive and director of finance.

Creating good financial and business planning and budget-setting processes

• Risks and uncertainties need to be identified, quantified and managed.

• Longer-term business plans play an important part in ensuring financial stability, although currently the majority of plans project only one year ahead.

• Longer-term plans must be supported by clear financial and activity plans.

• Annual budgets should be achievable and budgets aligned with forecasts of clinical activity.

• Budgetary systems need to motivate staff to achieve results, and should include incentives to reward good performance and penalties for poor performance.

Maintaining a clear framework of financial control

• Effective systems of control are necessary to exercise good financial discipline. The 'minimum control standards' laid down by the NHS Executive and the Welsh Office (now the NHS Directorate for Wales) are an essential feature of corporate governance in the NHS and it is important that NHS bodies achieve them.

• Responsibility for controlling budgets should be devolved to those who take decisions about using resources. However, where expenditure control fails, there may be a short-term need for the corporate centre of an NHS body to assume greater control to restore financial balance.

• Cost improvement initiatives should be targeted on the areas that offer scope for the greatest improvement. Clinical processes should not be excluded from review.

Establishing effective monitoring and management information systems

• Well-presented, concise and up-to-date financial reports must be sent regularly to the right people.

• Management information presented to board and authority members should combine financial and activity-related data.
Management consultants

Refer to:
Reaching the Peak? Getting Value for Money from Management Consultants (1994) 0118861271, £6

Background

The use of management consultants is well established in the NHS. They can be especially valuable where there is a lack of in-house skills available, to meet short-time scales or to provide independent review. However, during the early 1990s there were a number of well-publicised failures of large consultancy projects in the public sector. Earlier studies by District Audit showed that authorities had a poor record of implementing consultants’ recommendations and revealed weaknesses in the procedures used to select consultants and in the management of consultant contracts. Poor management of consultancy projects is a waste of a very expensive resource and, in addition, where proper procedures for selecting and appointing of consultants are not followed, officers and members can find themselves facing serious criticism.

Reaching the Peak identified the steps that NHS and other bodies need to take to ensure that they get value for money from their management consultants. It included a checklist of good practice, which was designed to be of practical assistance to project managers when commissioning and managing consultants. The report drew upon information gathered from in-depth fieldwork at eight health authorities and nine local authorities across England and Wales.

Key messages

Organisations employing consultants should:

- produce corporate guidelines on preparing project briefs and terms of reference. The discipline of preparing a brief forces officers to consider what they want to achieve from the project and a clear brief will help to ensure that there are no misunderstandings between consultant and client;
- review their standing orders relating to contractors to make sure they are clear, comprehensive and easy to use. In many of the authorities visited during the study, guidance on contracting and tendering was found in several places including standing orders, financial instructions, purchasing guidelines and other documents, some of which were produced many years earlier;
- ensure that competitive procedures are observed. Consultants are sometimes selected, often for the best of reasons, because they are personally known to the officers in charge. However, this practice may mean that tendering regulations are being contravened and that the organisation runs the risk of being accused of corrupt practices;
- make sure that the selection criteria for consultants are clearly specified in advance, particularly where they need to be based on factors other than cost, and the reasons for the final decision should be recorded in the contract file. Specifying a price range when tenders are invited can make it easier for consultants to assess the scope of the project and the final decision can then be made primarily on the basis of quality;
- establish written agreements with consultants before work starts. Contracts should be price-fixed, payments should be linked to the completion of tasks and the types of expenses to be paid should be specified. Almost one-third of the projects examined had no written agreement of any kind, risking the omission of important tasks and making it difficult to obtain redress in the event of any conflict with the consultant;
- refer decisions on the choice of consultants for larger projects to an appropriate board or committee;
- develop codes of practice for contract management and establish systems for monitoring the progress of projects, and the standards and targets to be reached;
- improve budgetary control. Separate budget codes should be used for individual consultancy projects. Managers should make sure that payments to consultants can be tracked through the financial system;
- set up a central consultancy project reference file, containing a brief description of each project, name of the consultancy firm and client department, and estimated cost, as well as a contract file for each consultancy project; and
- evaluate all but the shortest projects on the basis of whether the work was completed on time and within budget, the extent to which objectives were achieved and the quality of in-house project management. In most cases, post-mortems are carried out only when things go wrong and valuable lessons are lost. The results should be recorded centrally and on the contract file, ideally on a brief standard evaluation form.
Mergers

Refer to:

Background

The Audit Commission produced Less Dangerous Liaisons to help those leading mergers to ensure that strategic objectives are achieved and that continuity of service is maintained throughout the merger process. The paper focused on factors that top managers need to consider early in the run-up to reorganisation. It drew upon a review of the relevant literature along with interviews with experts and senior executives of organisations that have experienced merger, including 5 private sector companies, 1 trade union and 20 public sector bodies across England and Wales.

A recent major reconfiguration of health trusts in Wales has led to a number of mergers, and current reforms may lead to further reconfiguration of existing trusts and authorities in England.

Key messages

- Managing mergers is difficult and, in many cases, mergers have turned out to be disappointing in achieving predicted benefits. Where organisations have a choice about whether to merge or not, they should consider carefully which is likely to be the best path for them to take.
- The scale of the task should not be underestimated. Early planning is important, with clear objectives and realistic timescales.
- Senior managers will effectively need to balance their time between strategic and operational issues. A ‘transition team’ will be needed, to make sure that effort is focused where it is needed to plan for the merger while maintaining effective service delivery.
- Appointing a chief executive to the new organisation early in the process is important or, failing this, nominating an alternative source of executive leadership. The chair and the non-executive directors need to be in place as soon as possible after the merger.
- The new organisation will also need strategic aims and values. The more involvement that staff, trade unions, staff associations, professional bodies and other stakeholders are given in developing these, the more commitment they are likely to feel to the new organisation and the quicker the transition will be.
- Decisions concerning staff changes need to be taken as early as possible to avoid prolonged uncertainty, loss of staff morale and the potential loss of valuable staff. This means effectively communicating the implications of the merger to all those who will be affected by it and reassuring staff whom it is hoped will stay. Where necessary, plans for staff cuts should be put in place and arrangements for redundancy reviewed. How management treats those who have lost their jobs will affect staff morale for many years.
- Systems that are critical to continuous service delivery need to be identified as early as possible and measures taken to guard against service failure. Where possible, old systems should be maintained for a while as back-up should anything go wrong and new systems should be tested.
- ‘Organisational culture’ is a nebulous concept, but can be characterised as a set of shared values, ideas and assumptions. The cultures of the two merging organisations need to be examined, and a new culture for the merged organisation developed using a variety of team-building and cross-working techniques.
Background

There are currently around 3,700 non-executive directors sitting on the boards of NHS trusts and health authorities in England and Wales. While they are not strictly equivalent, many of the issues addressed in Taken on Board will also be of relevance to the role of non-executive directors of primary care groups, local health groups and primary care trusts.

The Department of Health and the Welsh Office issued Codes of Conduct and Accountability in 1994. These set out the principles of corporate governance in the NHS and outline the role of the non-executive director. Non-executive directors are expected to contribute to overall strategy, monitor the performance of the trust, help to develop policy and enhance the board's responsiveness to the public. The Audit Commission published this paper in order to assist with the development of this role.

Taken on Board drew upon information gathered from in-depth fieldwork at 19 NHS trusts across England and Wales, as well as research into the role of non-executive directors in the public sector.

Key messages

- The study found that the most common barrier to the effectiveness of non-executive directors was a lack of knowledge of the structures and functions of the health service. This can be addressed through appropriate induction, training and ongoing development, which should be tailored to the knowledge and skills of individual non-executive directors.
- Groups may be established to allow non-executive directors from different boards to meet and exchange experiences.
- To be effective, non-executive directors need appropriate and manageable amounts of information.
- The chair of the board should ensure that non-executive directors are given a clear outline of their responsibilities and of how their performance is to be assessed. Feedback should be given (perhaps relatively informally), with a view to planning ongoing development. An opportunity for non-executive directors to feed back to the chair should also be provided.
- Non-executive directors are likely to have areas of specialism and this valuable expertise should be the basis of informal insight and advice; but the board as a whole should maintain responsibility for monitoring performance in all areas of service.
- Non-executive directors need to develop an independent understanding of the organisation and its services, drawing upon views from outside the top executive group on the board. They should be encouraged to 'walk the shop floor', although it should be clear that it is not part of their role to become involved in operational issues. It is good practice to advise the relevant executive director in advance of any such visits and to discuss any observations afterwards.
- Board meetings should concentrate upon discussion rather than the giving of information by executive directors. This will allow non-executive directors to play a more active role. The chair has a responsibility to lead non-executive directors in making constructive challenges and in ensuring that the organisation's performance is robustly monitored.
- Taken on Board recommended that reviews of the quality of medical care, based on the outcomes of clinical audit, should be part of a regular dialogue between the board and medical staff, with board members drawing upon the expert advice of clinicians in interpreting data. Boards will now have explicit responsibility for the quality of services provided and, in trusts, this responsibility is embodied in the new duty of clinical governance set out in the Health Act 1999. Non-executive directors have an important role in ensuring that there are comprehensive reporting systems on quality and outcomes. When these systems report inadequate performance, non-executive directors should monitor the taking of remedial action and further reporting.
- The board should receive feedback on the implementation of major decisions.
- Non-executive directors should be involved in formulating the strategy from the start and have influence over the allocation of funds.
Partnership

Refer to:
186240075X, £15

See also:
1862401187, £25

Background

Partnership working is, potentially, a powerful tool for tackling difficult cross-cutting issues and for making more efficient and effective use of scarce resources. It enables agencies to deliver co-ordinated packages of services to individuals and can reduce the impact of organisational fragmentation. Agencies may also enter into partnerships to bid for, or gain access to, new resources or to meet statutory requirements such as the duty of partnership set out in the Health Act 1999, for example.

Recently, both the numbers of partnerships and their scope have increased, both in response to central requirements and as a result of local initiatives. However, effective partnership working is difficult to achieve. There may be conflicting priorities for action and a lack of agreement on action. Partners may feel more or less involved in decision-making, or may feel required to make a disproportionate contribution to help to achieve the partnership’s objectives. And, given the nature of many problems that are tackled by partnerships, there may be little or no way of knowing whether the partnership is effective and whether its benefits outweigh its costs.

A Fruitful Partnership aimed to help board and local authority members, and senior officers in local government, the NHS and the police to make better decisions about when to set up a partnership and to help to improve the effectiveness of existing and future partnerships. Others contemplating or already involved in partnerships, including voluntary and private sector organisations, may also find it useful. The study drew upon information gathered from in-depth fieldwork in 14 partnerships from across England and Wales.

Key messages

- Where entering into a partnership voluntarily, agencies should consider carefully what they hope to achieve and examine whether there are simpler ways of realising these objectives. Alternatives might include:
  – consultative arrangements where a single agency retains responsibility for decisions and actions;
  – networks of personal or professional relationships which do not involve organisational commitment; and
  – contractual relationships.
- The agencies involved need to have clear and shared objectives.
- There should be a realistic plan and timetable for achieving these objectives.
- There needs to be commitment from all agencies to take account of the partnership’s work when planning their mainstream activities.
- There needs to be a clear framework of responsibilities and accountability.
- To be successful, there should be a high level of trust between partners.
- There should be realistic ways of reviewing the success of the partnership’s work. This should involve an understanding of the costs of partnership, the use of appropriate performance indicators, as well as other methods of evaluation such as user surveys, focus groups or a formal independent evaluation study.
Private Finance Initiative

Refer to:


Background

Public services have traditionally been financed either by central or local taxes. The Private Finance Initiative (PFI) offers a way to bring private sector money and skills into the provision of public services. However, a decision to enter into a PFI contract can commit a public body to paying out millions of pounds for decades ahead. Given the typically long-term consequences of PFI deals, it is important that those responsible for taking such decisions operate within a framework that provides them with the information that they need to demonstrate the proper stewardship of public funds.

The Audit Commission produced this paper to help trust board members and chief officers to identify the issues that need to be addressed both when considering a PFI route and, once this option has been chosen, to ensure proper control of the procurement process. Taking the Initiative drew upon information gathered from 26 PFI schemes across England and Wales in sectors as diverse as the NHS, prisons, universities and police, and views were sought from individuals working in both the private and public sectors.

Key messages

- Health trusts need to have a clear understanding of this new form of procurement and how it differs from other options. They particularly need to understand that it is not a free good, but rather that it spreads the costs of development over many years. Where PFI is used to finance a project, future financial decisions will have to take account of PFI commitments for many years to come.

- PFI should always follow and never drive the way that planning is undertaken. Some schemes that may be attractive to private sector partners may not be priorities for the trust.

- It is important that the trust board supports the PFI concept, and that trade unions and medical staff are in agreement with the main aims of the PFI policy. The support of the main purchasers of healthcare is also essential. Time and resources invested in seeking the views of key stakeholders and trying to secure their agreement will allow the trust to provide a unified front to potential partners.

- Because PFI contracts bundle so many elements together – the provision of services and the purchase of an asset – the need for high-quality skills at negotiating complex transactions should not be under-estimated. While such skills can be bought in at a price, it is important that trusts also build up the skills of their own staff to oversee ongoing and future PFI procurements. Trusts often have many of the necessary skills in-house and free advice is available from organisations such as the 4Ps or departmental finance units.
Each side in a PFI agreement needs to understand the concerns of the other in order to identify common interests and to resolve problems together.

The authority or trust must be clear about its main requirements and also that PFI is a realistic option before engaging in discussions that will cost it and its private sector partner's time and money.

The trust should be a tough negotiator and seek to transfer as much risk as it can to the private sector; for example, the risk associated with time delays or costs coming in over budget. However, transferring risk can increase costs and in some cases it may be more cost-effective to retain certain risks. Risk is likely to be affordably transferred only if the receiving party has a reasonable influence over associated events or if it is a common business risk, such as general taxation rates.

At different stages in a typical PFI process major decisions will have to be made that commit the body to a course of action. These include:
- agreeing a clear business case;
- engaging and controlling external advisers;
- selecting the information to be issued to respondents to the formal advert;
- selecting a long-list from respondents;
- evaluating initial respondents and selecting a shortlist of bidders;
- selecting the information to be included in the invitation to tender that is sent to the short-listed bidders;
- selecting a preferred bidder from the short list;
- negotiating and agreeing a contract; and
- establishing contract management arrangements.

At each stage the trust needs to identify who should take key decisions and ensure that the legal powers needed are available.

A trust considering PFI must be able to demonstrate that it has taken all reasonable steps to satisfy itself that the scheme offers value for money. These should include implementing a well-conducted competitive process and establishing a reliable estimate of in-house provision against which to compare bids and assess overall affordability (including the costs of retaining the risks that would be transferred to the private sector under a PFI procurement). The trust should also ensure that the rate of return for the private sector partner is not excessive when compared to industry or economy norms.

Payment mechanisms for PFI contracts are usually linked to availability of service, performance against predetermined standards and, in some cases, usage or demand for the service. It is important to design a contract monitoring system that is simple enough to operate in a busy working environment, but which can ensure that significant financial penalties are imposed for sub-standard service.

The implications for staff and other stakeholders need to be clearly communicated.
Probity

Refer to:
Protecting the Public Purse 2: Ensuring Probity in the NHS (1994) 0118861468, £10
Protecting the Public Purse: Ensuring Probity in the NHS: Update (1996) 1862400091, £6
Protecting the Public Purse: Ensuring Probity in the NHS: Update (1998) 1862401306, £10

See also:
Opportunity Makes a Thief: An Analysis of Computer Abuse (1994) 0118861379, £8.50
Ghost in the Machine: An Analysis of IT Fraud and Abuse (1998) 1862400563, £15

Background

Protecting the Public Purse was in part produced in response to inquiries made by the Public Accounts Committee in 1993 into the question of probity in the NHS. It aimed to identify the most significant areas of risk and to make recommendations to board members, chief internal auditors, the police and policymakers on how they could improve probity in the NHS.

The initial study drew upon a survey of finance directors in every NHS body in England and Wales; interviews with managers and auditors in NHS trusts, health authorities and family health service authorities; a study of management letters to NHS bodies; and in-depth fieldwork at 17 NHS bodies across England and Wales. Follow-up surveys were carried out in 1996 and again in 1998 and the results were reported in two respective update reports.

Key findings

- The level of detected fraud rose from £750,000 in 1994/95 to over £2.5 million in 1997/98. Most of this detected fraud was identified in England. For example, in 1997/98, only £20,000 of fraud was detected in the NHS in Wales. The level of detected fraud remains small compared to the total annual NHS expenditure in England and Wales of £34 billion, and there are indications that the levels of actual fraud are much higher.

- Risks of fraud are particularly high in primary healthcare services, where almost 60,000 professionals are involved in submitting millions of claims each year and where the regulations governing reimbursement are complex and confusing. However, only 77 cases (76 cases in England and 1 case in Wales) were detected in 1997/98 for this type of fraud.

- Between the initial and most recent reports there were a number of positive developments:
  - most NHS bodies had put in place a corporate governance framework for preventing fraud;
  - a new NHS director of counter-fraud services was appointed;
  - health authorities started to implement the recommendations of two efficiency scrutiny committees; and
  - the Prescription Pricing Authority’s Investigation Unit set up an anti-fraud unit to combat prescription charge evasion and prescription fraud. However, in 1998, 9 per cent of health authorities and 12 per cent of trusts still did not have anti-fraud and corruption strategies in place.

Key recommendations

- Health authorities require robust systems for checking the accuracy of claims by opticians and GPs and for monitoring the level of fees claimed by different practitioners.
- NHS trusts need to concentrate their anti-fraud work on areas of greatest risk, such as contracts for goods and services, and payroll expenditure including locums and bank nurses.
- Audit committees of authorities and trusts should examine closely the quality of internal systems for identifying fraud and the ability of internal audit to successfully investigate any indications of fraud and corruption.
- Current procedures for monitoring dentists need to be developed to concentrate on fraud as well as clinical negligence.
Trust management

Refer to:
Trusting in the Future: Towards an Audit Agenda for NHS Providers (1994) 0118861042, £8.50

See also:
Taken on Board: Corporate Governance in the NHS: Developing the Role of Non-Executive Directors (1995) 0118864033, £6

Background

After the health service reforms of 1991 there was a steady increase in the number of NHS trusts. At the time of the report, trusts were providing 90 per cent of all hospital and community health services and, today, all such services are provided by trusts. Expenditure by trusts currently accounts for 72 per cent of the total NHS budget in England and 61 per cent of the total NHS budget in Wales.

Trust status brought new freedoms in the delivery of services and the use of resources. But new freedoms also brought new responsibilities. The Audit Commission produced Trusting in the Future to help trust boards and managers to meet these responsibilities. The key messages from this report are still relevant to trust boards and managers today. Trusting in the Future drew upon in-depth fieldwork in nine NHS trusts across England and Wales.

Key messages

- The trust board is responsible for setting long-term goals in an overall strategy. The strategy provides the framework for shorter-term business plans. It should contain:
  - a current analysis of the organisation and the environment in which it works;
  - an assessment of future demand;
  - a framework for the following year which sets broad targets for each business unit but does not specify how they are to be achieved; and
  - a framework for long-term development, covering any changes proposed in the core functions of the organisation, workload predictions and capacity intentions, and major capital investments or disposals.

- All strategies should be developed in consultation with staff.

- The trust board is responsible for ensuring that there is an effective system of accountability in place throughout the organisation, covering both performance and the conduct of individuals. As well as creating a framework of accountability, the trust board must ensure that it is implemented effectively through monitoring mechanisms such as:
  - quarterly or bi-annual performance reviews of business units;
  - individual performance appraisal;
  - complaints monitoring systems; and
  - internal audit.
• Trust boards are responsible for reviewing the performance of the organisation as a whole, ensuring, in particular, that it remains financially viable. Ideally this should involve:
  – an outsider's comparative view of structure and process, such as some form of accreditation or value-for-money audit carried out by external auditors;
  – qualitative assessment through observation, interviews and discussion with community health councils;
  – the use of comparative performance information;
  – the use of information on performance against targets;
  – the use of financial information; and
  – the views of service-users.
• Individual board members must be properly selected, inducted and supported. *Taken on Board: Corporate Governance in the NHS: Developing the Role of Non-executive Directors* (1995) provides some good practice guidance in this area and a summary is provided in this compendium.
• In a rapidly changing environment, trusts need to be able to manage change as well as continue to provide existing services reliably and efficiently.
• At the time of the report, changes high on the agenda of most trusts included introducing business units and clinical directorates, involving professionals in management, changing operational processes and redesigning jobs. *Trusting in the Future* provided guidance for introducing these changes effectively. Currently, the changes facing health trusts lie in responding to the Health Act 1999, which makes provision for the proposals set out in the White Papers, *The New NHS: Modern, Dependable* (1997) and *NHS Wales: Putting Patients First* (1998). Health trusts should incorporate necessary changes into their strategies and business plans, ensuring that there is clear accountability and a timetable for implementation.
• Clinical directors heading clinical directorates or business units should be properly supported in their management role by a suitable business manager and/or senior nurse manager, and have assistance from staff with management accounting and information skills.
• Managers need good information on activity, staffing and costs in order to deliver their business plan effectively. The study found that such information was often unavailable.
• Overall, productivity of clinical staff varied by up to 50 per cent between similar trusts. Productivity is maximised if staff are well informed about the organisation and clear about what is expected of them personally; if they are suitably trained and experienced to carry out the required tasks; and if they are given feedback on how well they have done. This was often not the case. For example, in an Audit Commission survey of 400 staff carried out as part of the study, 50 per cent of respondents disagreed with the statement, 'I am generally well informed about what's happening in the trust.'
• Processes underlying the delivery of services need to be regularly reviewed and improved. Changes should be based on users' needs, straddling organisational and professional boundaries where necessary. Good supporting evidence, including that obtained from clinical audit, is required to guide change effectively. Changes should be properly evaluated once they are implemented. The summaries contained in this compendium provide good practice guidance to assist with identifying areas where changes may result in improved service delivery.
IT and information management

IT security

Refer to:
Opportunity Makes a Thief: An Analysis of Computer Abuse (1994) 0118861379, £8.50
Ghost in the Machine: An Analysis of IT Fraud and Abuse (1998) 1862400563, £15

See also:
Protecting the Public Purse 2: Ensuring Probity in the NHS (1994) 0118861468, £10
Protecting the Public Purse: Ensuring Probity in the NHS: Update (1996) 1862400091, £6
Protecting the Public Purse: Ensuring Probity in the NHS: Update (1998) 1862401306, £10

Background

As organisations rely more heavily upon technology, the need to protect themselves from computer abuse increases. Yet few organisations do so effectively. Prompted by a continuing lack of authoritative information on the threat posed to public sector bodies by IT crime, the Audit Commission has undertaken regular surveys of IT fraud and abuse in the public and private sectors. Ghost in the Machine, the most recent report, drew upon survey information from 900 organisations in England and Wales, and Opportunity Makes A Thief drew upon survey information from 1,000 organisations in England and Wales.

Key findings

- Reported losses were approaching £4 million from just over 500 incidents.
- The percentage of organisations reporting incidents had risen from 12 to 36 per cent between 1990 and 1993 and by 1997 this figure had risen to 45 per cent. The increase was greater in the public sector than in the private sector so that, by 1997, one-half of all public sector organisations had reported incidents.
- Senior management often lacked a commitment to crack down on fraud and abuse. For example, the survey in 1997 found that only one-half of computer fraudsters were dismissed or prosecuted.
- Frauds or cases of abuse often occurred because of the absence of basic controls, with one-half of all detected frauds found by accident.
- Virus infections were the most prevalent form of abuse, despite the widespread safeguards available. The average cost to organisations of virus infection had risen from around £1,000 per incident in 1994 to £1,700 in 1997.
- The percentage of organisations reporting hacking incidents had trebled between 1993 and 1997. Increasingly, hacking is likely to become the means for further abuse and not just an end in itself. Hackers were as likely to be from within the organisation as from outside.
- All financial systems are at risk from fraud – payroll, debtors and creditors, stocks and claims systems have all suffered incidents. And in many cases in the organisations surveyed basic controls were lacking.
Organisations must make an explicit commitment to sound IT security.

- Only 19 per cent of organisations reported compliance with the British Standard for Information Security Management (BS7799).
- In *Opportunity Makes a Thief* (1994) the Audit Commission had urged management to exercise better control over procedures to prevent computer abuse. However, *Ghost in the Machine* (1998) found that nearly as many abuses were carried out by management as administrative staff. A system of controls based on management alone was therefore not likely to be effective.
- The Internet has developed rapidly over the last few years. Because it is not a controlled facility, there are increased risks of virus infection, data corruption, deletion or alteration and unauthorised access to networks and systems. In 1997, 95 per cent of respondents were using the Internet, but 15 per cent did not know what additional risks Internet activity presented and whether their systems were secure. It also provides opportunity for misuse by staff.

**Key recommendations**

- Organisations must make an explicit commitment to sound IT security. Centrally, there should be an up-to-date security policy and anti-fraud strategy. The British Standard for Information Security Management (BS7799) provides a suitable standard.
- There should be adequate security awareness training; line managers should have responsibilities for encouraging security; and security guidance should be readily available in a form that is easy to read.
- Basic controls should be in place. These should include:
  - effective processing procedures with input and transactions authorised; adequate and timely reconciliation procedures; clear management trails; and good control procedures for unusual items; and
  - effective controls on unauthorised access including effective anti-virus control, adequate password controls and activities traceable to individuals.
- Organisations should monitor attempts at password-guessing.
- Organisations should bar access to specific Internet sites; monitor terminal activity, keeping a log of Internet sites visited; tell staff of the unacceptability of downloading pornographic material from the Internet; and review 'after hours' activity in accessing the Internet.
- Staff should be aware of their responsibilities under the Data Protection Act 1984, and with regard to the use of unlicensed software.
- Audit and security reviews of all key systems should be undertaken regularly.
Information management in community-based services

Refer to:

See also:
For Your Information: A Study of Information Management Systems in the Acute Hospital (1995) 0118864165, £10

Background

Providing healthcare in the community has become increasingly important for the NHS. But it is a complex process, involving many different kinds of clients served by different care professionals who provide a wide range of services at different locations. Community-based health services also work alongside a range of other agencies such as general practices, acute hospitals and voluntary organisations, as well as local authority services such as social services, housing and education. In addition, many trusts have been moving from hierarchically managed professions to locally based multidisciplinary teams that are often integrated with general practices. Given these complexities, it is especially important that staff have access to accurate, comprehensive and timely information in order to care effectively for patients and to plan and monitor services.

Comparing Notes concentrates on the services that are provided by district nurses, health visitors and remedial therapy staff, which are common to nearly all community trusts. However, the principles also apply to many other community-based health services, such as those for patients with mental health problems or learning disabilities. The report is aimed particularly at those trust boards and health authorities that have to make decisions about whether, and how, to invest in information systems.

Comparing Notes drew upon information gathered from in-depth fieldwork at 12 community trusts, 2 health authorities and several GP fundholding practices across England and Wales.

Since Comparing Notes was published, the NHS Executive and the Welsh Office have produced information strategies. These are Information for Health: An Information Strategy for the Modern NHS 1998–2005: A National Strategy for Local Implementation (NHS Executive, 1998) and Better Information, Better Health: Information Management and Technology for Healthcare and Health Improvement in Wales: A Strategic Framework 1998–2005 (Welsh Office, 1998). Each sets out the Government's intention to invest in modernising the way that the NHS collects, stores and uses information. The strategies aim to ensure that health authorities, health trusts and primary care groups/local health groups have the best information services and systems. They envisage the use of electronically held records for everyone in the country, on-line access to patient records for all NHS clinicians, and seamless care for patients through GPs, hospitals and community services which all share information from the NHS information highway.

Furthermore, since the publication of Comparing Notes, the Department of Health and the Welsh Office have also issued guidance requiring NHS trusts and health authorities to establish a strategy for managing
Health trusts should review how data is collected in order to eliminate unnecessary duplication.

Key findings

- Much data was collected with little thought as to how it would be used.
- Each profession, and sometimes each professional, tended to keep their own notes. Data such as patient and GP details, social circumstances, diagnosis, care to date and a history of treatment was often collected and recorded more than once. And, in many cases, health professionals did not know which other professionals were working with a client.
- Even within professions, most information was collected on forms designed for a single function and this information was not, therefore, integrated with information collected for other purposes; this resulted in duplication and inefficient use of staff time.
- Data from external sources, such as GPs or hospitals, was often unreliable and/or difficult to obtain. This led to clinical staff wasting time chasing missing data and the risk that important clinical decisions were based on incomplete data.
- Few computer-based information systems were useful in supporting patient care. Many systems were out-dated and badly designed. For example, they did not provide a summary of information held on individual patients and did not allow clinical staff to use the data to produce information that would allow them to review or improve the care that they provided.

Key recommendations

Health trusts providing community-based services should:

- define what kind of information should be collected and who should collect it;
- review how data is collected in order to eliminate unnecessary duplication; for example, by improving the design of a small number of critical forms or considering the use of hand-held devices for collecting information in electronic form;
- promote data-sharing through multidisciplinary, patient-held and shared records;
- establish standards for transferring data to other agencies and make staff aware of policies and procedures for protecting the confidentiality of patient data;
- invest in information systems and training to enable staff to generate useful management information from data that is collected;
- involve clinicians and other information-users in developing information systems to ensure that they work in practice; and
- ensure that senior management is committed to information projects.
Information management in the acute hospital

**Refer to:**
For Your Information: A Study of Information Management Systems in the Acute Hospital (1995) 0118864165, £10
See also:
Comparing Notes: A Study of Information Management in Community Trusts (1997); 1862400490, £20
Setting the Records Straight: A Study of Hospital Medical Records (1995) 0118864122, £10

**Background**

Good information management is vital to a hospital. The primary purpose of information is to support clinical decisions, of which most are based upon information that has been collected on previous occasions; for example, the results of clinical tests, reports from other professionals and other medical history. Modern healthcare also requires the collaboration of many different professionals in the care of a single patient so that each professional, both inside and outside the hospital, requires access to the same basic information about the patient. The effective management of information will also support the monitoring of professional performance, clinical research and effective hospital management. An average acute hospital spends about 15 per cent of its resources on gathering information, which includes the 25 per cent of doctors’ and nurses’ time that is spent collecting and using information.

*For Your Information* examined how hospitals could improve the management of information. It drew upon information gathered from in-depth fieldwork at seven hospital trusts and from visits to a further eleven hospital trusts, five health authorities and ten GP practices across England and Wales.

Since *For Your Information* was published, the NHS Executive and the Welsh Office have produced information strategies. These are Information for Health: An Information Strategy for the Modern NHS 1998-2005: A National Strategy for Local Implementation (NHS Executive, 1998) and Better Information, Better Health: Information Management and Technology for Healthcare and Health Improvement in Wales: A Strategic Framework 1998–2005 (Welsh Office, 1998). Each sets out the Government's intention to invest in modernising the way that the NHS collects, stores and uses information. The strategies aim to ensure that health authorities, health trusts and primary care groups have the best information services and systems. They envisage the use of electronically held records for everyone in the country, on-line access to patient records for all NHS clinicians, and seamless care for patients through GPs, hospitals and community services which all share information from the NHS information highway.

Furthermore, since the publication of *For Your Information*, the Department of Health and the Welsh Office have issued guidance requiring NHS trusts and health authorities to establish a strategy for managing records and to put in post a senior manager with responsibility for managing its implementation. The guidance places specific emphasis on the confidentiality and security of patient information following the Caldicott Committee Report on the Review of Patient-identifiable Information.
Key findings

- Although clinical staff were required to collect data, they often made little or no use of it. If they found the data of little use, clinical staff were also unlikely to have put much effort into ensuring the accuracy, completeness or timeliness of the data that they collected.
- Forty per cent of the medical staff interviewed made little or no use of information that was reliant on coded clinical data, because they did not trust the data and felt that it lacked necessary detail. There was some justification for this lack of trust. For example, in the majority of hospitals studied, more than 5 per cent of clinical codes used were invalid.
- Information systems were often poorly designed, generally reflecting the lack of a coherent approach and poor user-involvement in the design of systems.
- Many information systems were out of date, inflexible, expensive to support and difficult to train staff to use effectively.
- The majority of information systems encountered during the study did not communicate with one another, so that data had to be entered more than once. In one hospital, there were more than 40 separate audit systems, not one of which shared links with other systems.
- Those responsible for purchasing information systems did not know enough about the technology that they were buying, resulting in systems that were led by the technology rather than the needs of the users.

Key recommendations

- Trust boards need to educate themselves about information issues in general, as well as the key information issues at their hospital, and ensure that information managers are represented at board level.
- Hospitals should develop their information technology plans into a strategy and link systems by developing corporate standards.
- Systems that are easy to use and that concentrate on supporting patient care should be developed. These should allow data to be sorted for individual patients and should enable users, where possible, to generate their own information from the data.
- Clinicians should take the lead responsibility for clinical data and coding.
- The procurement of information systems should be based on an adequate understanding of the technology available and should be driven by a specification of the functions that the system is to serve. The specification should draw fully on the views of those who will use the system. And the procurement process should be flexible enough to encourage productive collaboration between the trust and system suppliers in meeting these needs.
- Senior management needs to be involved in the procurement and implementation of information systems, and should be kept informed of progress.
- Hospitals should make sure that they have adequate specialist staff, and that all staff are properly trained to make full use of all available information.
Medical records in hospitals

Refer to:

Setting the Records Straight: A Study of Hospital Medical Records (1995) 0118864122, £10

Background

Good medical records are essential for the effective care of patients. They provide a record of symptoms and treatment; provide a communications channel between different professionals in the hospital and the community; are used for research and clinical audit; provide management information; and may also provide evidence in the case of litigation.

The Audit Commission estimated that, in 1992/93, the staff costs associated with keeping hospital medical records were over £300 million. Despite this considerable expenditure, however, the Health Service Commissioner reported that there were ‘inadequacies in clinical as well as nursing records’ and that, all too often, ‘the quality of care [was] damaged by failures to pass on or record important information’.

Setting the Records Straight was concerned with the use of case-notes in hospitals and drew on information gathered from in-depth fieldwork at 20 hospitals and from short visits to a further 20 hospitals.

Since Setting the Records Straight was published, the NHS Executive and the Welsh Office have produced information strategies. These are Information for Health: An Information Strategy for the Modern NHS 1998–2005: A National Strategy for Local Implementation (NHS Executive, 1998) and Better Information, Better Health:

Information Management and Technology for Healthcare and Health Improvement in Wales: A Strategic Framework 1998–2005 (Welsh Office, 1998). Each sets out the Government’s intention to invest in modernising the way that the NHS collects, stores and uses information. The strategies aim to ensure that health authorities, health trusts and primary care groups/local health groups have the best information services and systems. They envisage the use of electronically held records for everyone in the country, online access to patient records for all NHS clinicians, and seamless care for patients through GPs, hospitals and community services which all share information from the NHS information highway.

Furthermore, since the publication of Setting the Records Straight, the Department of Health and the Welsh Office have issued guidance requiring NHS trusts and health authorities to establish a strategy for managing records and to put in post a senior manager with responsibility for managing its implementation. The guidance places specific emphasis on the confidentiality and security of patient information following the Caldicott Committee Report on the Review of Patient-identifiable Information.

Key findings

- Only half of 200 sets of case-notes reviewed by the study team had an index and a clear structure, but these are essential if doctors are to access information quickly.
- Twelve out of 16 hospitals visited had multiple case-notes for individuals, compromising patient care and leaving the hospital open to negligence claims.
- On average, only 40 per cent of coding of case-notes was completed within four weeks of discharge.
Wherever possible, doctors and managers should discourage the use of more than one set of case-notes.

**Key recommendations**

- In a survey of 12 hospitals, case-notes that were not on the library shelves took five times as long to find, sometimes requiring all the library staff to do a search of the hospital.
- Hospitals with libraries where anyone could take records out were more likely to have higher percentages of case-notes unaccounted for.
- Medical records managers were limited in their ability to manage medical records effectively because they had no authority over those staff who are authorised to use the records.

- Hospitals should establish a ‘case-note architecture’, which sets out the optimal content and order of case-notes, and clear guidelines and standards for staff.
- Case-notes can be made easier to use by removing less essential material. This will also make them easier to store.
- Wherever possible, doctors and managers should discourage the use of more than one set of case-notes.
- Hospitals should review their management arrangements for coding to ensure that it is carried out quickly and accurately. Doctors should take responsibility for producing clear statements of diagnoses and procedures and should participate in validating the coding process.
- The library should be ‘closed’ to all but records staff, who should be appropriately trained, and there should be robust arrangements for tracking records when they are not in the library. The extra staff time required for this is unlikely to be greater than the time currently spent chasing lost notes.

- Hospitals should have a clear policy for retaining, archiving and destroying case-notes.
- Medical records officers should be given greater authority over the use and management of case-notes.
- Hospitals should explore the potential of adopting patient-held records or electronic patient records.
Staff management

Hospital nursing

Refer to:

The Virtue of Patients: Making Best Use of Ward Nursing Resources (1991) 0118860682, £9.50 (out of print)

See also:

Finders, Keepers: The Management of Staff Turnover in NHS Trusts (1997) 1862400148, £10

Background

Nursing staff costs are by far the largest item in hospital trust budgets, and nurses also have effective control over many other areas of hospital expenditure. At the time of the study, acute hospital nursing faced a period of significant challenge, with reforms of the NHS and an older and frailer inpatient population that required more highly skilled nurses. But the decline in school-leaver numbers, coupled with an increase in young women’s career expectations, posed – and continues to pose – problems for recruitment and retention. As a result of these pressures, nursing skills had to be deployed and managed as effectively as possible and The Virtue of Patients, and two accompanying handbooks for ward sisters and managers, aimed to support trusts in achieving this objective.

The Virtue of Patients, and the accompanying handbooks, drew on information gathered from in-depth fieldwork at 39 general medical and surgical wards in 10 NHS hospitals chosen from across England and Wales. These were selected to provide a cross-section of sizes, management structures and approaches to promoting quality of care.

Key findings

• While patients invariably said that nurses were wonderful, the findings suggested that many patients wanted more information and a greater say in what happened to them in hospital. The study found, for example, that the majority of patients would prefer not to be woken so early, yet this was common practice on many wards.
• Patients often did not know which nurse, or group of nurses, was looking after them.
• Many hospitals did not pay enough attention to assessing the quality of nursing. And, in some hospitals, the effort put into improving quality was being wasted because frameworks for quality assurance were lacking and standards were not being systematically monitored.
• The length and use of afternoon shift overlaps varied from three-quarters of an hour to as much as four hours.
• Many nurses spent over one-quarter of their time on clerical and housekeeping tasks.
Some wards have successfully used a method of allocating patients to nurses in order to improve continuity of care.

Key recommendations

- More attention should be paid to identifying patients' views and nursing care should be tailored more to the needs of individual patients by eliminating unnecessary ward routines that exist solely for the convenience of staff.
- Continuity of care can be improved by better rostering and more stable ward staffing. Some wards have successfully used a method of allocating patients to nurses in order to improve continuity of care.
- Delivering better patient care requires improvements in quality assessment and assurance. This should involve seeking staff and user views, the audit of care processes and the use of quality of care indicators such as the number of medication errors or the incidence and rate of change in the size or severity of pressure sores.
- Savings could be achieved by reducing the length of overlap between morning and afternoon shifts to around one hour.
- Trusts should reduce the amount of time that nurses spend on clerical and housekeeping duties by delegating these tasks to trained support workers wherever possible.
- Ward establishments should be reviewed annually in consultation with the ward sister, taking into account the current and prospective workload and the management responsibilities of ward staff. More frequent reviews may be justified if workload varies significantly from that which has been planned for. A zero-based review of establishments should be carried out periodically.
- Workload assessment should be used to review the numbers and mix of staff on duty in order to improve the match of staff to workload. Flexible rostering agreements can be used to better match staffing to workload and to reduce the excessive employment of temporary staff. These arrangements are common in private hospitals and in the USA. Nurses specify which shifts they would be prepared to work and when they would like additional time off and are contacted by telephone to change shifts if workload is unexpectedly high or low.
- Investment needs to be made in post-registration education, and individual performance reviews should be used to identify professional and managerial needs systematically.
Locum doctors

Refer to:
Cover Story: The Use of Locum Doctors in NHS Trusts (1999) 1862401500, £20
See also:
Finders, Keepers: The Management of Staff Turnover in NHS Trusts (1997) 1862401500, £20

Background

Locum doctors provide continuity of service when posts are vacant or permanent staff are absent. On an average day, 3,500 locums are employed in England and Wales at an annual cost of £214 million (1996/97).

In 1997, the NHS Executive and Welsh Office produced the Code of Practice in the Appointment and Employment of HCHS Locums in response to concerns about the quality of care being provided by locum doctors. Appointing and reviewing the performance of locum doctors were often considered to be weak; locums often worked in unfamiliar surroundings without adequate support or supervision; and locums who had not held permanent jobs for a while were likely to find it difficult to keep their skills up to date.

Cover Story aimed to examine current practices in the employment of locum doctors and to provide practical guidance to trusts on how to improve their use and management of locums. The study drew upon information gathered from in-depth fieldwork at 15 health trusts across England and Wales, interviews with experts in the field, secondary data analysis, and surveys of 405 directors of personnel and 400 locum doctors across England and Wales.

Key findings

- There was little evidence either to confirm or disprove the widely held view that locum doctors are of lower quality than permanent staff. However, locums tended to work under less than ideal circumstances and those without permanent positions may have found it difficult to keep their skills up to date. It was important, therefore, that trusts' own controls on the quality of care provided by locums were robust.
- Many of the competence checks that should have been undertaken on appointment were often not carried out, and trusts placed considerable reliance on the agencies that supplied them.
- Despite the requirement of the Code of Practice in the Appointment and Employment of HCHS Locums (NHSE/Welsh Office, 1997) that trusts should have introduced arrangements for performance review of locum doctors by December 1997, only 36 per cent of directors of personnel in the health trusts surveyed in June 1998 reported that this had been done.
- Many trusts used locums unnecessarily to cover planned leave where this could be covered internally.
- There was wide variation in the amount spent on locums by similar trusts, even allowing for location and type of trust.
- A wide variation in the hourly rates charged by agencies for locum doctors suggested that there was scope for some trusts to negotiate better deals. Six of the fifteen trusts visited were not using the NHS Supplies national contract for medical locums and had not sought competitive tenders for medical locum agency services.
- Controls over payments to agencies were often applied inconsistently, exposing many trusts to the risk of error or fraud.

Key recommendations

- Trusts should appoint a senior doctor or associate medical director to take managerial responsibility for ensuring the quality of locums employed.
- Trusts should have adequate induction programmes for locum doctors and provide a reasonable level of oversight. Locums should work unsupervised only where they have been deemed competent to do so by an appropriate consultant.
- A comprehensive performance review system for locums is essential to ensure that any problems in clinical competence are addressed at an early stage.
- Trusts should minimise the use of locums through effective workforce planning. For example, they should:
  - provide internal cover where possible for planned leave;
  - facilitate cross-cover between complementary specialties;
  - introduce flexible working arrangements to attract and retain permanent staff;
  - ensure effective recruitment procedures to fill vacancies quickly; and
  - ensure effective teamworking to guard against doctors undertaking inappropriate duties.
- Trusts should ensure that they are achieving value for money from medical locum agency services by employing recognised good practice in the procurement of services. They should ensure that they have properly specified contracts with agencies and use a smaller number of agencies.
- Trusts should be aware of the NHS Supplies standard contract for medical locums.
- Internal audit should undertake sample checks on payments for locums.
Medical staffing

Refer to:
The Doctor's Tale Continued: The Audits of Hospital Medical Staffing (1996) 0118864327, £10

Background

Hospital doctors are central to the delivery of high-quality patient care. They are the most important determinants of what hospitals do and consequently their use of resources. Doctors are also a significant resource in their own right. In 1993/94 they accounted for £2,000 million of NHS expenditure and in 1996/97 for £2,700 million. This is the equivalent of about 14 per cent of an acute hospital's budget.

The working practices of hospital doctors in the UK need to adapt to a range of changes. These changes include:

- advances in medical technology;
- increased patient expectations;
- a more structured approach to medical training, with a reduction in the time that it takes to train as a specialist; and
- government policies that aim to:
  - increase the number of doctors;
  - increase the share of patient care provided by fully trained specialists; and
  - reduce the long hours worked by many junior doctors.

The Doctor's Tale focused on issues in three main areas: the skill mix and deployment of medical staff; the contribution of consultants to the work of a hospital; and the organisation and management of medical training. The study drew upon data and information from 26 hospitals across England and Wales, including a survey of 1,100 individual doctors who worked at these hospitals. The Doctor's Tale Continued reported on the findings from local audits that followed the original report.

Since the reports were published, a number of changes have taken place:

- consultant numbers have continued to increase, enabling more sessions to be covered by specialists rather than doctors in training;
- the organisation and delivery of training for doctors has improved. Structured programmes, including part-time training, have been introduced for doctors undergoing specialist training and the Royal Colleges have introduced similar training programmes for their senior house officers;
- progress on reducing junior doctors' hours has continued, such that the majority of posts now comply with the UK target of a maximum 56 hours per week. The NHS faces a new challenge to reduce hours to the EC working time directive's maximum of 48 hours a week; and
- a new duty of clinical governance will lead to greater participation of doctors in national clinical audit. Trusts will also be required to have programmes for the continuing professional development of doctors that they employ.

Key findings

- The Audit Commission concluded that hospital doctors' working arrangements had not adapted quickly enough to the rapidly changing environment in which they worked. The traditional view of service issues as the province of managers, with patient care and medical training the province of doctors, was no longer considered to be tenable.
- Workload was poorly matched to staff availability. The number of doctors on duty tended to be based on custom and practice and was poorly related to the demands of patient care or medical training.
- The workloads of individual consultants and junior doctors still depended heavily on the level of personal referrals to individual consultants, rather than on the needs of the specialty as a whole.
- Many women, and increasingly men, faced personal and family commitments that made it difficult for them to pursue a medical career under existing employment conditions. Forty per cent of women respondents to the Audit Commission's own survey, and nearly one-third of men in another major survey, cited onerous on-call duties as being the most important constraint on their careers. Training structures were also inflexible, with a shortage of part-time training opportunities.
- The wide variation in the operating and outpatient workloads of consultants could not be explained by the complexity of cases and emergency workloads.
- The number of fixed sessions in consultants' job plans is the key factor influencing their output. Through consultants' job plans, trusts are able to reconcile competing demands, set priorities and ensure sufficient contracted activity and theatre and clinic capacity to support each consultant post.
But trusts often made poor use of job plans. Twenty-five per cent of consultants did not have them and, even where they did, four out of ten job plans had not been recently reviewed. There was a twofold variation in the average number of fixed sessions per consultant for similar-sized departments with similar ranges of work.

- Continuing professional development was not always available or taken up. And the quality of continuing professional education and development was often not monitored.
- Many junior doctors felt unsupported in their work and felt that the facilities offered to them were poor.
- There was significant variation between hospitals in the tasks carried out by junior doctors, nurses and other professionals. Over 40 per cent of junior doctors did not have job descriptions of any sort.
- The amount of supervision that junior doctors receive varied and different standards were applied to operations during the day and out of hours. Some junior doctors were being expected to perform beyond their level of training or were being used only for procedures with which they were already familiar, and so were therefore not extending their competence.
- Guidelines for training laid down by the General Medical Council and the Royal Colleges were often poorly implemented. Many doctors did not receive induction training, especially at specialty level. Only 54 per cent of junior doctors at the study sites had an educational supervisor and, of these, one-third lacked individual training programmes and fewer than half discussed their progress with their supervisors.

**Recommendations**

Hospital trusts should:

- develop medical staffing plans in collaboration with purchasers of clinical services and medical education and training, as an integral part of business planning;
- ensure that all consultants have job plans (or similar documents) that specify all their duties and responsibilities. There should be explicit rules for setting the number of fixed commitments, which are common to all consultants working in a specialty or trust, and explicit reasons should be given where these comprise less than 70 per cent of total contracted time. Trusts should monitor compliance with job plans, which should be reviewed annually and linked to service and training priorities;
- develop policies for the continuing professional development of career-grade doctors as part of their training strategies, reflecting non-medical as well as medical training needs;
- provide all junior doctors with job descriptions that set out all the service and training components of their work;
- have a scheme of delegation and supervision as part of their risk management and training strategies in order to achieve a better match of staff capabilities with work demands. Junior doctors should have explicit guidance about the levels of supervision that they should receive and about when they should seek advice. Consultants should be made aware of their supervisory responsibilities;
- ensure that junior doctors have access to a consultant at all times and in all settings. One consultant from each specialty should be designated at any given time to be available for junior doctors to contact and should be empowered to take decisions about the treatment and care of patients under other consultants where necessary. For this to happen, consultants need to work together as a team and to come to an agreement on clinical approaches: and
- develop policies that offer more support to doctors with family commitments. The majority of students entering medical school are now women and meeting the needs of staff with family commitments will be vital to effective workforce planning.
Staff turnover

Refer to:
Finders, Keepers: The Management of Staff Turnover in NHS Trusts (1997) 1862400148, £10
See also:
Trusting in the Future: Towards an Audit Agenda for NHS Providers (1994) 0118861042, £5

Background
Hospital and other healthcare trusts took over responsibility for employing staff in 1990. At the time of the Audit Commission’s study, high staff turnover rates were resulting in poor continuity of staff and high recruitment and training costs. The costs of high turnover can be substantial: it can cost over £5,000 to recruit a member of staff, with significant further costs for induction training and initial lower productivity once the recruit is in post.

Finders, Keepers examined how trusts could influence the level of staff turnover and drew upon information gathered from in-depth fieldwork in 16 NHS trusts across England and Wales.

Key findings
- High staff turnover was a growing and increasingly expensive problem for healthcare trusts.
- Rates of staff turnover varied considerably between different trusts, and also within and between different specialisms. For example, annual staff turnover for clerical staff varied from between 4 and 30 per cent, and turnover for physiotherapy staff varied from between 8 and 76 per cent.
- More than half the variation in turnover rates could be explained by differences in how trusts manage their staffing and plan for likely skill shortages.
- Most people left their jobs because they were dissatisfied with them, not because of the range of alternative jobs on offer – poor promotion prospects and insufficient job satisfaction were the commonest reasons.

Key recommendations
Health trusts should:
- develop an understanding of the local and national labour markets, and the reasons for high staff turnover by:
  - monitoring key indicators such as turnover rates, vacancy levels and recruitment delays;
  - tracking developments in local labour markets and in wider labour markets for specific skills; and
  - understanding the attitudes and aspirations of staff;
- design services to make the best use of the skills likely to be available by:
  - drawing on good practice from elsewhere;
  - reviewing staff structures and redesigning jobs; and
  - buying in services which depend on scarce skills where appropriate
- set coherent policy frameworks and develop action plans that include:
  - developing reward systems that make staff feel valued;
  - providing opportunities for flexible working;
  - improving recruitment processes;
  - working with local education and training consortia to ensure that future staff needs can be met;
  - providing training opportunities for existing staff; and
  - communicating effectively with all staff.
Support services

Energy use

Refer to:
Saving Energy in the NHS (1991) 0118860496, £5

Background
The NHS is one of the largest energy users in the UK, with expenditure on energy representing almost 2 per cent of total national energy usage. Saving Energy in the NHS examined how NHS bodies could more effectively manage their use of energy and drew on information gathered from over 450 hospitals across England and Wales.

Key findings
- Between 1981 and 1991 the NHS saved £379 million in energy costs. However, these savings reflected lower fuel prices rather than efficiency savings. In fact, using a measure that allows for mild or severe winters, consumption of electricity had actually increased.
- Measurement of energy consumption in hospitals in England and Wales using a normalised performance indicator developed by the Audit Commission demonstrated a wide range of performance between similar hospitals in terms of their energy consumption per patient. Some larger acute hospitals, for example, used almost three times as much energy as others.
- Inadequate attention was given to energy management. For example, responsibility for energy use was often not clearly defined; there was often poor consideration of investment options; and there was often a lack of relevant technical expertise in hospitals.
- Energy efficiency was not given proper consideration in the design of new hospitals, and energy-saving measures (for example, lagging, time controls, or heat recovery systems) were not being installed in older hospitals where it would be cost effective to do so.
- The quality of management information was generally poor and often there were no management reports on energy use. Budget arrangements often gave no incentive to realise savings.

Key recommendations

Health trusts should:
- raise awareness of the need for energy efficiency. This requires the commitment of senior management and should lead to an energy policy statement and an annual energy management report setting out progress on the introduction of energy efficiency measures and savings achieved;
- make better use of available technology such as energy management systems; and
- give managers real incentives to reduce energy consumption. These should be underpinned by introducing systems that set realistic targets for reductions, provide accurate information on energy use, and base budgets on consumption.

The NHS Executive and NHS Directorate for Wales should:
- provide incentives to local NHS services to conserve energy.
Estate management

Refer to:
0118860518, £5

Background

In 1991, the NHS in England occupied around 1,700 hospitals as well as many other buildings such as day hospitals, clinics and health centres, staff accommodation, ambulance stations and offices. In 1990, the value of this estate was assessed as £24 billion for capital charging purposes. In Wales, in 1991, the estate included about 180 hospitals and, at December 1989, its 'existing use' value was about £700 million. These capital assets incur substantial running costs: maintenance, cleaning, rent and rates, and energy costs together amounted to more than £1 billion in 1989/90 when the report was published.

Property requirements are not fixed. The practice of healthcare alters over time and makes new demands on the size and type of hospitals and support buildings. For example, institutions for people with mental handicaps and those who are mentally ill are closing, and in the acute sector, shorter stays in hospital and the growth of day surgery are affecting how hospital space is used.

NHS Estate Management and Property Maintenance considers the value-for-money aspects of estate management and property maintenance. It drew upon information gathered from in-depth fieldwork at six health authorities, shorter visits to four health authorities and data gathered from a further four health authorities across England and Wales.

Key findings

- At least 10 per cent of the estate was identified as surplus to needs and some buildings were used inefficiently. Local studies suggested that about £300 million per annum could eventually be saved if the estate were thoroughly reviewed and matched to changing needs.
- In 1991, the backlog of maintenance and repairs to NHS property was estimated at £2.1 billion.
- Management staff were often found to lack the necessary skills to manage a property portfolio effectively.
- Maintenance unit costs were rarely known, and contractors were often not selected on the basis of cost and performance.
- In some trusts, the volumes of planned preventative maintenance were higher than was necessary for reasons of safety or efficiency.
- Sickness levels and unproductive time of maintenance staff were often disproportionately high.

Key recommendations

Health trusts and commissioning bodies should:

- develop plans that identify the maintenance backlog for individual buildings and their patterns of use;
- develop strategies to maximise the use of buildings and dispose of those not needed, in co-operation with other providers;
- review their property to identify sources of funds that could be used for maintenance to reduce any backlog of maintenance and repairs;
- establish separate client and contractor roles for maintenance;
- use competitive tendering to let schedule of rates contracts for buildings maintenance;
- review the use of planned preventative maintenance programmes to see if they can be reduced without compromising standards;
- calculate and review unit maintenance costs to identify where efficiency savings can be made; for example, by examining payroll costs of operatives, supervision and management levels, proportion of operatives' time spent directly on maintenance tasks, and operatives' rate of work on tasks; and
- monitor sickness levels of maintenance staff and take action when target levels are exceeded.
Hospital waste

Refer to:

Background

An average acute hospital of 500 beds produces over 10 tonnes of waste a week. About half of it is 'household' waste such as paper, bottles, cans and kitchen scraps. In 1997, disposing of this cost about £20–£70 per tonne. The remainder is 'clinical' waste, which includes blood bags and human tissue. In 1997, this cost between £180–£320 per tonne to dispose of. It is more expensive to dispose of than household waste because it is hazardous, and because there are tighter regulations governing its disposal. In total, waste disposal in 1995/96 cost the NHS over £30 million.

The NHS and Community Care Act 1990 abolished Crown Immunity, and with it protection for hospitals from prosecution under environmental regulations. The Environmental Protection Act 1990 introduced new, and tighter, regulations on incineration of clinical and other hazardous waste. As a result, many hospitals had to close their existing incinerators and make alternative arrangements. Then, in 1995, the Department of the Environment and Welsh Office jointly published a White Paper, Making Waste Work: A Strategy for Sustainable Waste Management in England and Wales and this provided a new framework for waste management that aimed to reduce levels of waste and increase recycling.

Getting Sorted aimed to assist trusts in meeting these challenges and drew upon information from in-depth fieldwork at 13 hospital trusts and information collected from visits to a further 16 trusts across England and Wales.

Key findings

• There was almost a threefold variation in hospitals in the cost per bed per year for contracting out the removal of waste.
• The costs of disposing of clinical waste through specialist contractors varied from between £180 and £320 per tonne.
• Material costs for items such as bags and labels varied significantly between trusts, often because of different bulk purchasing arrangements.
• Nearly two-thirds of both clinical and household waste was generated by wards.
• Trusts need to do more to improve their methods of handling and moving waste to minimise the danger to those who move it and to those who work in, or visit, the hospital. For example, porters handling clinical waste were provided with protective clothing, including gloves, at 11 out of 13 hospitals visited. However, they were observed wearing them at only four of the hospitals.
• There was almost a fourfold variation in the level of clinical waste generated by hospitals. Evidence suggests that this was because staff in some hospitals were unaware of the higher cost of disposing of clinical waste and often did not have access to the different bags needed to segregate different types of waste. The study estimated that better segregation of waste could save up to £10 million annually.

Key recommendations

Hospital trusts should:
• have a clear and well-publicised waste management policy in which responsibilities and lines of accountability are clearly set out, with all parts of a hospital playing their part to make the policy work;
• translate the waste management policy into protocols for those who have to operate it in practice;
• ensure that, where the disposal of waste is contracted out, they carry out an adequate analysis of the options available locally, taking into account levels of risk;
• consider reducing packaging, replacing disposable with re-usable equipment and recycling where possible;
• ensure that bags of waste are placed in locked wheeled bins to avoid repeat handling. They should also ensure that porters wear the protective clothing provided; and
• ensure that appropriate bins and bags are conveniently positioned close to wards and other sources of clinical waste to allow staff to segregate their waste accurately.
Sterile services

Refer to:
Value for Money in NHS Sterile Services (1991)
0118860488, £5 (out of print)

Background

Much of the equipment used by hospitals needs to be sterilised – for example, equipment used in surgical procedures or materials used in microbiology laboratories. Some of this equipment (syringes and needles, for example) is disposable, but some of it (surgical instruments, for example) needs to be re-sterilised each time it is used. In 1989/90, the NHS spent around £200 million a year on these services, about half of it on buying or making disposal single-use items, and the remainder on sterilising re-usable equipment.

At the time of the report, sterile services were facing a number of challenges. These included the need to achieve 'good manufacturing practice' standards to demonstrate quality for product liability assurance, and the need for cost-effective service provision in the decentralised management structure envisaged by the NHS reforms of the time.

Value for Money in NHS Sterile Services was a joint exercise with the Department of Health and drew upon information from local audits in nearly 100 district health authorities. More detailed financial information was gathered from 35 early audits across England and Wales. The report also drew upon information gathered from audits in Northern Ireland and Germany to identify good practice for implementation in England and Wales.

Key findings

- Hardly any NHS facilities met the 'good manufacturing practice' standards guidelines applied to commercially sourced products, as set out in the Guide to Good Manufacturing Practice for National Health Service Sterile Service Departments, published by the Institute of Sterile Services Management in 1989. These standards have now been superseded by Quality Standards and Recommended Practices, also produced by the Institute of Sterile Services Management. These reflect the requirements of the EC Medical Devices Directive 93/42.
- Most NHS users of sterile products had no information on the cost of the sterile products that they used. However, where managers priced individual items or reported monthly costs to users this had, in the view of managers, led to reduced wastage.
- Almost 50 per cent of single-use packs were manufactured internally rather than sourced from a commercial supplier. But unit costs were on average 25 per cent higher than commercial packs and 55 per cent higher when overheads and capital charges were taken into account.
- Informal contacts between sterile service department managers and users were rarely sufficient to ensure that users' changing needs were identified.
- On average, stocks could be reduced by 40 per cent without affecting service levels.

Key recommendations

For health trusts

- A business plan should be developed which sets out how in-house sterile services are to meet the quality standards and how recommended practices should be applied to commercially sourced products, and the investment necessary. The plan should explore the options of supplying other users and also of using other suppliers.
- Sterile services and sterile packs should be priced to make users aware of the full cost of production.
- A suitably trained sterile services manager should be responsible for managing all sterile products within a dedicated budget.
- Trusts should phase out in-house single-use pack production in favour of a limited range of commercially available supplied packs.
- User groups should be established to review the need for sterile products and services in the context of full costs.
- Trusts should aim to reduce total stock to less than a month's supply.
- Where possible, surplus surgical instruments should be re-allocated or disposed of, to achieve cash-flow benefits.
Supplies management

Refer to:
Goods for Your Health: Improving Supplies Management in the NHS (1996) 1862400024, £15

Background
High quality and assured availability of equipment and materials are important to effective patient care. Moreover, substantial amounts of money are involved. In 1994/95, the NHS spent £4.4 billion on supplies (approximately £2.5 billion on the areas that are the focus of this report). A typical trust spends between one-fifth and one-quarter of its annual revenue expenditure on supplies.

Goods for Your Health focused primarily on the procurement and management of clinical supplies, office supplies and other facilities expenditure, although most of the recommendations will be relevant to the whole range of supplies management. The report drew upon information from in-depth fieldwork at 15 NHS trusts, as well as other organisations in the public and private sectors across England and Wales.

Key findings
• There was significant variation in total supplies expenditure, with some hospitals spending 50 per cent more than others to treat a similar mix of patients.
• Trusts' arrangements for selecting products were weak, with inadequate standardisation and aggregation of demand.
• On average, the administrative cost for a typical trust to place an order for an item delivered directly from a supplier was about £30. The cost of about 24 per cent of purchases by trusts fell below this level, so that the cost of the process outweighed the cost of the product.
• There was significant variation in the prices that trusts, and indeed different parts of the same trust, were paying for identical items.
• An average trust was found to hold £600,000 worth of stock. Large stock holdings are undesirable, since stock can often become obsolete and is expensive to store.
• There was significant variation in the use of consumables, both between and within trusts treating a similar case-mix of patients.
• There was a lack of involvement in supplies management at board level, with few trusts addressing the issues strategically.

Key recommendations
For health trusts
• Ensuring effective competition between suppliers, aggregating demand across the trust, using longer-term contracts and providing year-end flexibility can reduce the cost of goods and the procurement process.
• Trusts should work in partnership with external suppliers to eliminate process costs to the mutual advantage of both parties.
• Trusts require adequate stock management information. In some trusts, this will require an investment in materials management systems.
• Users should be involved in selecting the products to buy, although the approach taken should guard against a trust holding a wider than necessary range of the same item.

For commissioning bodies
• Boards should support the supplies process by ensuring that their trusts have a clear strategy and that a system of accountability is established.
The NHS spent £52 million on water and effluent charges in 1992/93, and by 1996/97 this figure had increased to £60 million.

**Background**

The NHS had spent £52 million on water and effluent charges in 1992/93, and by 1996/97 this figure had increased to £60 million. Excluding hospital laundry use, more than half of the water is used for flushing toilets and for washing. The cost of water in England and Wales is not high in comparison with other industrialised countries, but costs in the late 1980s were rising more rapidly than in most of these countries. If costs were to be contained, hospitals would need to give greater attention to their use of water. *Untapped Savings* examined the use of water by hospitals to identify how improved management could reduce water use and the cost to the NHS. The report drew on information from over 300 hospitals.

Since the report was published, the amount of water used per patient day (inpatients and day cases) has fallen by 5 per cent, although recently this trend has levelled off. However, in those hospitals which consumed most water, use has fallen by as much as 10 per cent. In addition, the cost per 1,000 litres of water has decreased by 9 per cent in real terms. The combined effect of reduced consumption and reduced cost is a saving of about £5 million each year to the NHS. But, despite these improvements, there continues to be wide variation in the cost of water for hospitals, which suggests that there is still scope for some trusts to agree more favourable rates with suppliers.

**Key findings**

- The costs of water to the NHS rose rapidly in the late 1980s and early 1990s.
- Water use varied between hospitals. In the lower quartile of acute hospitals, use per patient day was 530 litres or less, but in the upper quartile of acute hospitals it was over 1,130 litres per patient day.
- Water bills were not always accurate. At one health authority, errors totalling £155,000 were identified over a four-year period.
- Water and sewerage costs varied significantly in different parts of the country due to variation in charges levied by suppliers.
- Water wasted through leaks is typically in the range of 15 to 30 per cent of total consumption and, in some hospitals, accounted for about half of all water used.

**Key recommendations**

**Health trusts should:**

- adopt a policy for water management that includes specific consumption targets and an investment plan for achieving the targets;
- check water bills for errors (which are common) and make sure that the most economic tariffs and metering arrangements are used and charged for;
- record accurate information on water consumption and compare consumption to performance yardsticks;
- negotiate more favourable water and sewerage charges with existing or alternative suppliers;
- install technology for reducing consumption – for example, controlled toilet flushing cisterns and percussion taps; and
- monitor water consumption for possible leaks, then track down and rectify leaks in water pipes.
Section 2: Delivering value for money

The processes underlying the delivery of services need to be reviewed regularly and improved in response to changes to government policy, changes in local needs and technological changes. Processes also need to be reviewed regularly in the light of developing good practice. A robust management framework will provide the basis for identifying and implementing necessary changes. The Audit Commission’s value-for-money studies examine these areas of service delivery which, at the time, were seen to hold the most significant potential for efficiency and effectiveness gains. Many of the issues and much of the good practice set out in national value-for-money reports and reviewed through local audits remain relevant to today’s NHS.
Accident and emergency services

Refer to:
By Accident or Design: Improving A&E Services in England and Wales (1996) 011886436X, £15
Accident and Emergency Services Follow-up: Progress Against Indicators from By Accident and Design (1998) 1862401225, £5
See also:
Children First: A Study of Hospital Services (1993) 0118860968, £9.50

Background

Each year, patients make almost 15 million visits to accident and emergency (A&E) departments in England and Wales. A&E departments are one of the principal interfaces between the community and the hospital and often act as the ‘front door’ of the hospital, receiving patients referred by GPs as well as emergency admissions resulting from accidents or acute illness.

At the time of the study, the numbers of people attending A&E departments had been increasing at a rate of around 2 per cent a year since 1981. This increase had included a significant rise in GP referrals for emergency hospital treatment. The increased use of A&E departments, coupled with concerns about long waiting times and the quality of care received by patients, prompted the Audit Commission to undertake this study.

By Accident or Design looked at the extent to which value for money was obtained from A&E departments, and how quality of care could be improved. It drew upon secondary analysis of national data as well as information gathered from in-depth fieldwork at 11 hospital trusts and information gathered from shorter visits to a further 13 hospital trusts across England and Wales. Accident and Emergency Services Follow-up reported on progress against key indicators over the two years following the original study.

Key findings

- Long waiting times were common, with many patients waiting two hours or more for emergency treatment or an inpatient admission. Patients whose imminent arrival had been notified often fared as badly as those who self-presented. The follow-up study found that, although total A&E attendance has stabilised since 1996, waiting times have continued to increase.
- Management information was generally found to be poor, with departments having only a limited idea of the quality of initial assessments of patients, and how long patients really had to wait.
- Triage systems (to sort patients according to urgency) were generally not monitored for quality, and staff were sometimes inadequately trained.
- The Patient's Charter measured the percentage of patients assessed by a triage nurse within five minutes of entering an A&E department. However, not all hospitals with good Patient's Charter ratings on this measure were prompt in initiating or completing treatment.
- Some A&E departments had half as many doctors as others in relation to the number of patients attending.
- Most hospitals had well below the number of doctors recommended by the British Association of Accident and Emergency Medicine. It was estimated that an additional 25 per cent more senior house officers and 43 per cent more middle-grade doctors would have been needed across England and Wales to comply with these standards. The follow-up study found that the number of doctors had risen in 85 per cent of A&E departments since the time of the study, although some of this increase was to compensate for reductions in junior doctors’ working hours rather than representing an increase to the total number of hours.
- Most patients were treated by relatively inexperienced junior doctors. Almost 60 per cent of A&E departments had only one consultant, and there was a marked variation between hospitals in the number of hours per week that a senior or middle-grade doctor was present on site.
- Emergency nurse practitioners – who are authorised to diagnose, treat and discharge patients (in compliance with agreed protocols) without consulting an A&E doctor – were employed in one-third of A&E departments. However, in most of these hospitals they were not being utilised to the full extent of their skills and training.
- Not all hospitals had 24-hour trauma teams on-site, and even where such teams did exist, not all staff had the necessary skills or training. The follow-up study found that the proportion of doctors with specialised life-support training has, however, increased since the original study.
• Too many patients paid repeat visits to A&E departments for follow-up examinations.
• Care for vulnerable patients, such as frail older patients or children, who account for over one-quarter of all A&E patients, was frequently poor with medical staff lacking appropriate skills. However, the follow-up study found that the availability of nurses in A&E with special training in treating children is improving, albeit slowly.
• Seriously ill patients were less likely to achieve a good outcome if treated at units where there was less specialist support. It had been suggested that larger hospitals could more easily provide such support round the clock. However, only one in three A&E departments treated more than 50,000 patients a year.

Key recommendations

For hospitals trusts
• Although matching A&E staff to demand is not easy, hospitals with A&E departments should analyse patterns of workload and waiting times by the hour of the day and the day of the week and use this to plan staffing levels. This analysis will help to ensure that sufficient doctors and nurses, qualified to an appropriate level, are available at any given time.
• Clinical audit of triage practices is needed to identify training needs and staff shortages.
• By Accident or Design suggested that the potential of telephone triage advice should be investigated to keep patients, who could safely be dealt with by their GP, out of A&E. Such advice is now becoming available throughout England and Wales as 'NHS Direct' is introduced.
• Hospitals should ensure that junior doctors have access to experienced support at all times, including at night and weekends. Ideally there should be a senior or middle-grade doctor in all A&E departments for at least 15 hours each day, and clear rules are needed for informing the on-call consultant about clinically complex cases or unacceptable waiting times.
• Nurse practitioners and experienced triage nurses may be enabled to request certain X-rays and diagnostic tests to reduce congestion and waiting times.
• Hospitals should ensure that essential support to A&E, including expertise and equipment for resuscitating and diagnosing severely injured patients, is readily available for 24 hours a day. Trauma resuscitations should be carried out by a defined team with clear roles, according to a standard methodology such as advanced trauma life support (ATLS).
• Hospitals with A&E departments should ensure that at least one nurse is employed with sufficient seniority to raise awareness of issues in the treatment of children, and a paediatrician should be available on call 24 hours a day.
• A senior manager should have responsibility for implementing initiatives to reduce waits for admission to an inpatient bed, including agreeing protocols and procedures with all receiving specialties and referring GPs.
• Hospitals should ensure that patients receive good written instructions and information upon discharge.
• Hospitals should follow up frail elderly patients discharged directly from A&E.

For commissioning bodies
• Commissioning bodies should set realistic and measurable targets for A&E waiting times for each 'triage category'.
• Commissioning bodies should promote closer integration of pre-hospital care with A&E care for major trauma and other emergency cases. Improved communication between A&E departments and ambulance crews, for example, would enable a more prepared response by the receiving hospital.
• Commissioning bodies should review the activity of small A&E departments with good access to alternative facilities with respect to staff, facilities, cases seen and the needs of the local population, with a view to considering merger.

For the NHS Executive and the NHS Directorate for Wales
• The NHS Executive and NHS Directorate for Wales should ensure that there is a framework of performance measures for all A&E departments which reflect real waiting times for patients.
• The NHS Executive and NHS Directorate for Wales should standardise triage categories to facilitate national comparison of waiting times and case-mix.
Ambulance services

Refer to:
See also:
By Accident or Design: Improving A&E Services in England and Wales (1996) 011889436X, £15

Background

Emergency ambulance services provide a response at all times to members of the public (mostly through 999 calls) and to GPs needing to have patients admitted to hospital urgently. During 1996/97, ambulance services attended around three million public calls and around one million GP urgent calls in England, and around 160,000 public calls and around 100,000 GP urgent calls in Wales. In England, this cost £440 million (roughly £110 per call) and in Wales it cost £33 million (roughly £127 per call).

Ambulance services have conventionally been judged on how quickly they respond to emergency calls. Until 1997, all emergency calls were judged by the same response-time standards. But since then, the Patient's Charter has set a response-time standard of 'within eight minutes' for specified life-threatening situations. Services in England and in Wales are now expected to work towards meeting this on 75 per cent of occasions by 2001. This new target is very demanding, especially as the emergency workload has grown steadily during the 1990s.

A Life in the Fast Lane therefore concentrated on operational efficiency and quality of service. It drew upon information gathered from in-depth fieldwork at 7 ambulance trusts, a postal survey of all 42 ambulance services and a postal survey of nurses in hospital accident and emergency (A&E) departments across England and Wales.

Key findings

• The average cost of responding to a call was twice as expensive in some services than in others. This was largely for reasons outside management's control. For example, in rural areas the population is more scattered and ambulances have further to travel. However, the review also found genuine efficiency differences between services. For example, sickness rates and vehicle fleet management costs varied between ambulance services.

• Certain services had improved their response time greatly by analysing the database of 999 calls to anticipate hour-by-hour where demand was likely to occur, and then systematically stationing crews to allow a rapid response. However, this approach meant that more attention had to be paid to the needs of crews, who as a result spent much less time at an ambulance station.

• Delays occurred in activating crews, particularly where services were working with outdated communication systems. Delays also occurred at hospitals, sometimes due to arrangements with A&E staff or departmental layout.

• GPs' requests were often delayed due to the pressure of work in responding to 999 calls.

• Several ambulance services reviewed the quality of care systematically, by issuing protocols and systematically checking that crews were observing them. But, in others, such clinical audit was hindered by poor record-keeping or limited audit resources.

• Some hospitals had joined with the ambulance service to audit the care given to the patient right through to discharge, thus enabling them to assess the outcome of care.

• Normally, patients are transported to the nearest hospital with an A&E department. But the nearest hospital may not be able to deliver the best treatment for some patients, such as those already under the care of a consultant at a different hospital, or those who need specialist facilities. Guidance issued by the Department of Health and Welsh Office in the early 1990s allowed for discretion as to where patients were initially transported. Many trusts, however, have not exercised this discretion and, where they have, ambulance crews have generally lacked clear guidance or protocols.

• A&E departments need information about badly injured patients before the patient arrives. A survey of A&E nurses showed that, while crews generally passed on this information well, messages back to the crews were sometimes delayed or misconstrued when passed through the control room.

• Many 999 calls would probably be more appropriately dealt with by GPs or other agencies, or even by self-help.

• Many ambulance services want to develop alternative responses to the minor calls that they receive; for example, by calling out a district nurse to treat more patients safely in their own homes.
Many also wanted the freedom to send out a single experienced member of staff or to relax the response time targets for the less urgent calls.

• Because each ambulance trust operates over several health authority areas, the typical health authority spends only 1 or 2 per cent of its total budget with the ambulance trust. Consequently, the commissioning of ambulance services does not always receive the attention it deserves from health authorities. Performance information on costs, stakeholder views and clinical effectiveness for ambulance services is also sparse, and commissioning bodies have little experience of other providers.

• Health authorities have not always involved the ambulance service fully in developing local strategies.

Key recommendations

Ambulance trusts should:

• review rotas against demand by time of day and day of the week, considering also whether response times are consistently poor at particular times;
• identify any causes of delay in activating crews and review the use of standby points to ensure that ambulances are being deployed close to where calls are most likely to occur;
• analyse time spent at the scene and at the hospital to identify whether excessive delays are associated with, for example, particular stations or hospitals;
• review practice on where to transport patients and introduce protocols empowering crews not to transport to the nearest A&E department wherever this would not be in the patient’s interest.
Ambulance trusts should also ensure that, where possible, there are arrangements with minor injuries units to receive specified categories of patients;

• monitor cost and efficiency. There are two key indicators that should be included: number of responses per hour and cost per hour. Trusts should also monitor, and keep under review, the costs of sickness absence and fleet maintenance;
• make clinical audit effective by ensuring that patient report forms are fully completed for as many patients as possible; by reviewing how findings are communicated to front-line staff; by co-ordinating their programmes with those of other services; and by sharing findings and setting up joint audits with local acute hospitals where practicable;
• formalise their arrangements for obtaining clinical input, either by employing medical or nursing staff at a senior level, or through a formal service agreement with an external clinician (drawing upon local staff with a pre-hospital emergency care qualification whenever possible). They should also give a medical adviser or clinical employee the right of access to the trust board; and
• ensure that control room staff are adequately trained to pass on clinical messages between receiving hospitals and ambulance crews.

A&E departments should:

• participate in joint audits wherever practicable; and
• set up systems for giving feedback to ambulance crews about patients and their treatment.

Commissioning bodies should:

• normally purchase national standards of service;
• set up joint commissioning arrangements with any other purchasers that commission from the same provider;
• ensure that funding and support is available to trusts to run an adequate clinical audit programme;
• consider response time performance in dealing with GP urgent calls as well as public emergency calls; and
• keep the ambulance service appropriately involved in strategic planning decisions and try to broker joint approaches to significant unresolved problems between hospitals and the ambulance service.

The NHS Executive and the NHS Directorate for Wales should:

• review the outcome of mergers between ambulance trusts;
• provide guidance on whether some patients could safely remain at home following treatment by paramedics;
• By Accident or Design recommended that the NHS Executive and Welsh Office should reconsider whether, for some of the least serious 999 calls, it would be safe to relax response-time targets or the requirement to send a full ambulance response.
Since the report was published, the NHS Executive has encouraged ambulance trusts to submit plans for such pilot schemes. And the ‘NHS Direct’ telephone advice line, to be introduced as part of the Government’s information strategy, may in time reduce the number of minor calls received by the ambulance service.
Anaesthesia and pain relief

Refer to:
Anaesthesia Under Examination: The Efficiency and Effectiveness of Anaesthesia and Pain Relief Services in England and Wales (1997) 1862400601, £20
Managing Pain after Surgery: A Booklet for Nurses (1998) 18624010120, £4.75
See also:
The Doctor’s Tale Continued: The Audits of Hospital Medical Staffing (1996) 0118864327, £10

Background
Anaesthetists are directly involved in the care of two out of three acute hospital patients and are the single largest group of doctors in any acute hospital. As well as anaesthetising patients for surgery, they often take a lead in intensive care services, provide pain relief for women in labour, work with patients with chronic pain and provide pain relief for patients after surgery.

Anaesthesia Under Examination examined the value-for-money aspects of anaesthesia and pain relief services. It drew upon a review of the relevant literature, information gathered from in-depth fieldwork at 7 hospital trusts, data collected from a random sample of a further 40 hospital trusts; and informal discussions with a range of clinicians, managers and local auditors across England and Wales.

Key findings
• The average cost per session of anaesthetists’ clinical work varied by up to 77 per cent across trusts, with a 15 per cent variation between the upper and lower quartile.
• The number of consultant anaesthetists increased by 41 per cent between 1986 and 1996. However, the increase was largely due to a growing non-surgical role (for example, in intensive care and maternity units); to a reduction in the service contribution made by junior doctors due to new restrictions on working hours; and to new specialist training which does not permit middle-grade trainees to work as many solo sessions as they did previously. Consequently, more than half the trusts surveyed continued to experience a shortage of consultants and one in five trusts was likely to have difficulties in meeting all of its commitments as a result.
• Consultant anaesthetists were generally scheduled to attend most clinical sessions. However, legitimate absence meant that, on average, one-third of planned consultant sessions were covered by trainees or non-consultant career-grade doctors.
• Each patient should be anaesthetised by someone with the appropriate experience and skills. However, some patients requiring complex anaesthesia were anaesthetised by trainee doctors, either because surgery was performed at night when consultants were on-call but not in the hospital, or when trainees were covering for consultant absences.
• Close to one-fifth of patients did not meet the anaesthetist before theatre at all and a similar number did so for five minutes or less. This was often because patients were admitted on the day of surgery and anaesthetists experienced difficulty in finding patients quickly. Anaesthetists often received little advance notice of who was on their lists and their resulting failure to see patients prior to surgery potentially left patients feeling anxious and ill-informed.
• Many patients did not receive the pain relief that they needed after surgery because of poor collaboration between surgeons, anaesthetists and nurses.
• The resources that trusts invested in maternity and chronic pain services varied greatly, and were not based upon clear evidence of the effects on patients.
• Clinicians did not always use best practice pain relief methods, and mechanisms for informing staff about best practice were often weak. Most clinics were providing some procedures that have been proven to be ineffective.

Key recommendations
Hospital trusts should:
• consider increasing the number of non-consultant career grade doctors in order to reduce the difficulties associated with consultant shortages. Where these staff are employed, they should be used only for work appropriate to their levels of skills and experience. There should be a policy in place for the continuing professional development of these staff;
• agree explicit rules for calculating half-days for fixed commitments. They should employ consultants on contracts with seven half-days for ‘fixed’ commitments, a high proportion of which should be directly clinical, unless there are clear reasons why this is not appropriate locally. More of the clinical sessions in a consultant’s job plan should be sufficiently flexible to allow for more appropriate cover of absences;
• translate job plan commitments into a template rota that matches contract commitments and patient care needs. The template should be reviewed at least annually, to ensure that it still meets requirements, and job plans should be adjusted as required;
• agree guidelines about which grade of anaesthetist is appropriate for each level of case complexity and ensure that only genuine emergencies are operated on at night. Consultants should take active responsibility for ensuring that trainee doctors and non-consultant career grade doctors follow national guidelines and procedures, such as the recommendations made by the National Confidential Enquiry into Perioperative Deaths, and that they are clear about when they should seek assistance from a consultant;
• agree and issue screening checklists for completion by patients and/or nurses before admission to help ensure that the necessary information is available for the anaesthetist in advance of surgery. A systematic way of assigning priorities where anaesthetists are unable to visit all patients preoperatively should be established to ensure that the most at-risk patients do receive a visit;
• agree a policy that states who is responsible for giving information about anaesthesia and pain relief to patients. Who has given what information to the patient at each stage should be recorded in the notes so that any omissions can be rectified later on;
• ensure that there is an acute pain team, or some other mechanism, to provide written information and guidelines, to train staff about the management of pain, and to provide a focus for improved teamworking;
• recognise the importance of training ward nurses who are best placed to monitor patients’ changing pain levels and ensure that there is adequate co-ordination between surgeons, anaesthetists and nurses;
• review anaesthetic staffing for services for women in labour in the light of caesarean and normal labour epidural rates and not simply the number of deliveries;
• monitor annual changes in anaesthesia event rates; and
• review chronic pain treatments on offer in the light of evidence of their effectiveness. They should also involve the lead clinician for chronic pain in contract discussions to ensure that a realistic contract is agreed.

Commissioning bodies should:
• include specific standards about pain relief following surgery in contracts.

Professional bodies, the NHS Executive and the NHS Directorate for Wales should:
• support research to establish new evidence-based guidelines for determining staffing levels and grade-mix for obstetric anaesthesia.

The NHS Executive and the NHS Directorate for Wales should:
• support research on whether the demand for doctors can be reduced, and better use made of consultants’ time, by allowing others who are appropriately trained to monitor/maintain anaesthesia without a medically qualified anaesthetist continually present in the operating room.
Care services for older people

Refer to:
Coming of Age: Improving Care Services for Older People
(1997) 1862400598, £20

Background

Those aged over 65 make up 14 per cent of the total population, but they account for nearly half of all health and social services expenditure. Those over 75, and especially over 85, use care services even more intensively. And more people are living longer. The number of people aged over 85 has nearly doubled since 1981, and will double again by the middle of the next century.

Coming of Age looked at arrangements for the continuing care of older people leaving hospital and drew upon information gathered from in-depth fieldwork at 12 local authorities, health authorities and associated trusts in England and Wales.

Key findings

- Health and social services are locked into a vicious cycle. As hospital admissions rise and lengths of stay shorten, increasing demands are placed upon social services departments. For example, 18 per cent of older people were hospital inpatients at some time during 1994, compared with 13 per cent in 1982. However, the average length of stay in geriatric wards fell by 45 per cent between 1990 and 1995. Consequently, nearly two-thirds of social services gross expenditure on the care of older people was spent on residential and nursing care, reducing the resources available for alternative services which could minimise admissions into hospital care.
- The quality of the assessment process – which determines whether an elderly person can go home or requires care in a residential setting – varied, and reviews to check that care packages were still appropriate were often considered a low priority.
- Standards on the maximum time between assessment and the putting in place of a care package varied from between five days and six months.

Key recommendations

Commissioning bodies and social services departments should:

- share information on current needs and existing services and set up systems for continuously updating this information;
- agree respective responsibilities for discharging older patients and time standards for different parts of the process. All discharge delays should be audited and the reasons for delay identified. Assessment procedures upon discharge should be reviewed;
- plan jointly and work with provider agencies to develop new forms of provision. Social services departments, in particular, need to develop more sophisticated funding and contracting mechanisms to promote improvements in quality and innovation; and
- regularly monitor to ensure that care plans are being achieved, that high-quality services are being delivered, and that resources are being targeted effectively.

For the NHS Executive and NHS Directorate for Wales

- Local initiatives alone are unlikely to be sufficient in addressing the problem. Central government needs to conduct a national review of the funding and organisation of long-term care and clarify the respective roles and responsibilities of the NHS and local authorities to provide this.
Children’s hospital services

Refer to:
Children First: A Study of Hospital Services (1993) 0118860968, £9.50

See also:
By Accident or Design: Improving A&E Services in England and Wales (1996) 011886436X, £15

Background
Healthcare services for children have changed rapidly over recent years as a result of new developments in surgical and medical techniques, an increased emphasis on parental involvement, and an increase in care at home. In total, about 10 per cent of expenditure on hospital and community health services is spent on providing services to children.

There are well-established principles for the care of children in hospital, going back at least as far as the Platt report of 1959. In England, these have been set out in The Welfare of Children and Young People in Hospital (1991). In Wales, since the report was published, the policy framework for children’s services has been updated in The Health of Children in Wales (1997) which draws together the advice set out in a range of earlier protocols.

Since the report was published, the Department of Health has also published The Patient’s Charter: Services for Children and Young People (1996), and the Welsh Office has published The Patient’s Charter: Services for Children and Young People in Wales (1997), although the standards contained in these charters are not routinely monitored. And a health select committee inquiry in 1997 identified many similar issues to those highlighted by the Audit Commission’s study.

Children First focused on six key principles for the care of children and young people in hospital:
• strategic commissioning;
• child and family-centred care;
• specially skilled staff;
• separate facilities;
• effective treatments; and
• appropriate hospitalisation.

The report drew upon information gathered from in-depth fieldwork at 10 hospitals and additional information gathered from visits to a further 12 hospitals across England and Wales.

Key findings
• Despite the existence of agreed principles for the provision of children’s services, awareness of them was not widespread and they were often not implemented locally. This was manifest in a lack of written policies, a lack of management focus and poor communication between staff and parents.
• Although some hospitals did have child- and family-centred policies, these had usually been developed by enthusiastic staff and were not consistently applied across wards or departments.
• Commissioning bodies often did not even recognise a need for a strategy for children’s services, let alone have one. And a general lack of needs data and information on the services available made contract specifications weak.
• The outcomes of treatment are not routinely monitored, making it difficult to know whether treatments are effective. For example, glue ear, a common childhood condition, was most commonly treated surgically. But there were wide variations in admission rates from one region to another, with no certainty about the appropriate indications for surgery.
• Many hospitals did not meet the requirements set by the Department of Health and Welsh Office for at least two Registered Sick Children’s Nurses (RSCNs) to be on duty 24 hours a day, particularly in respect of providing staff cover at night.
• The Royal College of Physicians recommend that more experienced junior doctors are on hand to provide ‘safety net’ cover to first-line staff inexperienced in paediatrics. However, 16 per cent of district health authorities had no experienced junior staff and a further 8 per cent were without these staff most of the time.

• Some surgeons were undertaking too few cases of certain kinds of operations to maintain the special skills needed.

• There was often a lack of separate facilities for children and, even where these were available, they were utilised predominantly by paediatricians rather than surgeons, who often prefer to see children in adult wards dedicated to their specialty. And where separate children’s facilities do exist, the specific needs of adolescents are often poorly catered for.

• There was a tendency for special care baby units in some local hospitals to take on complex cases that they were not adequately equipped to handle. Fewer than 30 per cent of 52 units surveyed were doing more than 500 intensive care days per year, which is the minimum recommended to maintain adequate skills.

• The average length of stay of child inpatients had steadily fallen since the mid-seventies. But, for a range of conditions, there continued to be wide variation between hospitals in the length of hospital stay, suggesting that some children could be discharged earlier.

• The number of first-time admissions had risen, suggesting that although lengths of stay were generally not as long as before, more children were being treated in hospital.

**Key recommendations**

**For NHS trusts**

• Hospitals need a written strategy for providing services to children which is based on national principles and standards, and the good practice guidelines contained in *Children First*. Written policies, covering different aspects of provision, should also be in place to ensure that policy and procedures are understood by all those involved, and applied consistently throughout the hospital.

• Hospitals should establish a senior management team comprising a consultant with overall responsibility for policies for all children's services, a senior children's nurse (above ward sister level) to provide the focus for implementing policies consistently in all parts of the hospital, and appropriate managerial and financial support.

• A ‘named nurse’ should be allocated to each patient with responsibility to oversee his or her care. And parents should be involved more through better written information and closer integration into the care team.

• Some treatments, such as childhood cancer services and neonatal intensive care, should not be routinely carried out or managed entirely at local hospitals.

• Hospitals should meet the Department of Health and Welsh Office requirement for at least two registered sick children’s nurses (RSCNs) to be on duty 24 hours a day. This can often be achieved through improved rostering rather than by employing additional staff.

• Policies should be in place to ensure that all children admitted to hospital are cared for in separate facilities. Facilities should take account of the differing needs of young children and adolescents.

• Hospitals should look at how they can improve A&E facilities for children. A separate waiting area and a separate treatment room can make a significant difference and need not involve extensive capital expenditure.

• Better training of existing staff, clear guidance and the employment of medical staff who are experienced in treating children in A&E can reduce admissions significantly.

• Better discharge arrangements should be introduced; for example, giving results of tests to families after discharge if there is no medical reason for the child to remain on the ward.

• More care should be provided at home by specially skilled nurses, in some cases with 24-hour access by telephone.

**For commissioning bodies**

• Health authorities need to recognise that the treatment of children requires a separate strategy from that of adults. As a minimum, all providers should have a written policy for the care of sick children that covers Department of Health and Welsh Office guidelines.

• Commissioning bodies should ensure that funding is available for providers so that adequate medical staff ‘safety net’ cover can be provided.

• Treatment outcomes should be monitored, particularly for glue ear and intensive care for newborn babies, and the results should be used to inform policy and practice.
Commissioning specialised services

Refer to:
Higher Purchase: Commissioning Specialised Services in the NHS (1997) 1862400725, £20
See also:
Dear to Our Hearts?: Commissioning Services for the Treatment and Prevention of Coronary Heart Disease (1995) 0118864262, £10

Background
The term 'specialised services' covers a wide range of treatments that are difficult to define. They include techniques such as kidney dialysis, infant cardiac surgery and bone marrow transplants, and account for about £1.4 billion of NHS expenditure each year across England and Wales. Overall, they are grouped together because:
• they are not offered at all hospitals;
• treatments usually have a high unit cost; and
• small numbers of patients receive them.

Specialised services are difficult to commission. High unit costs combined with low patient numbers make planning and budgeting difficult. This process is further complicated because demand is rising as new treatments are developed, diagnosis improves, and more techniques require repeat treatments.

Higher Purchase drew upon information gathered from in-depth fieldwork at 14 health authorities and related provider organisations; from national surveys of specialist providers for two 'tracer' services (genetics and cochlear implants); and from a workshop for consumer organisations and users of specialised services.

Since Higher Purchase was published, the Government has launched a new initiative to improve the quality of health services. It includes the creation of a new body, the National Institute of Clinical Excellence (NICE) which will produce clinical guidelines based on relevant evidence of clinical- and cost-effectiveness. NICE (rather than commissioning bodies) is therefore likely to be the appropriate body to take action on a number of the recommendations concerning clinical quality standards.

Current NHS reforms make regional offices of the NHS Executive accountable for ensuring that effective commissioning arrangements for specialised services are established in each region. In Wales, the five health authorities have established the Specialised Health Services Commission for Wales to co-ordinate their purchasing activity. The recommendations, therefore, should be considered in the context of the frameworks established regionally and in Wales.

Key findings
• Health authorities found it difficult to obtain good quality information on specialised services and treatments because:
  – much activity and cost information was hidden in block contracts and a lack of standard definitions made it difficult for authorities to draw comparisons across hospitals;
  – information on service quality was also poor. For example, contracts for over one-quarter of centres doing cochlear implants (a surgical technique to help with some types of deafness) specified no quality standards at all. And many authorities asked only for information on processes, such as waiting times, and not for meaningful measures of patient outcome, even where there are well-established outcome measures available;
• sources of information on the appropriateness and clinical effectiveness of specialised services were numerous, but covered only a small fraction of all treatments and services provided by the NHS and sometimes gave conflicting messages. In some instances, health authorities were carrying out duplicate reviews of available effectiveness information. And sometimes health authorities were unaware of new treatments that were being used.
• Access to specialised services was uneven. Whether a patient was offered a particular treatment varied depending upon where they lived. And patchy provision of services was made worse because some health authorities were choosing not to fund unproven new treatments at all.
• Only 25 per cent of health authorities had written protocols, agreeing with providers the levels of care and the criteria for prioritising patients and treatments.
**Key recommendations**

**Commissioning bodies should:**

- establish separate contracts or agreements for specialised services so that they can monitor use. They might also consider developing condition-based service agreements to enable the monitoring of services from a patient’s perspective;
- agree with other purchasers common standards for cost, quality and activity information to enable monitoring and quality assessment across larger population bases. They should identify reasons for variations between providers, especially in price – although it should be borne in mind that comparisons between hospitals can be extremely misleading for specialised services, where patient numbers are very small and patients are very ill or have complex medical needs;
- establish meaningful clinical quality standards in agreements for specialised services, wherever possible. This may be easier for some services than others; for example, the results of hearing performance tests provide a good outcome measure for cochlear implants and the National External Quality Assessment Scheme genetic centres have developed a series of meaningful quality measures for genetic services. Commissioning bodies should also consult with users, consultants and referring GPs on the quality of existing services and in developing their quality specifications;
- agree evidence-based protocols, in consultation with GPs and referring clinicians, that define the types of patients and conditions that should be given priority for each specialised service;
- clarify the processes and mechanisms for setting priorities and making decisions about funding new treatments;
- actively plan specialised service provision, identifying gaps in current services and working with trusts to predict future changes in treatments. They should put ideas to trusts and not simply respond. For example, one health authority invited bids from local trusts for inpatient eating disorder services where no local NHS facilities existed;
- establish a medium-term strategic plan to cover all specialised services, identifying future priorities for investment;
- carry out at least one strategic review a year of a specialised service including user views, needs assessment, evaluation of treatments, comparative information on prices and quality and costed options for future development. Given the development of national service frameworks for some specialised services, commissioning bodies should focus their efforts on areas of local importance that are not being addressed nationally;
- review, service by service, the best form of collaboration with other commissioning bodies. The options include the establishment of joint-purchasing consortia, risk-sharing arrangements, co-ordination on service developments or informal networking on contract intentions, but with each commissioning body acting independently. Under the new reforms, the NHS Executive regional offices in England and the Specialised Health Services Commission in Wales will lead this work;
- ensure that staff are kept up to date with changes in specialised services through regular dialogue with clinical directors and one-off educational events; and
- establish longer-term agreements with trusts to allow improved forward planning, allowing risk to be spread across a number of years, and for longer-term relations to be developed with providers. Current reforms require that longer-term agreements replace annual contracts with providers.

**Higher Purchase** recommended that commissioning bodies should, in the absence of a national clearing house, collaborate with other commissioners in carrying out assessments of new treatments and should encourage the recruitment of patients to recognised trials to improve the evidence base for future purchasing decisions. NICE is now charged with carrying out this function under current reforms of the NHS.

**Hospital trusts should:**

- ensure effective clinical audit of specialised services and disseminate the results to commissioning bodies and other trusts.

**Commissioning bodies should agree evidence-based protocols, in consultation with GPs and referring clinicians, that define the types of patients and conditions that should be given priority for each specialised service.**
Communications between hospitals and patients

Refer to:
What Seems to be the Matter?: Communications between Hospitals and Patients (1993) 011886100X, £9

Background

As healthcare processes and organisations become increasingly more complex, so the need to communicate with patients clearly about both the clinical and non-clinical aspects of their care grows. Provision, however, has not kept up with this growing need, and lack of information and problems in communicating with health professionals usually come at the top of patients' concerns. There is evidence to show that if providers improve communication with patients they can improve the effectiveness of care, increase efficiency and improve their reputation locally with both patients and purchasers.

What Seems to be the Matter looked at communication with patients, relatives and carers in acute hospitals. It considered not only the giving of information, both general and clinical, but also the ways in which information is obtained from patients, either unsolicited (in the form of complaints) or solicited (by techniques such as surveys). The report drew on information gathered from in-depth fieldwork at eight NHS trusts and from shorter visits to a further eight NHS trusts across England and Wales.

Since the publication of the report, the NHS Executive has issued guidance on establishing complaints procedures. This requires trusts and commissioning bodies to establish and publicise written complaints procedures that allow for local resolution of complaints and an independent review process.

As part of the current reforms, an annual national patient survey will be conducted to provide high-level feedback of the views and experiences of patients.

Key findings

- Generally, patients did not receive all the information that they required, and some – for example, those with disabilities or those who did not speak English – had particular difficulties.
- General information about the hospital was often either not available in written form at all, or was badly distributed or of poor quality.
- Individual patients have different needs, preferences and expectations in relation to clinical information. However, in interviews carried out by the College of Health on behalf of the Audit Commission, the most prevalent theme was the desire patients had for more clinical information. Relatives and carers often also needed this information, although the need to observe patient confidentiality requires care.
- Little time was allowed in many instances for patients to elicit information from professionals or to be able to discuss their concerns. For example, the average length of a consultation for men with a prostate problem was seven minutes, in which time the patient was examined and was also briefed about his condition, appropriate treatment, surgical procedures and their risks and outcomes, before being admitted as an inpatient.
Patients did not always get information when they needed it, perhaps receiving it only when they were unable to absorb it, or when it was too late (for example, being informed of the risks of an operation after the decision to operate had been taken).

During a consultation, options for treatment were often discussed while patients were still undressed and on the examination couch, making it potentially more difficult for patients to ask questions or absorb what was being said.

Patients were not always told whom they could contact between out-patient appointments for advice or information. For example, of the eight rheumatology departments studied, only two gave patients the name, number and availability of a nurse whom they could call with queries. In both departments, patients frequently asked for advice about their drugs and possible side-effects, and medical staff believed that providing this had helped to keep down the number of follow-up out-patient appointments.

Arrangements for providing interpreting facilities for patients who do not speak good English often put confidentiality at risk.

Communication between clinical staff was also sometimes poor, so that the patient was either given apparently conflicting information, or was not given some information at all.

Patients were rarely asked for their views and, when they were, inappropriate research methods – such as poorly designed questionnaires with closed questions that do not necessarily reflect the concerns of patients – were used.

### Key recommendations

#### For hospital trusts

- Senior professionals and hospital managers should develop an understanding of what it is like to be a patient in their hospital, so that they can help to develop effective hospital-wide policies on different aspects of communication with patients. These efforts should extend to all patients, including those who have a disability and those who do not speak English. This can be achieved by accompanying individuals through the system; listening to complainants; consulting appropriate voluntary and self-help groups; and by instigating well-designed research projects.

- Hospitals should develop a plan that specifies the general hospital information to be produced, including written leaflets and pamphlets, signs, guiding, notice boards, and information given via other media. It should also set out how this will be distributed; the quality standards that will apply; who is responsible for production and distribution; and the costs. And it should set out the training needs of switchboard operators and other front-line staff and how these are to be met. In addition, the plan should also specify monitoring arrangements.

- Hospitals should review out-patients’ appointment systems so that consultations are spaced at intervals to allow clinical staff enough time for communication and for patients to be dressed when they meet the doctor to discuss diagnosis and treatment. Patients might also be encouraged to prepare a list of questions in advance of their consultation.

- Systems should be in place for ensuring that patients and relatives know whom they can talk to about clinical matters and how to contact them. Patient documentation should record information given to patients, and the provision of clinical information to patients, should be included in medical audit and multidisciplinary meetings.

- Trusts should establish mechanisms for obtaining feedback from patients and relatives about their information needs and their views of the clinical information provided.

- Improved arrangements for interpreting for non-English-speaking patients should be established.

#### For commissioning bodies

- Commissioning bodies should work towards defining communication standards; for example, in relation to general information complaints-handling and clinical information.
Coronary heart disease

Refer to:

Dear to Our Hearts?: Commissioning Services for the Treatment and Prevention of Coronary Heart Disease (1995) 0118864262, £10

Background

Coronary heart disease (CHD) is a narrowing of the arteries supplying the heart, leading to angina, heart failure and heart attacks. The care of CHD patients costs the NHS over £1 billion each year, divided more or less equally between hospital and community-based services. Despite recent falls in mortality rates, CHD remains a major health problem, accounting for one-quarter of all deaths. The health service provides CHD-related care in several different ways. These are:

• primary prevention to reduce the risk of CHD;
• case finding, treatment and secondary prevention;
• emergency care for people with heart attacks;
• hospital inpatient care for CHD patients; and
• cardiac rehabilitation services in hospitals and within the community.

Dear to Our Hearts? examined commissioning practices and considered ways in which commissioning bodies could improve services for preventing and treating CHD. It drew upon information gathered from in-depth fieldwork at nine health authorities across England and Wales as well as a review of the available literature and interviews with experts in the field.

Currently, both the NHS Executive and the NHS Directorate for Wales are developing national service frameworks for cardiac care, which are to be implemented locally through 1999 and 2000.

Key findings

• There had been significant reductions in death rates from CHD, mainly due to risk reduction. However, reducing death rates does not necessarily justify spending on health promotion, since primary CHD prevention campaigns were not well assessed and their effectiveness was uncertain.
• The use of prescribed drugs could be particularly effective in preventing CHD from getting worse. However, the effectiveness of such treatment depended on the abilities of GPs, and there was evidence that such treatments were not being used as much as they usefully could be. GPs were also normally the first to recognise CHD symptoms and refer patients to hospital.
• Around 40 per cent of all people suffering a heart attack died within the first week. One-quarter died before they reached hospital. Training programmes on how to recognise heart attacks and how to give resuscitation; the availability of up-to-date monitoring equipment at cardiac units; and fast emergency service response times could reduce the death rate.
• There had been a recent and significant increase in ‘tertiary care’ – surgical intervention to repair damaged hearts, usually by repairing or replacing blood vessels in the heart (‘revascularisation’) – although the rates varied significantly between different health authorities and may have been too low in some areas.
• Insufficient attention was paid to aftercare following release from hospital. Caring for patients after discharge from hospital was a relatively inexpensive form of care, which could significantly improve the quality of patients’ lives and reduce death rates. It could also reduce demand for further, expensive, hospital treatment.

Key recommendations

Commissioning bodies should:

• set themselves challenging CHD reduction and health improvement targets;
• develop comprehensive CHD strategies based on available evidence and on consultation with patients, carers, and professionals;
• address themselves to tackling the disease in a co-ordinated way rather than focusing upon individual services. Consequently, all relevant services should be linked into an overall programme for the prevention, detection and treatment of CHD;
• establish agreement on how best to balance the benefits of increasingly sophisticated medical interventions (for example, bypass operations) with CHD prevention work and improving care for CHD patients after discharge;
• develop primary care services to take a lead role in preventing and diagnosing CHD;
• make sure prevention campaigns are properly evaluated;
• consider, where revascularisation rates are low, how supply of this service could be increased and ensure that patients with the most urgent need are treated promptly;
• review the provision of follow-up care after patients are released from hospital; and
• use persuasive argument, available evidence and purchasing power to influence the type and quality of CHD care available locally to reflect best practice.
Day surgery

Refer to:
A Short Cut to Better Services: Day Surgery in England and Wales (1990) 0118860305, £8.50
All in A Day’s Work: An Audit of Day Surgery in England and Wales (1992) 011886081X, £6
Day Surgery Follow-up: A Review of Progress Against Indicators from A Short Cut to Better Services (1998) 1862401233, £5

Background

A Short Cut to Better Services examined the role of day surgery (surgery carried out during the day, with no overnight stay), and Measuring Quality reported the results of the survey of day case patients undertaken as part of the study. In 1992, the subject was re-visited in All in A Day’s Work, which reported on the results of local audits. And in 1998, the Commission published Day Surgery Follow-up: A Review of Progress Against Indicators from A Short Cut to Better Services, to look at changes that had taken place between the 1990/91 and the 1997/98 audits.

There is no evidence that, in appropriate cases, day surgery results in worse outcomes. It offers three advantages over inpatient admissions: it is usually more convenient for patients; faster turnover allows waiting lists to be reduced; and hospital costs are reduced.

Using a basket of 20 representative procedures, A Short Cut to Better Services assessed the potential for increasing the amount of day surgery. Because of the lack of attention paid by many hospitals to measuring the quality of services offered to patients, the Audit Commission also asked the London School of Hygiene and Tropical Medicine to develop and conduct a survey of day-case patients. The two later reports drew on information obtained from local audits.

Key findings

• It was estimated that if all district health authorities performed day surgery at optimum levels, an additional 186,000 patients could be treated each year without increased expenditure. The increased use of day surgery could therefore help to address the Government’s priority for reducing hospital waiting lists.

• By 1997/98, the use of day surgery for nearly all surgical procedures had increased. In some cases, the increase was particularly significant. For example, in 1990/91 virtually no cataract operations were carried out by day surgery. By 1997/98, over 60 per cent were. Despite the increase in levels of day surgery, ‘stay-in’ rates – where people admitted for day surgery are kept in because of complications – had not changed significantly over this period.

• However, there were still significant variations between trusts in the use of day surgery. Variation in day surgery rates for different procedures within trusts is also wide, and very few trusts have an equally high level of day surgery use across all procedures.

• The original study found that many hospitals did not have a dedicated day surgery unit, which is essential for high quality and efficient day surgery. Where such units did exist, they often did not have their own operating theatre. Since then, the position has greatly improved. Seventy-five per cent of hospital trusts had a day surgery unit in 1990/91. By 1997/98, this figure had increased to 93 per cent. Of these, the proportion with attached theatres had increased from one-half to two-thirds.

• In 1990, many day surgery units were under-used. By 1997/98, the average throughput of patients per bed has increased from 17 to 20 a month, with the greatest increases in those units with their own theatre. Staff productivity was also found to have increased as throughput has increased. However, higher throughputs may have been due to an increase in minor, non-sterile investigative procedures rather than in surgery.

• Clinicians’ preferences had a major effect on day surgery rates, with greater variation in day surgery rates between individual surgeons than between hospital trusts. However, follow-up work found that the picture was changing, with peer pressure bringing those more reluctant surgeons in line with best practice.

• In the original study, it was found that managers had poor financial information on which to make decisions, and were worried that clinicians would think that they were getting too involved in medical decisions. By 1998, the availability of management information had improved greatly.
The vast majority of day-case patients were satisfied with their treatment. The proportion who were dissatisfied was similar to the proportion of inpatients who were dissatisfied. Dissatisfaction expressed by patients tended to be with the facilities offered, poor information about treatment and poor pain control.

**Key recommendations**

**For hospital trusts**
- Consultants should consider all patients for day surgery (for appropriate procedures), assessing their suitability on both medical and social grounds. Records should be kept so that the reasons for existing levels of day-case surgery can be better understood.
- Managers should make sure that there are no contractual or organisational barriers to using day surgery, and that clinicians are not discouraged from using day surgery through the funding policies of the trust.
- Managers and clinicians should make sure that day surgery facilities are used only for surgical procedures rather than for non-sterile investigative procedures.
- Trusts should take special steps to extend day surgery to procedures where there are long waiting times, or where increases in day surgery levels have been small.

**For commissioning bodies**
- Commissioning bodies should consider stipulating levels of day surgery in their contracts with trusts, based on agreement of what is achievable.
- Commissioning bodies should look at whether increased capital investment is needed in their areas to establish day surgery units.

**For professional bodies**
- The Royal Colleges should ensure that adequate training and professional development is available for clinicians carrying out surgical and investigative procedures.
District nursing

Refer to:

District nurses provide vital nursing care for patients in their own homes and also provide support for their carers. Half the population over 85 is seen by a district nurse, some of whom are visited as often as two or three times a week. In total, the service cares for nearly three million patients a year at a cost of around £650 million.

However, the demands on district nursing are increasing. The elderly population is growing and patients are being discharged from hospital earlier. Patients are more likely to need specialist care at home, especially those with acute or degenerative diseases. Furthermore, there are fewer newly qualified district nurses. The numbers entering training has declined by one-third since 1990, and 10 per cent of district nurses are currently over retirement age.

The changes envisaged in the recent white papers, The New NHS: Modern, Dependable and NHS Wales: Putting Patients First, present district nurses with a chance to develop their role in multidisciplinary assessment, in the implementation and management of care packages, and in liaison with social services and others.

First Assessment examined the care of patients from referral through assessment to discharge, reviewing how trusts could manage the demand for district nursing services and improve both the quality of care and service efficiency. The report drew on information obtained from a survey of 187 health trusts that was carried out by local audit managers, a postal survey of 1,500 district nurses, in-depth fieldwork at 7 NHS trusts and visits to a further 11 NHS trusts across England and Wales; as well as information from interviews with 40 patients and 10 carers from 2 NHS trust areas in England.

Key findings
- The purpose of district nursing services was not well defined and the nature of the service varied from area to area. Few trusts or health authorities had worked systematically with other healthcare providers, social services, patients and carers to identify how the service could best meet locally identified needs. Defining need for district nursing is not straightforward, but a lack of clear service objectives and referral criteria leads to uncertainty, and to patients who could benefit from the service not being referred while others are referred inappropriately.
- The service is demand-led, shaped around the referrals it receives, mostly from GPs and hospitals. But the referral process was not working well. Referral rates varied significantly between trusts and, overall, district nurses regarded one in ten referrals as inappropriate. They also considered one in five referrals to lack necessary information.
- The lack of systematic caseload profiling meant that patients often remained on the books longer than necessary.
- Staffing costs accounted for between 75 and 80 per cent of expenditure on district nursing, but staffing costs per patient hour varied significantly between trusts.
- Grade-mix varied significantly between trusts, with qualified district nurses accounting for between fewer than 20 per cent to more than 50 per cent of all staff. These differences could not be explained in terms of patient needs.
- The quality of care varied significantly between trusts and often fell below good practice guidelines. For example, patients with leg ulcers should be screened for arterial disease using Doppler ultrasound but, on average, only one-half were and in one trust, as few as 20 per cent of assessments indicated a Doppler score.
- Clinical practice was rarely overseen by trust managers and peers, and fewer than half of district nurses had received clinical supervision in the previous 12 months.
- The number of clinical nurse specialists was often small compared with the number of community nursing staff and, in many cases, they were used inappropriately. In those trusts where nursing staff had ready access to clinical nurse specialists, there tended to be better systems that ensured quality of care – such as condition-specific assessment documentation and guidelines on clinical practice. Staff were also more likely to have received recent training in assessment.
- Methods for seeking user feedback were frequently neither reliable nor robust, and survey questions were such that they elicited responses that were not capable of generating sufficient information to drive operational change.
- Few trusts had asked patients and carers what they wanted from the district nursing service at night and the availability of these services varied between trusts. Thirty-two per cent of trusts had no service
available after midnight. This often resulted in inpatients being admitted unnecessarily to hospitals or nursing homes.

Key recommendations

Health trusts should:

- work with commissioning bodies to define the objectives and role of the service more clearly;
- agree with local social services and others how social care needs will be met and co-ordinated so that users receive care from the appropriate provider at the right time;
- influence and manage demand by improving the referrals process. Trusts should produce criteria for referrals and communicate these to GPs and other potential referrers. Trusts should ensure that the information provided at the time of referral is as complete as possible by developing a clear checklist of the information required. Trusts should also ensure that there is liaison between community and hospital staff in order to review hospital discharge arrangements;
- use systematic and regular caseload profiling, looking at the numbers of patients, frequency of visits, patient condition and other relevant information, in order to encourage patient discharge and transfer them to more suitable services where appropriate, and to better align skills and resources with need;
- improve the quality of assessment by using standardised assessment documentation for specific conditions. These prompt the assessor systematically and comprehensively to seek the appropriate information and ensure that they assess the patient in line with best practice;
- review the role and activity of clinical nurse specialists to ensure that expensive clinical nurse specialist time is used to best effect and ensure that ‘link’ nurses (who disseminate good practice to community nursing staff) have enough time and seniority to perform their role effectively;
- ensure that evidence-based clinical guidelines and protocols are in place and are implemented in practice;
- ensure that adequate arrangements for clinical supervision are in place. Arrangements should be clear to all staff, and supervision should be given by staff with sufficient authority to address weaknesses in clinical practice and to act upon any training needs; and
- review the numbers and mix of staff on duty against patient needs at different times, including out of hours.

Commissioning bodies should:

- work with trusts and other providers of health and social services to define the objectives of the district nursing service more clearly, taking into account the needs and views of patients and carers;
- work with trusts to adopt a more proactive approach to identifying need at the community and practice levels; and
- work with trusts to increase public awareness of what the service can offer and to enable more patients and carers to have direct access to the service.
GP prescribing

Refer to:
A Prescription for Improvement: Towards More Rational Prescribing in General Practice (1994) 018861220, £6

Background

In 1992/93, GPs spent around £3.3 billion in England and £0.25 billion in Wales prescribing drugs for their patients. This accounted for 10 per cent of all NHS expenditure and was almost four times the level of hospital drug expenditure. It also represented an increase of 14 per cent over the previous year’s expenditure.

A series of initiatives to control expenditure on prescribed drugs included the ‘selected list’, increased information provided to GPs on drugs and prescribing costs, target budgets, and incentive schemes. Concerns about increasing expenditure on GP prescribing and also about inappropriate prescribing – for example, the long-term prescribing of medicines such as sleeping pills which can be addictive – prompted the Audit Commission to undertake this study.

A Prescription for Improvement drew upon national data and information gathered from in-depth fieldwork at ten family health services authorities. Interviews were also conducted with nearly 100 GPs and their staff; 6 hospital consultants; 11 hospital pharmacists and their staff; 8 community pharmacists; 8 community health council chief officers; 10 regional health authority pharmacists (with the remainder surveyed by telephone) and a range of other experts from across England and Wales.

Since the publication of A Prescription for Improvement, expenditure on prescribed medicines has continued to increase, albeit less rapidly than at the time of the study. Expenditure on GP prescribing across England and Wales now stands at around £5 billion per year. Some of this reflects an increase in preventative prescribing and the prescribing of new drugs for previously untreatable conditions.

Under current NHS reforms, primary care groups or local health groups and primary care trusts will be set a single unified budget for hospital and community health services, general practice and GP prescribing. As a result, the cost of GP prescribing will have a more direct effect on the resources available to be spent on other services.

Key findings

• The average ‘real’ cost per prescription had increased by 16 per cent, and the number of prescriptions had increased by 30 per cent over the ten years prior to the study. These increases were due to factors such as increasing numbers of elderly people; more treatment in the community; continuing clinical and pharmaceutical developments, increasingly intense marketing by pharmaceutical companies and to hospitals, ‘shifting’ costs to GPs by reducing their own prescribing to out-patients and patients who have been discharged.

• The ‘shifting’ of costs from hospitals to GPs described above was likely to have been more expensive overall, since drug companies often price products to give hospitals greater discounts than those available to community pharmacists. Also, as a consequence, GPs were increasingly being asked to prescribe expensive specialist drugs for infertility, growth deficiency, organ transplantation, chemotherapy, home dialysis and HIV that until recently were prescribed by hospital doctors. Not all GPs had the knowledge, experience or back-up to supervise these treatments safely.

• The study found wide variations, even between neighbouring practices, in the numbers of patients diagnosed as having conditions such as asthma and hypertension. And although most prescriptions were for patients with common, stable and chronic conditions, the drugs used to treat them varied enormously. The study also found wide variations between GPs in the average amount spent per patient.

• There was evidence that some drugs may have been under-prescribed at the time of the study. For example, inhaled steroids, which can reduce the frequency and severity of asthma attacks, can be used in conjunction with bronchodilators to assist the patient during an attack. However, 25 per cent of practices prescribed less than one-quarter of the number of days’ supply of the preventative drug than they did the bronchodilators. Although prescribing these drugs, which cost over 2.8 times as much per item as the bronchodilators, would have increased expenditure at that time by £75 million, it might have proved cheaper for the NHS overall as it would be likely to reduce the need for emergency hospital admission.

Since the publication of A Prescription for Improvement, follow-up work has found an increase in preventative prescribing, with the prescription of inhaled steroids increasing by 20 per cent. However, there is still a need to increase
prescribing of certain medicines. For example, research has demonstrated the benefit of more preventative prescribing in conditions such as heart disease.

Some drugs, however, were found to be over-prescribed. For example, antibiotics were found to be commonly used for the treatment of viral infections where they have no or little demonstrable effect, and ulcer-healing drugs were sometimes being prescribed for inappropriately long periods or for minor symptomatic relief.

Since the publication of *A Prescription for Improvement*, there has been a 33 per cent increase in the use of ulcer-healing drugs, which now cost the NHS £0.5 billion pounds a year. However, in contrast, prescribing of drugs widely agreed to be of limited clinical value has fallen.

- The study identified significant potential savings from GPs prescribing cheaper alternative drugs where possible. For example, it was estimated that using alternative and less expensive drugs, where these were equally suitable, could have saved £110 million. And on a sample of 20 drugs, it was estimated that prescribing cheaper generic versions (where the patent of a proprietary medicine had expired) could have saved £85 million. The study also identified a potential £30 million savings from prescribing modified release and combination drugs only in cases where it was strictly necessary.

Since the study, the percentage of drugs prescribed generically has risen from 45 per cent to over 60 per cent. This change alone would – had prices remained constant since the study – have resulted in savings of £36 million a year. Nevertheless, recent research carried out since the original study suggests that there is still considerable scope for additional economies to be made. Realising these further savings will require greater time and effort by GPs than the changes, such as generic prescribing, have achieved to date. Most doctors are under considerable time pressure and, in the short run, it is usually quicker to prescribe a familiar medicine than to consider alternatives.

Key recommendations

**GPs should:**

- ensure that they prescribe preventative treatments where this is likely to improve patient care and save the NHS money overall;
- avoid over-prescribing and reduce their use of drugs that the British National Formulary has identified as having limited clinical value;
- use cheaper alternative drugs where appropriate; use ‘generic’, rather than patented versions of drugs where it is possible and safe to do so; and make more selective use of expensive format preparations;
- have a policy on what kinds of drugs can be issued on repeat prescription and have guidelines for the issue of repeat prescriptions. GPs should regularly check that repeat prescriptions are still appropriate for patients’ needs;
- examine reasons for any differences between neighbouring practices in levels of diagnosis of common and chronic conditions. Primary care groups, local health groups and primary care trusts will also be well placed to examine the clinical justification for the wide variations in prescribing volumes and choices that persist between GP practices;
- regularly review the principles of prescribing, as well as the relative merits of different drugs. Single practitioners may find it useful to set up local area networks for this purpose. Practice formularies and treatment protocols may help to focus discussion; and
- take longer with patients to reduce inappropriate prescribing and also to improve the information given to patients which may, in turn, act to reduce consultation rates.

**Hospital trusts and GP practices jointly should:**

- ensure that joint hospital and community formularies should be developed and reviewed. These should indicate clearly which drugs are recommended for initiation in general practice. The respective responsibilities of consultants and GPs for initiating medication, subsequent prescribing and periodic review should be clarified, and shared-care protocols developed that take account of cost effectiveness.

**Health authorities (or primary care groups, local health groups or primary care trusts) should:**

- set out a clear vision of what represents rational prescribing and take the lead in providing practices with information and support; and
- ensure that there are well-founded joint hospital and community formularies and shared-care protocols agreed.
Hip fracture in elderly patients

Refer to:
United They Stand: Co-ordinating Care for Elderly Patients with Hip Fracture (1995) 0118864343, £10

See Also:
By Accident or Design: Improving Accident and Emergency Services in England and Wales (1996) 011886436X, £15

Background

The number of people who fracture their hip is rising. In part, this is because the population of elderly people who are vulnerable to hip fracture is increasing. In 1994 there were 57,000 hip fractures a year. However, estimates of numbers of hip fractures expected in 2016 varied from between 60,000 and 117,000. If the worst case resulted, then an additional eight district general hospitals would be needed to cope with the extra demand.

Considerable progress has been made in recent years in the treatment of hip fractures, and almost all can now be repaired surgically. Most patients can walk again within a day or two and be home in a few weeks. But the process of care is often complex, and prompt treatment and effective co-ordination of services are required if it is to be successful, especially for patients who are frail. Inadequate care at any stage can lead to poorer outcomes.

United They Stand examined what happened when patients were first admitted to hospital, described the treatment that patients received and reviewed the process of rehabilitation and the return home. Many of the issues highlighted by the study are also relevant to the care of elderly people with other conditions. The study drew on information gathered from in-depth fieldwork at nine hospitals across England and Wales.

Key findings

- The Patient's Charter states that all patients should have an initial assessment within five minutes of arrival at accident and emergency (A&E). Many hospitals met this target, but patients often then waited for several hours for a full assessment which also tended to delay treatment. Ninety-six per cent of patients waited longer in casualty than the target time of one hour set by the Royal College of Physicians (RCP).

- Ten per cent of operations reviewed by the study team were conducted by both surgeons and anaesthetists of the most junior grades, working without supervision. The RCP recommends that these complex operations should be carried out only by experienced doctors.

- The RCP recommends that the operation is carried out within 24 hours. However, waiting longer than this is not uncommon, with up to 50 per cent of patients in some hospitals waiting more than 24 hours.

- Where there is formal liaison between orthopaedic and elderly care doctors, lengths of stay are shorter and more patients return home.

- The RCN recommends that post-operative care should be carried out by a multidisciplinary team. However, in spite of the clear advantages of a multidisciplinary approach, the study found:
poor referral practices, with therapists (especially occupational therapists) often not seeing patients until they had been referred by doctors and nurses rather than making direct contact in the hospital;

- failures in communication, with the different professionals rarely coming together to discuss plans and progress;

- poor service organisation. For example, in one hospital studied, physiotherapists were linked to consultants who had patients on a number of different wards and, consequently, they found it hard to organise sufficient time with the nurses, occupational therapists and social workers on each ward; and

- inadequate staffing levels, with posts for therapy staff frequently unfilled.

Few hospitals organised rehabilitation well. For example, few hospitals had a range of options to suit both those who were likely to recover quickly and those who were likely to take longer to recover and who would require much more support.

Key recommendations

For hospital trusts

- The orthopaedic directorate should audit the time to surgery for hip fracture patients and investigate reasons for any delay.

- Managers and doctors should identify reasons for any delays in transferring patients to wards and bring A&E, orthopaedic and radiology staff together to review ways of speeding hip fracture patients through the A&E department.

- The orthopaedic directorate should audit the number of operations performed by unsupervised junior doctors.

- Arrangements for ensuring suitable liaison between orthopaedic and elderly care doctors should be clear and unambiguous. Each directorate should share responsibility for establishing procedures, protocols, communication and liaison mechanisms, and for ensuring that they are observed.

- Clinicians and managers should work together to devise a formal multidisciplinary team approach, with joint goals for patients who are undergoing rehabilitation.

- Patients, relatives and carers should be kept informed throughout the process, notwithstanding the need to observe patient confidentiality.

For commissioning bodies

- Commissioning bodies need to specify good practice, and should consider extending it to the care of the elderly with other conditions.
Housing and community care

Refer to:
Home Alone: The Role of Housing in Community Care (1998) 1862400989, £20

Background
Although Home Alone was primarily aimed at housing authorities, it also contained many recommendations of relevance to health bodies and emphasised the preventative potential of housing and support. Housing is an important element in supporting vulnerable people in the community by providing a stable base for independent living and access to other services. Over 1.3 million vulnerable people benefit from housing and support services. These include 450,000 units of sheltered housing; 83,000 units of supported housing; re-housing services; adaptations such as stairlifts and ramps; community alarms; and informal advice and support.

Demands on housing authorities have increased as the stock of social housing has contracted, the number of frail elderly has grown as people live longer, and increasing numbers of people with mental health problems live independently in the community. However, the housing aspects of community care have received relatively little attention and Home Alone was designed to help fill this gap. The report drew upon information gathered from in-depth fieldwork at 14 housing and 5 social services departments, along with surveys of local authorities and providers of supported housing and four focus groups of tenants with mental health problems.

The duty of partnership under the Health Act 1999 should help to ensure that local authorities and health services work jointly to address the issues raised in this report.

Key findings
- Too many resources were locked into crisis management rather than prevention. A tenancy crisis followed by hospitalisation could cost over £5,000 for someone with mental health problems.
- Frail older people and those with physical disabilities were waiting up to two years for routine property adaptations such as stairlifts and ramps.
- The 530,000 units of sheltered and supported accommodation for vulnerable people are not always located where need is greatest.
- Joint working between housing, social services and health is often too dependent on individual initiative, rather than resulting from a systematic framework of shared procedures and processes.
- Current financial arrangements for housing and support are complex and fragmented and do not encourage the best use of public money.

Key recommendations
Local authorities and health agencies should:
- establish a joint vision and common objectives for housing and community care services across agencies;
- jointly map current needs and resources to provide information for strategic decision-making;
- ensure that there are strategies in place to address housing and community care issues;
- develop effective joint working on a day-to-day basis to eliminate gaps and overlap in support; and
- ensure that appropriate performance measures are used to monitor housing and community care services.

Central government should:
- develop a national strategy to meet the housing and support needs of vulnerable people living in the community; and
- consider reforming the funding framework.
Maternity services

Refer to:
First Class Delivery: Improving Maternity Services in England and Wales (1997) 1862400237, £15
First Class Delivery: National Survey of Women’s Views of Maternity Care (1997) 1862400652, £6.99

Background

Maternity services provide care for women and babies during pregnancy, during labour and childbirth, and post-natally. They are provided by a range of professions in primary, community and secondary care settings. In 1994/95 these services provided care for around 650,000 women and their babies at a cost of around £1.1 billion.

Recommendations set out in the Changing Childbirth report (1993) were endorsed by government which, through the NHS Priorities and Planning Guidance, required maternity services in England to implement them. In Wales, policy on maternity services is based upon The Protocol for Investment in Health Gain Maternal and Early Childhood Health (1991) and The Maternity Service Review (Wales, 1996). Both policies prioritise a ‘woman-centred’ approach, which places equal emphasis on clinical effectiveness, efficient use of resources and the experiences and views of service users.

First Class Delivery examined the phases of maternity care from these three different perspectives, examining effectiveness in clinical practice; efficiency of service provision; and women's views of their care. The report drew upon information gathered from in-depth fieldwork at 13 health trusts; a survey of 2,375 recent mothers; shorter visits to 12 health authorities and a survey of 300 general practitioners across England and Wales.

Key findings

- Many women would prefer community ante-natal care provided by midwives and general practitioners rather than ‘obstetrician-led’ care based in hospitals. And community-based care is likely to be significantly less costly than hospital-based care.
- The extent to which obstetricians see women with uncomplicated pregnancies varied from not at all to four or more contacts. In uncomplicated cases, there is no evidence to suggest that higher levels of contact result in health benefits for the mother or baby, although they do increase the likelihood of hospital admission.
- Many hospital trusts routinely offered more ante-natal checks than necessary. The Audit Commission estimated that the annual cost of the pattern of ante-natal checks found by the study was £10 million more than would be required were a reduced pattern of checks to be implemented, such as that recommended by the Welsh Office in The Protocol for Investment in Health Gain Maternal and Early Childhood Health (1991).
- Care during labour was found to be lacking in continuity and provided by too many different professionals.
- Variations in practice in different areas, and high levels of some procedures across the country, suggested that some interventions were being carried out unnecessarily.
Although health trusts may have ensured that clinical practices are based on the best available evidence, they may have placed less emphasis on ensuring that childbirth is a satisfying experience for the mother and baby. In addition to improving women's experiences of care, scientific evidence suggests that emotional support is likely to reduce the need for medical intervention.

Women made more negative comments about postnatal care than any other aspect of maternity care. In particular, many women found that information on infant feeding was conflicting.

Hospitals varied considerably in the ways that they organised post-natal care, and how much they spent on it. The time spent in hospital after giving birth, too, varied significantly between different hospitals.

In some cases, sick babies were admitted to a special neo-natal unit. Staffing and staff skills, however, were found to be variable in these units and, in some cases, parents felt excluded and found it difficult to be involved in their baby's care.

Women felt that they lacked information about their options for care to assist them in making informed choices.

Key recommendations

Health trusts should:

- develop maternity policies. These should take women's needs and views into account, clarify the objectives of all stages of maternity care and contain monitored standards. Health trusts should use such policies to inform the planning of staff, facilities and equipment;
- provide women with appropriate and consistent information on the services that are available during all stages of the maternity care process;
- review the staffing and skills mix needed at all stages of maternity care and ensure that the skills available at clinics and elsewhere are appropriate and not duplicated;
- provide ante-natal support in a way which is specific and appropriate in each case, and which takes the woman's wishes into account, with as much support provided in the community as possible;
- review the number of ante-natal checks carried out. Ante-natal care should be targeted on women with complex needs while ensuring that a minimum recommended number of checks is available to all women;
- fully involve women in decisions made during labour – for example, on pain relief – with continuous support by a minimum number of professional staff;
- ensure that surgical interventions in labour are kept to a minimum, as these are distressing to the mother and are expensive. Better collection of data on interventions would assist in this, with peer review and clinical audit of the figures and practices;
- ensure appropriate staffing levels and skills mix in neonatal units. Where activity levels are insufficient to sustain adequate medical and nursing skills, trusts should consider stopping the provision of long-term specialist intensive care services as part of strategic planning at the regional level; and
- make sure that babies are admitted to neonatal units only where necessary, and that appropriate support is provided so that parents can visit their babies and be involved in their baby's care.

Commissioning bodies should:

- work with GPs and trusts to improve the oral and written information available to pregnant women about their care, including determining who will provide it, where it will take place and what it will involve;
- actively involve women who use local maternity services and health professionals in helping to determine priorities;
- work closely with GPs, trusts and neighbouring authorities to plan services;
- take the lead in determining the kinds of ante-natal screening and scanning that will be available;
- ensure that agreements are specific so as to reduce duplication between GPs and trusts and ensure that specialist services are effectively targeted;
- define the data that they require trusts to collect on neonatal activity, along with a clear requirement for the ongoing audit of admission rates; and
- utilise the British Paediatric Association (BPA)/ British Association of Perinatal Medicine (BAPM) standards in the contracting process

The NHS Executive and NHS Directorate for Wales should:

- support research into efficient and effective ways of meeting women's needs for information about services;
- develop a framework for local policies on ante-natal screening and scanning;
- support research into cost-effective post-natal care;
- support research into organisational, as well as clinical, aspects of maternity care;
- support the dissemination of evidence-based information to health professionals and service users; and
- take steps to improve national maternity care data, including key indicators of case-mix.
Mental health services for adults

Refer to:
Finding A Place: A Review of Mental Health Services for Adults (1994) 0118861433, £11

Background

Each year, about one-quarter of the population consult their GP with a mental health problem such as anxiety or depression. Most of these individuals recover over a period of weeks or months with help from their GP, family and friends, but around one in ten receive specialist care from mental health professionals.

Mental health policy has changed considerably over the years. For many years there was more emphasis on providing care in large remote hospitals, but now the aim is to provide most people with a range of community services, supported by hospital care only when necessary.

Mental health services had been receiving renewed attention at the time of the study, due to the inclusion of mental health as a key area in the Government’s public health strategy and because of concern over the adequacy of community care.

Since Finding A Place was published, the Department of Health has published a White Paper, Modernising Mental Health Services: Safe, Sound and Supportive (1998). This sets out new proposals for mental health services in England, including plans to invest £700 million in mental health services over a three-year period and to establish national service frameworks setting out detailed service models and performance standards. The White Paper places a new emphasis on partnership between the different agencies involved in providing services to those with mental health problems, and the 1999/2000 National Priorities Guidance gives joint responsibility to health and social services for mental health services provision.

In Wales, there are plans to review the All-Wales Mental Health Strategy (1989), which continues to provide the framework for the provision of services to those with mental health problems, and to develop national service frameworks setting out detailed service models and performance standards. There are also plans to develop a separate strategy for child and adolescent mental health services.

Finding A Place considers services for adults with mental health problems. It does not address services for children or the elderly, or specialties such as drug or alcohol abuse services. The Audit Commission, however, will be publishing a report on child and adolescent mental health services during the autumn of 1999. Finding A Place drew on information from in-depth fieldwork at 12 health authorities and a survey carried out by auditors in 90 NHS trusts covering England and Wales.

Key findings

- Local needs varied fourfold between health authorities using the Jarman index of deprivation, but resources were not distributed in a way that reflected this.
- The needs of individuals suffering mental health problems were wide ranging, and required a co-ordinated response from a wide range of agencies. Poverty and poor housing, for example, were common among people with mental health problems and were high priorities for users. However, these were often overlooked by professionals, who tended to focus on treatment and therapy.
  - The Care Programme Approach, where a single plan sets out the contributions from each service and a single worker keeps in touch with the individual and makes sure that all elements of the plan are implemented, was introduced in 1991. However, this approach was not implemented in all areas.
  - Health authorities spent the bulk of their resources, an average of 66 per cent, on hospital beds. However, beds were not targeted effectively on those with the most severe mental illness. It was estimated that by using beds more selectively, £100 million (1994 prices) could have been released for community-based services.
  - Community-based services were patchy and under-resourced. However, they were favoured by users and carers and, where effective, could help to prevent the need for admission to acute care.
  - Community mental health teams varied significantly in the degree to which they prioritised those with the most severe problems. And, once on the caseload, people with more severe problems were not necessarily seen any more often than those with lesser needs, even though they were likely to have benefited from more frequent contact. If all teams had focused their efforts on people with severe and long-term problems to the same extent as the top quartile in the study sample, almost one-fifth more people with serious mental illness could have been provided with services, and those already on the caseload could have been provided with better care.
Primary care teams were not adequately supported to provide care for those with less severe mental health problems. For example, most practice nurses see mental health work as part of their role but do not feel adequately trained for it. Primary care services have the advantage of not carrying any of the stigma of specialist mental health services, are locally accessible and can provide continuity over a long period of time. They also have an important role in suicide prevention. Most of those who commit suicide have contacted their GP within the previous month.

An extra 6,000 community places could have been provided (at a cost in 1994 of £40 million) through savings released by matching the level of support in staffed accommodation to the needs of residents.

Key recommendations

For commissioning bodies

- Flexible and responsive community services, providing a combination of practical help, social care and treatment, are vital. Commissioning bodies should work with health providers, social services, housing, the criminal justice system, providers of education and employment services, users and carers and other voluntary or interest groups to establish clear strategic plans for mental health services.

For commissioning bodies and mental health service providers

- Purchasers and providers should make better use of local information on needs to distribute resources and to work out the appropriate mix of community and hospital services required.

For mental health service providers

- Providers should establish that those with a severe mental illness are the service’s priority and work with local teams to define the criteria for receiving a specialist service, in hospital and in the community. Management arrangements for community professionals should incorporate caseload monitoring and review.

- Hospital and community services should be managed as part of an integrated system. The community mental health team should be the focus point for assessment, through which access to other services is obtained. Providers should appoint clinicians, especially psychiatrists, to work across both hospital, community-based and, ideally, multi-agency provision to help ensure continuity of approach.

- The Care Programme Approach should be developed jointly between agencies and should dovetail with care management in social services. Clear criteria need to be established to define those entitled to receive a care programme. And the system needs to be monitored to check that care programmes are being implemented as planned.

- Hospital care should be reserved for those with the most serious problems, and criteria for admission should be agreed locally.

- Providers should review their use of 24-hour staffed housing to determine its adequacy. The intensity of support should be reduced where it is not justified by levels of dependency.

- Provided that advice and assistance is available when needed, GPs and primary care staff should be encouraged to take responsibility for people on their list with long-term needs for mental health care, and should participate in care programmes.

For NHS Executive and NHS Directorate for Wales

The report recommended that central government review the way that it allocates resources for mental health services across different areas and between social care and health to reflect local need. The Department of Health expects that, in England, the Government’s new proposals will help to address existing inequities. In Wales, it is likely that the review of the All Wales Mental Health Strategy (1989) and other reviews of the NHS in Wales, will result in revised funding arrangements for mental health service provision.
Background
Pathology is a clinical service, which carries out investigations on specimens from patients as an aid to the diagnosis, management and treatment of disease. Over the years the practice of pathology has become steadily more diverse and complex, with the number of requests for investigations growing steadily and the range of diagnostic tests increasing.

The Pathology Services and Critical Path studies examined the management challenges facing pathology services and provided advice on how pathology services could be managed more effectively. The Pathology Services drew on information gathered from in-depth fieldwork at ten health authorities across England and Wales. Critical Path reported the findings from the local audits that followed the publication of the original report.

Key findings
- There was evidence that different doctors, presented with similar patients, made different demands upon pathology services. Some may have been under-exploiting the potential of the service, while others were almost certainly using resources wastefully.
- Users of pathology services reported a high level of satisfaction with the accuracy of results and the technical standard of support provided.
- There were often delays in getting samples from the user to the laboratory, and getting the results back to the user, because of problems with transport arrangements. In many cases, pathology laboratories had no responsibility for or control of the transport of specimens and reports.
- Management of resources within laboratories was poor. Although accounting systems monitored expenditure, there was no way to relate this to usage. However, the costing model developed for the study showed very significant variations in productivity and costs per test.
- General managers lacked an understanding of the cost-drivers behind rising budgets for pathology services.

Key recommendations
For hospital trusts
- Guidelines and protocols governing pathology requests should be issued. Robust ways to monitor demand and feed price and demand information back to other clinicians should also be developed, so that clinicians can compare their use of pathology services with their peers. Personal contact between laboratory and clinical staff should be promoted to improve the management of demand and ensure that laboratory services adapt to meet changing needs.
- There should be better management of the transport links to and from laboratories. Laboratories should be given responsibility and devolved budgets for transport and be held accountable for performance. Perhaps with pathology laboratories managing the transport element directly.
- Better information systems need to be established, especially with regard to unit costs, to allow managers to identify areas of high cost. However, analysis of costs should be carried out in the context of the whole trust, so that costs are not reduced if, as a consequence, they will then increase elsewhere in the trust.
- Laboratories should be given greater control over their own resources, with the ability to develop within general objectives.
- External managers need to set budgets, agree objectives with laboratories and monitor outputs, rather than restrain inputs.
Radiology services

Refer to:

Background
Hospital radiology departments provide a wide range of diagnostic services (as distinct from radiotherapy treatment, which was not addressed in the report). Radiological techniques can be used to:
- establish a diagnosis;
- assist in treatment by minimising the degree of intervention; and
- monitor patients’ post-operative progress.

This century has seen radiology expand from plain-film X-rays to increasingly sophisticated technologies: fluoroscopy, ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI). Much of the equipment used in these techniques is very expensive: asset values are often significantly larger than annual revenue budgets.

Radiology services in England and Wales cost around £600 million in 1993/94 – and there is always scope for investing further in new equipment to take advantage of new technologies. Such large sums necessitate tight budgetary and asset management to make sure that radiology services are provided cost-effectively.

Improving Your Image drew upon information from in-depth fieldwork at 9 NHS trusts and from pilot audits at a further 8 NHS trusts, a survey of 950 clinicians and interviews with approximately 80 patients across England and Wales.

Since Improving Your Image was published, the Government has produced an information strategy which envisages using a new NHS electronic superhighway for radiology requests and results within the next five years. This is likely to affect the way that radiology services will be organised in the future.

Key findings
- Workload had grown, on average, by 5 per cent a year since 1970.
- It was estimated that 20 per cent of the X-ray examinations carried out were unlikely to be of benefit to patients. These unnecessary X-rays cost the NHS at least £20 million annually, and increased radiation health risks.
- There were variations of up to 30 per cent in unit costs of staff, consumables and equipment between similar radiology departments. It was estimated that if all the departments that spent above an expected level (identified through the Audit Commission’s cost diagnostic) were to reduce their spending to this expected level, around £30 million could have been saved each year.
- Most patients were happy with their experiences in radiology departments. However, although only a minority of patients complained of long waiting times or of not being given adequate information, the consequence for those that did was often added anxiety.
Although hospital clinicians had a high level of satisfaction with those aspects of radiology services that were, in their view, of the greatest clinical importance, they were less satisfied with the time taken to provide reports of their patients' examinations.

Full use of all equipment keeps costs down, yet it was not unusual to find rooms occupied for less than half a working day. And, in many departments, the distribution of workload throughout the day was uneven, which contributed to poor asset utilisation. The distribution of workload was affected by inpatients arriving in large numbers in the late morning, the scheduling of out-patient clinics and the arrival of GP referrals on a walk-in basis.

Radiographers' productivity and the mix of radiographer grades varied significantly between trusts. Some of this variation was due to the characteristics of the sites, but much was unexplained and had a substantial effect on cost differentials between trusts.

Limited investment over many years had left many departments with cramped accommodation for patients and equipment, which was awkward to use and difficult to adapt to changing demands and new equipment.

**Key recommendations**

**For hospital trusts**

- Directors of radiology should publicise Royal College of Radiologists referral guidelines to hospital clinicians and GPs, agreeing any local modifications. Compliance with referral guidelines should be monitored as part of the clinical audit programme.
- Managers should establish service level agreements as a way of clarifying what hospital departments and GPs want and expect from the service and what the service can realistically provide. These should cover the volume of work attainable, the type of work and the quality of service.
- 'Hot reporting' – sending patients back to their clinician with a copy of their results – should be explored as a way of reporting results more quickly (although results may be transferred electronically in future under the Government's information strategy).
- Trusts should reduce the variation in workload by influencing patients' arrival patterns wherever possible.
- A systematic review of staffing and skills should be carried out. Trusts may adjust radiographer staffing more closely to the workload by employing part-time staff and bank radiographers.
- Where necessary, trusts should adjust the opening times of rooms to match levels of demand.
- Trusts should ensure that they have an advance capital programme that predicts likely future demands for new equipment and the need to replace obsolete equipment. Advice and support should be given to managers where private finance may need to be considered.

**Trusts should reduce the variation in workload by influencing patients' arrival patterns wherever possible.**
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The compendium is aimed primarily at NHS trusts and commissioning bodies, but will also be of interest to GP practices and local authority social services departments. Although there are no specific recommendations for primary care groups, local health groups and primary care trusts (since they did not exist when the reports were originally published), these new bodies will be interested in much of the good practice that is set out in the summaries.