Can we monitor the NHS plan?

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In *The NHS plan*, published in July 2000, the government set out a programme of investment and change 'to give the people of Britain a service fit for the 21st century'. (Department of Health, 2000a) It went on to say:

'The March 2000 Budget settlement means that the NHS will grow by one half in cash terms and one third in real terms in just five years. This will fund extra investment in NHS facilities...

7,000 extra beds in hospitals and intermediate care
over 100 new hospitals by 2010 and 500 new one stop primary care centres
over 3000 GP premises modernised and 250 new scanners
clean wards - overseen by 'modern matrons' - and better hospital food
modern IT systems in every hospital and GP surgery

... and investment in staff

7,500 new consultants and 2,000 more GPs
20,000 extra nurses and 6,500 extra therapists
1,000 more medical school places
childcare support for NHS staff'

The document went on to make further promises, including shorter waiting times and, 'by 2004 a £900 million package of intermediate care services to allow older people to live more independent lives.' Despite the allusion to Britain, the *NHS plan* applied only to England, but similar documents have also been published with plans for Scotland, Wales and Northern Ireland.

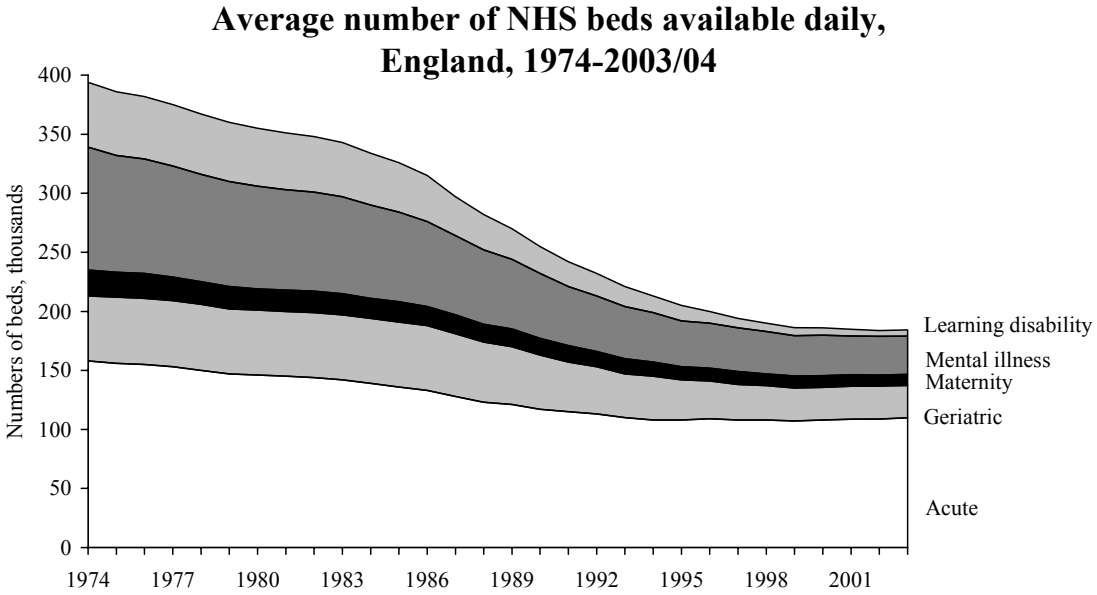
In England, a further document, *Delivering the NHS plan*, published in October 2002 set targets to be met for the NHS and social services to be met by 2008. (Department of Health, 2002a) Meanwhile, a plethora of documents issued by the Department of Health, the Treasury and the Prime Minister claim that the government is well on the road to meeting its targets. Verifying these claims is not easy. The baseline years change and so do the methods of compiling the data and the definitions used.

This article, based on a talk given at the February 2004 Radical Statistics conference, looks at the problems inherent in measuring progress towards a few of these targets and at the impact of privatisation on the data available.

More hospital beds?

The target of 7,000 more beds by 2004 in hospitals and intermediate care was modest, given the massive decline shown in Figure 1. Although much of the decrease was a result of the running down of long stay hospitals for people with mental illness or learning difficulties, there was also a decrease in acute and geriatric beds, described as 'general and acute' beds when the two categories are combined. The target in *The NHS plan* was for an increase of 2,100 general and acute beds and 5,000 intermediate care beds by 2004. (Department of Health, 2000a)

Figure 1



Source: DHSS and DH statistical bulletins 5/85, 1995/20, 1997/20 and 1998/31and KH03 1998/99 - 2003/04.
Graph by Alison Macfarlane

Data about bed availability in England are collected from NHS trusts through the KH03 statistical return and relate to the average number of beds available on each day of the period reported, usually a financial year. Data are published on the Department of Health web site. The average number of general and acute beds available daily decreased by 29,386 from 166,901 in the financial year 1989/90 to 138,047 in 1996/97, the financial year before the change of government. There was a further decrease of 5,435 to 135,080 in

1999/2000. After this, the overall numbers rose by 2,197 to 137,277 in 2003/04. Thus the target appears to have been met, although this needs to be set in the context of an overall decrease since the government came to power in 1997.

The more detailed analysis by ward type in Table 1 shows a slightly different picture, however. In the general and acute category, there were decreases in beds available for younger physically disabled people, children and older people and increases in beds for intensive care as well as for 'other' general and acute, the largest category. The increase in beds for adult intensive care are likely to be related to the target set in *The NHS plan* for a 30 per cent increase in critical care beds 'over the next three years'.

On the other hand, the numbers cannot be compared directly as data on critical care beds are compiled on a different basis. 'Snapshot' censuses are taken twice yearly using return KH03a. Data published on the Department of Health web site show that the numbers of beds in use as critical care beds rose by 990 from 2240 on 31 March 1999 to 3160 on 15 July 2004. This could well have contributed to the increase in intensive care beds and hence to the overall increase in 'general and acute' beds.

In contrast with acute beds, the availability of other types of hospital bed in England declined over the years 1999/00 to 2003/04, as Table 1 shows. The numbers of maternity beds declined by 894. The numbers of beds for people with mental illness or learning disabilities declined by larger amounts. Although this is line with policies in running down long stay institutions, the numbers of short stay beds for people with mental illness also decreased, as did the much smaller numbers of short stay beds for people with learning disabilities. In both cases, there were increases in numbers of beds in secure units.

Overall there was a decrease over the period 1999/00 to 2003/04 in the average numbers of beds available. To what extent have these been replaced by more appropriate facilities elsewhere?

Table 1, Average number of beds available in England, 1999/00 and 2003/04

Ward type	1999/00	2003/04	Difference
General and acute			
Intensive care: neonates	1,534	1,491	-43
Intensive care: paediatric	282	239	-43
Intensive care: wholly or mainly adult	2,531	3,283	752
Terminally ill / palliative care: wholly or mainly adult	457	386	-71
Younger physically disabled	1,176	914	-262
Other general and acute: neonates and children	9,807	9,191	-616
Other general and acute: elderly: normal care	26,243	25,557	-686
Other general and acute: elderly: limited care	1,619	1,874	255
Other general and acute: other	91,430	94,343	2,913
Acute	**107,217**	**109,846**	**2,629**
Geriatric	**27,862**	**27,431**	**-431**
General and acute, all	**135,079**	**137,277**	**2,198**
Maternity	**10,203**	**9,309**	**-894**
Mental illness (excluding residential care)			
Secure unit	1,882	2,557	675
Short stay	21855	21,233	-622
Long stay	10435	8,620	-1,815
Mental illness, all	**34172**	**32,410**	**-1,762**
Learning disabilities			
Secure unit	404	514	110
Short stay	1,628	1,440	-188
Long stay	4,802	3,258	-1,544
Learning disabilities, all	**6,834**	**5,212**	**-1,622**
Total for all wards	**186,290**	**184,207**	**-2,083**

Source: Department of Health KH03 returns

In addition, a further bed availability target to be met by 2008 was set in *Delivering the NHS Plan*, published in 2002. This announced that 'The extra investment will allow us to plan for an increase in treatment capacity equivalent to over 10,000 extra beds.' (Department of Health, 2002a) It is unclear to what extent this target would be met through actual expansion. The report suggested that increasing the proportion of operations done as day cases to 75 per cent would add an equivalent of an extra 1,700 general and acute beds. Added to this would be 'an additional 42 major hospital schemes mostly delivered through the PFI with 13 more schemes under construction', but this ignores the fact that PFI hospitals tend to be smaller than those they replace. An expansion of fast-track 'Diagnostic and Treatment centres' was also mentioned. As many of these would be run by the private sector, their capacity would not appear in NHS statistics.

Monitoring the private sector

This is part of the larger problem of the lack of data about private sector care, although the countries of the UK vary in the extent to which they collect these. In England, data about private nursing homes, hospitals and clinics were collected by the Department of Health as part of the process of inspection under the Registered Homes Act, 1984, and published in an annual Statistical Bulletin. The last such Bulletin, presenting data for 31 March 2001, showed that the numbers of beds in general nursing homes had declined from 165,836 in 1998 to 144,068 in 2001, while the numbers of beds in mental nursing homes had increased from 28,660 to 31,944 and numbers of beds in private hospitals and clinics had oscillated around 11,000. (Department of Health, 2002b)

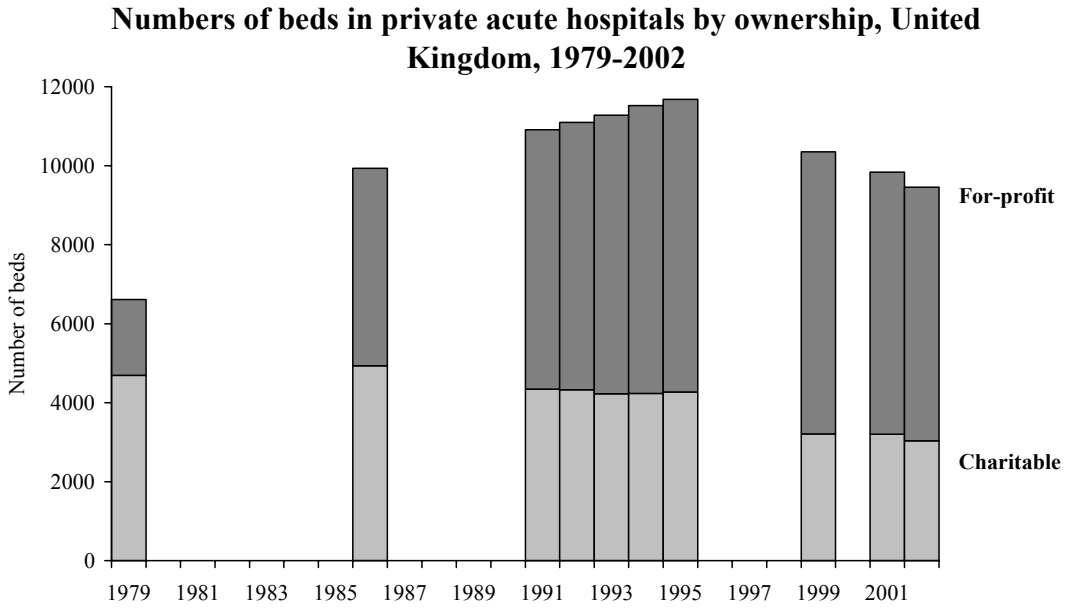
On April 1 2002, responsibility for regulation of private nursing homes and hospitals, along with that of residential homes, passed to the National Care Standards Commission. In March 2004, it published a volume of data about residential and nursing homes. (National Care Standards Commission, 2004) No further data have been published about private acute hospitals, regulation of which became part of the responsibilities of the Healthcare Commission from April 1 2004, when the National Care Standards Commission was abolished and the Commission for Social Care Inspection took on responsibility for residential and nursing homes.

The main source of data about private health and social care is the series of detailed publications produced by Laing and Buisson. Unlike

Department of Health statistics, which are available free of charge on its web site, only headline figures feature on Laing and Buisson's web site. The volumes themselves are sold at a substantial cost, as their function is 'market intelligence'. The 2003-04 edition of Laing and Buisson's flagship publication, Laing's Healthcare Market review, (Laing and Buisson, 2003a) cost £280 and some of its other publications cost over £500.

Figure 2, based on incomplete data from this and earlier sources, shows that while there was an expansion of capacity in the private acute hospitals in the early 1980s, it has tailed off since then. Recent trends reported by Laing and Buisson suggest that the demand for private health care funded by individuals or private health insurance has been sustained. The government's policy of using NHS funds to buy care in the private sector is getting a lukewarm welcome from private providers. This is because 'there are doubts over whether existing private hospitals will find NHS tariff prices sufficiently attractive'. (Laing and Buisson, 2003b)

Figure 2



Source: Independent Healthcare Association up to 1995, data for 1999 onwards from Laing and Buisson web site

On the other hand, the picture is different for mental illness. In 2003 Laing and Buisson reported in a press release on its web site that 'Mental health services are the fastest growing sector of independent healthcare as NHS agencies increasingly outsource acute psychiatric care, albeit

unwillingly, due largely to extreme shortages of NHS in-house psychiatric inpatient capacity. ... NHS (and local authorities) now fund about two thirds of patients in independent psychiatric hospitals, with virtually all this 'spot' purchasing.' (Laing and Buisson, 2003b)

Intermediate care beds

Intermediate care beds were a new concept arising out of the report of the National Beds Enquiry, published in 2000. (Department of Health, 2000b) The NHS Plan included: 'by 2004 a £900 million package of new intermediate care services to allow older people to live more independent lives'. The provision of intermediate care is Standard 3 of the National Service Framework for Older People, published in March 2001.

The Department of Health has described intermediate care as:

'an umbrella term used to describe a range of short-term treatment or rehabilitation services, with appropriate care support, designed to promote independence, particularly for older people. It is provided in a variety of settings, ideally in homely environments or in people's homes. Typically, these services aim to:

> Reduce the number of people going into hospital unnecessarily
> Reduce the length of time people stay in hospital unnecessarily following treatment when they are able to return home, and provide services designed to ensure they are able to cope independently again (both physically and emotionally) as soon as possible
> Ensure admission to long-term care (in nursing homes or residential care) only takes place when and if necessary'.

As part of this, the NHS Plan stipulated that there would be '5,000 extra intermediate care beds, some in community or cottage hospitals, others in specially designated wards in acute hospitals. Some will be in purpose built new facilities or in redesignated private nursing homes'. In addition, it stipulated that there would be 1,700 extra non-residential intermediate care places.

Data about the extent to which these are being provided are collected through the Department of Health's system of Local Delivery Plan Reporting. These data are provided by the NHS to the Department of Health. They are management information provided to the Department

of Health for its internal use. As such, they are not covered by the National Statistics Code of Practice and are not routinely published.
The instructions to primary care trusts about how to report total numbers of intermediate care beds define them in the following terms:

> 'Such figures would reflect the residential rehabilitation model of Intermediate Care, and may be either 'step down' (following stay in acute hospital), or 'step up' (referral by GP, Social services or 'Rapid Response' teams in cases which would otherwise necessitate acute admission or admission to longer term residential care.
>
> On the principle of fitting in with capacity planning and SaFFs we need to think in terms of 'whole time equivalents'. Calculating the bed capacity provided can be done by adding up the beds commissioned, ensuring that they are year round provision. If additional beds are commissioned for 6 months of winter, these can be pro rata for the year,
>
> e.g. 10 permanent beds + 10 extra for 6 months = 15 beds per year
>
> If spot purchasing, then add up the bed days commissioned or calculate the overall capacity with the resource available. Beds provided by Social Services in a Local Authority residential home, with input from dedicated health staff for rehabilitation, are NOT NHS beds unless they are fully commissioned/funded by the NHS. If only the healthcare professionals providing the rehabilitation are funded by health, these do not constitute health beds.'

The Statistical Supplement to the Chief Executive's Report to the NHS published in December 2004 includes data for intermediate care beds. The number available daily increased by 4,455 from 4,242 in 1999/00, the first year for which data were collected, to 8,697 in 2003/04, suggesting that the government had nearly met its target of 5,000 new intermediate care beds. What is unclear, however is whether there was any element of double counting, as intermediate care beds are not identified in the KH03 return. The numbers of intermediate care beds were reiterated in November 2004 in two documents reporting progress with the National Service Framework for Older People. (Department of Health, 2004c, 2004d)

As data about private acute hospitals and homes are no longer publicly available, it is not known how many intermediate care beds they contain. The data about residential and nursing homes published by the National Care Standards Commission (2004) did not identify intermediate care

beds. The publication also warned that changes in the regulatory system made direct comparisons with earlier data difficult.
In the absence of consistent and publicly available data, it is therefore impossible to assess whether the government has met its target for intermediate care beds.

More community care?

An important aim of intermediate care policies is to keep people from going straight from hospital into long-term care. Linked to this, the *NHS plan* aimed to enable 50,000 more people to live independently at home through additional home care and other support. (Department of Health, 2000a) A target was set to increase the proportion of people receiving intensive home care as a proportion of all people receiving intensive care at home or in a residential setting. The first target was to increase this to 30 per cent by March 2006 but a new target has been set to increase this to 34 per cent by 2008. (Department of Health, 2004d)

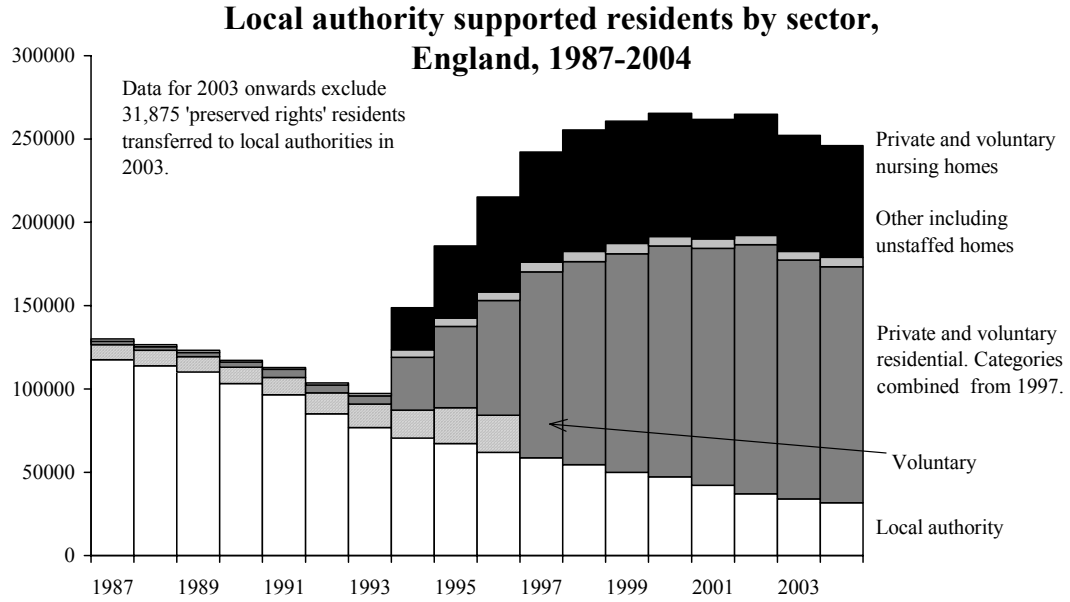
The impact of these policies is difficult to evaluate because of inconsistencies and gaps in the data about long term care and care in the community. The situation up to 2000 was documented in Nick Miller and Robin Darton's chapter in 'Facing the figures'. (Miller and Darton, 2000) In this the authors expressed the hope that the establishment of the National Care Standards Commission would provide an opportunity to introduce more consistent data collection but this appears to be wishful thinking. As mentioned above, changes in regulation added to the inconsistencies in data about facilities in residential care and nursing homes.

Unlike the Department of Health, the National Care Standards Commission focussed on the capacity of care homes and their ability to reach predetermined standards rather than the characteristics of occupants. In contrast to this, the Referrals, Assessments and Packages of Care (RAP) system was established to collect data about types of care offered to individual clients. It was established in 2000/01 after a dress rehearsal in 1999/00 and still has problems with non-response and data quality. (Department of Health, 2000e)

The Department also collects data about numbers of care home residents supported by local authorities. As Figure 3 shows, their numbers increased after the introduction of community care policies in 1993, but

have decreased since 2001, in line with more recent government policies. (Department of Health, 2004f)

Figure 3

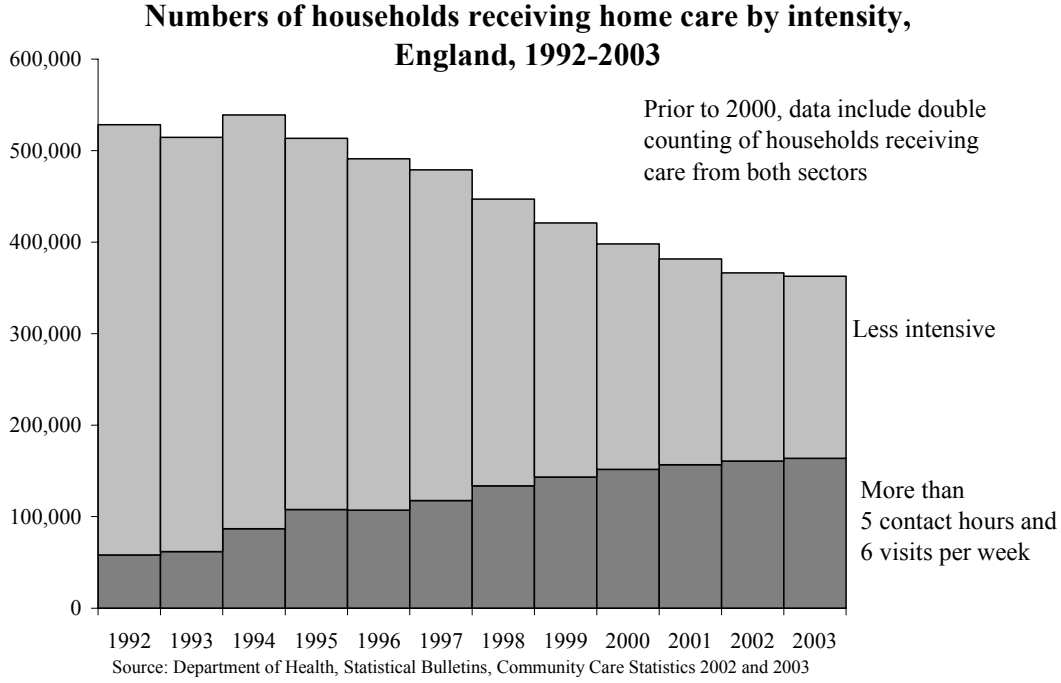


Source: Department of Health statistical returns. Graph by Alison Macfarlane

Not surprisingly, trends are less clear than they might be because of changes in definition. The distinction between private and voluntary homes was dropped in 1997. In April 2002, financial responsibility for support for 31,875 residents, who previously had 'preserved rights' to higher levels of income support from the Department for Work and Pensions was transferred to local councils. (Department of Health, 2003a) They have been excluded from Figure 3, to show the underlying trends.

The Department of Health also collects data from local authorities about home care services, formerly known as home help services and publishes them on its web site. Councils are increasingly contracting with private providers rather than employing the staff themselves. (Department of Health, 2004g) Figure 4 shows that the increasing numbers of people receiving intensive home help consisting of at least five hours or six visits per week has been offset by declining numbers receiving less intensive help and that overall numbers have decreased.

Figure 4



These data are expressed simply as numbers in documents related to the NHS plan and the National Service Framework for older people, with no discussion about how they relate to the needs of the population. In the set of Social Services Performance Assessment Framework Indicators, they are expressed as rates per 1,000 population, however. (Department of Health, 2003a) This reveals wide differences between councils. For example, councils in rural areas are much less likely to provide intensive home care than councils in urban areas and the differences persist after adjustment is made for indices of need. Thus even if targets are met nationally, this may not have much meaning locally.

Can we monitor the NHS plan?

These examples relate to just a tiny subset of targets in the *NHS plan.* They show how organisational changes and privatisation lead to changes definitions and methods of data collection, making it difficult to monitor trends over time. While some data and accompanying data definitions can be found on the internet, others are not publicly available and others are designated as 'management information'. Such information may be available on request but is not routinely published. To make it possible to monitor the government policies in *The NHS plan*, greater openness

and accountability are needed. It remains to be seen whether the Freedom of Information Act will have any impact on this unsatisfactory situation.

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