100 Ways Tories have failed the NHS
- with evidence supplied -

Page

GP Services

1. The number of unfilled GP posts has nearly quadrupled in 3 years (2.1% in 2010 to 7.9% in 2013) (evidence)

2. England's GP to Patient ratio has worsened by 4% as population increases and unfilled GP vacancies grow (evidence) Internet connection required to view this evidence

3. Of 27 EU Countries, the UK is ranked 24th for the number of working doctors it has per head of population (just 2.71 per 1,000 people) (evidence & evidence)

Internet required

4. 518 GPs surgeries have closed or merged under the Tories. The rate is accelerating with 90 closing in the first 5 months of 2014 (evidence)

5. GPs spend cash more efficiently than any other part of the NHS. It is sheer folly that the Tories have delivered a real terms funding cut of £987m to GPs (evidence)

6. Despite Cameron's promise that he will extend GP opening hours to 7 days a week, the number of GPs surgeries offering extended opening hours actually declined by 5.7% (or an extrapolated 477 surgeries) in just 1 year to 2012 (evidence & evidence)

A&E Services

7. Performance at England's A&Es has fallen to its worst levels since January 2004 (evidence & evidence)
Excel file

8. 4 million A&E patients have been kept waiting more than 4 hours under the Tories since Cameron became PM, a near tripling on a weekly basis (evidence) Internet required

9. Despite promising voters that no local NHS service would close without public consultation, 66 A&E and Maternity Wards have been closed or facing closure as a result of Tory Cuts (evidence)

10. The Tories scrapped Labour's 98% target at England's A&Es. This corresponded with an immediate deterioration in A&E waiting times (evidence & evidence)
Excel file

11. The Tories have shut or downgraded 1/3 of NHS Walk In Centres releasing up to 2million patients a year back in a struggling A&E system (evidence)

12. 16% of A&Es all types have closed since 2010 (evidence & evidence)
Excel file Excel file

13. The North East of England was completed ignored when extra cash was apportioned to deal with the A&E Crisis (evidence)

14. Avoidable admissions of over 75s presenting themselves at A&Es is up 34% since 2008 putting untold pressure on our A&Es (evidence)
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Waiting Lists

15. The number of emergency operations cancelled for a second time has climbed 42% in the most recent year compared to 2010-11. The number of cancelled operations, overall, appears to have stabilised (evidence)

Excel file

16. The average patient is now waiting 1 week longer under the Tories for treatment after referral (evidence)

Excel file

17. Under Labour, 92.9% of patients were being treated within 18 weeks of referral. That figure has fallen to 89.0% in the most recent month under the Tories (evidence)

Excel file

18. 3.2million patients are currently languishing on NHS Waiting Lists for treatment. This year's figures are the highest in at least 6 years (evidence)

NHS Ethics & Accountability

19. The Tories broke their promise not to have another top-down reorganisation of the NHS. They did so by introducing the Health & Social Care Act that abolished SHAs & PCTS and replaced them with CCGs (evidence)

Internet required

20. Without permission, or little warning, the Tories have made patient records (anonymised) available to these private health firms (evidence)

21. The Tories defied a Judge ruling & instructions by the Information Commissioner to publish the NHS Risk Register so that people could assess the dangers of the unprecedented NHS Reorganisation caused by the 2012 Act (evidence)

22. 1/3 of the GPs making decisions on CCGs as to who wins NHS Contracts actually has a financial link to a Private Health Firm themselves (evidence)

23. The Tories have handed over billions of pounds of NHS contracts to firms and at the same time exempted them from the Freedom of Information Act on the grounds that prying folk such as I will damage the commercial confidentiality of the companies. Labour have introduced a bill to try and change this (evidence)

24. The UK Statistics Authority reprimanded Jeremy Hunt for claiming that median waits at A&Es had halved under the Tories. The reality is that A&E performance is at its worst in 11 years (evidence)

25. High Court Judge & an Appeal Court Judge both found Jeremy Hunt to have acted improperly in downgrading Lewisham Hospital (evidence & evidence)

26. New clauses added to NHS legislation are designed to take power away from the public and concentrate it in the hands of private firms. The Tories have insisted that healthcare will not be exempt from TTIP. They have passed clauses to allow Jeremy Hunt to force NHS closures against the say of the local public, and diminish the court's role in holding him accountable. He has also passed regulations to push commercial competition in the NHS much more forcefully. All of this is anti-democratic (evidence , evidence & evidence)

Internet required

27. Jeremy Hunt & David Cameron have taken the ethics of the Department of Health to an all-time low. In particular, he seems hell bent on distorting or exploiting data to smear Andy Burnham. In particular, the use of unreliable hospital mortality data which has been rubbished by all major senior NHS experts has caused offence. Several senior NHS figures, Robert Francis, Bruce Keogh & Baroness Young have had to formally intervene to apologise, or ask Cameron & Hunt to desist (evidence, evidence & evidence)

Internet required

28. The links between Private Health lobbyists at the Tories are extensive. This blurs the accountability and transparency of policy making. For an insight into just how deeply intertwined lobbyists & the Tories have become, see some of this (evidence & evidence)

Internet connection needed to view this evidence

29. Despite gaining billions of pounds in NHS contracts, Private Health firms are paying very little tax. You can measure the amount of tax each Private Health Firm pays by typing their name into this database (see here Internet needed). You can also view an investigative report into Private Firms and tax avoidance here (evidence)

30. Tory MPs earn cash, shares, directorships and more from Private Health that firms that are profiting from NHS privatisation. They, mostly, declare this income and you can view it for yourself here (evidence) Internet needed

31. The Tories are at fault for scapegoating immigrants and blaming them for NHS budgetary pressures. For example, Jeremy Hunt said health tourists cost the NHS £2bn, but evidence shows this was a gross exaggeration (evidence)

NHS Staff Pay & Conditions

32. 78% of Nurses report increased stress levels in the last year, a further year on year increase this time of 5% (evidence & evidence)

33. The number of physical assaults on NHS Staff has climbed 21% under the Tories reaching record levels this year, and there have been ¼ million attacks on staff since 2010 (evidence & evidence)

34. In cash terms, the basic pay of an NHS Senior Manager has grown by 500% more than NHS Nursing & Midwifery Staff under the Tories (evidence)

Excel file

35. Whilst the mean annual earnings of Senior NHS Managers has climbed £6,556 under the Tories, Trainee Doctors have seen a £2,200+ fall, and Registrars a £1,366 drop in earnings. While the mean basic pay of a Senior Manager has jumped 15% it has fallen 4% for a trainee doctor, and that is before we even consider inflation (evidence)

Excel file

36. In 2010, 377,000 worked in other Health & Social Care non-NHS roles. Today that figure is just 263,000 (evidence & evidence)

Excel file Excel file

37. There are almost 137,900 Zero Hours Contracts in the Health & Social Care Sector. These contracts have more than tripled (up 270%) since 2010 (evidence & evidence)

38. In 2010, 1.596m worked in the NHS. Today, that figure is 21,000 less (evidence & evidence)

Excel file Excel file

39. The percentage of NHS Staff who feel bullied or harassed has doubled to 28% in just 3 years of Tory rule, 2010-13. This in part can be attributed to another imposed and needless top down reorganisation of the NHS (evidence) Internet connection required to view evidence

40. The percentage of staff reporting experiencing physical violence from patients has doubled in just 3 years, 2010-13. This is in part due to mental health cut backs and leadership from the very highest accusing nurses of lacking compassion (evidence) Internet connection required

41. The percentage of staff suffering work-related stress in all NHS Trusts has jumped from 28% to 38% in just 3 years, 2010-13. This in part is caused by cut backs and a cloud of negativity over staff (evidence) Internet connection required

42. Jeremy Hunt has subjected the majority of NHS Nurses to a real terms pay cut over 4 years. Nurses' pay has declined £2,000 in real terms. It is unacceptable that bankers' pay now grows six times faster than nurses (evidence, evidence)

Excel file

43. The Tories attempted to force in regional pay for NHS staff, beginning in the South West of England. Although they were defeated after a very strong public campaign, their intention is clear. The deal would have led to less pay, and poorer working entitlements for staff in regional

areas outside London, initially in the South West (evidence)

NHS Privatisation

44. Private Firms have been invited to bid for NHS contracts with a value of more than £16bn. On average, these firms say they will make a profit of between 5-8%. The funding pressures on the NHS mean that it has no room facilitate £800m-£1.3bn of profit on the contracts mentioned above, should they go to the Private Sector (evidence)

45. 33%, 56% or 70% of NHS Contracts tendered are now being won by the private sector depending on which data you read (evidence, evidence & evidence)

46. Number of GPs now advising their patients to take out Private Medical Insurance has more than doubled from 24% to 58% since the Tory NHS Act (evidence & evidence)

47. Tories said Doctors would control GP commissioning but less than 0.5% of GPs are involved in commissioning decisions. The proportion of GPS on CCGs has fallen from 56%, in their shadow format, to 49% and then 43% in the most recent year. Doctors are not even a majority of the people responsible for GP commissioning (evidence)

48. Persons or firms with a financial interest in private health have donated to the Tory Party in various ways. In 2012 the Tory Party passed the Health & Social Care Act which expanded the role of private medical firms. Among the chief beneficiaries of these developments have been firms with donor links to the Tory Party. This causes a

blurring that does our democracy few favours. In total, it is possible to link 744 donations from persons with past or present links to Private Health to the Tory Party.

49. There are now 500 hospitals being run by Private Health. The Private Health Sector now enjoys a £40bn share of the market. Its share of the acute sector has grown by £3bn in 4 years according to Laing & Buisson (evidence, evidence)

50. Referrals of NHS Patients to Private Hospitals, especially SPIRE & BMI has jumped 500% since 2010. This drain of cash away from NHS Hospitals is hurting the Trust Sector (evidence)

51. Private Patient Income at NHS Trusts has grown by 12% (£50m) from 2010-2013. We have no official data thereafter but some Trusts have reported an increase of up to 40% from PPI. At a time when hospitals are clearly struggling to manage public demand from NHS patients, it is imprudent that they increase the work they carry out for Private Patients (evidence, evidence, evidence)

52. In 2009, 83.9% of the UK's Health Sector was in Public ownership. Today, that figure is 82.5% and falling. Experts Laing Buisson, say that Private Health now controls £40bn of the health market, and that this has grown £0.7bn in 2 years (evidence & evidence)

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53. Tories often cite their reason for accelerating NHS Marketisation as an effort to improve patient outcomes.

That pretence was well and truly exposed when they sold Blood Plasma services to a US Hedge Fund (evidence)

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54. The Tories are selling off NHS land at a rapid scale. Already, the Tories have put at least 418 pieces of NHS amounting to 19 hectares up for sale to private property developers. They have set a target to sell off £5bn worth over the next 5 years. When NHS Propco was set up as a private firm, the Tories denied it was to pave the way for a large scale land sell off. Now, plans are indeed afoot for a major sell off (evidence & evidence)

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Wasting Taxpayers' Money

55. In 2009-10 the NHS spent £1.1bn Agency Staff. That has risen to £3.2bn for 2011-12 (evidence p.193) £3.9bn for 2012-13 and £2.9bn for 2013-14 (Evidence p.20 & evidence p. 193 Internet connection required

56. In 2009-10 £13m was spent by the NHS on redundancy pay-outs. That figure jumped to £211m in 2010-11 (evidence p.89) and £426m in 2011-2 (evidence p.118). It was £444m in 2012-3 and a further £196m in 2013-14 (evidence p.125) Internet connection required

57. After spending at least £1.1bn on NHS Redundancies, the NHS then rehired at least 18.7% of those initially made redundant. That includes 2,570 on a permanent basis and 1,380 on a temporary basis (evidence, evidence p.89, evidence p.118, evidence p.125). Other commentators put the figure closer to 40% see (here).

Internet required for most above links

58. The number of delayed transfers of care due to unavailability of care elsewhere has reached a record high in the most recent month. 6.14m bed spaces have been 'blocked' since August 2010, at a cost of £1.5bn to the taxpayer. The instances of gaps in Social Care provision being cited as the main reason are now at a record high (evidence) Excel file

59. The Top-Down Reorganisation of the NHS has wasted at least £1.1bn of taxpayers' cash at a time when the funding squeeze it at its worst since 1979 (evidence)

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60. The Tories have been dishonest about the claimed savings their reforms have delivered the NHS. The National Audit Office was unable to confirm at least £2.4 billion of the Savings the NHS claims it delivered (evidence) Internet required

61. NHS Spend on outside consultancy was £468m in 2009/10, £456m in 2011/12, £596m in 2012/13 & £584.7m in 2013/14 (evidence, evidence, evidence)

Internet access required to view this evidence

62. Despite the government's boasts about savings made from the NHS efficiency drive, a detailed study showed that 40% of NHS Trusts have failed to achieve their QIPP savings (evidence) Internet required

NHS Direct

63. The Tories shut down a highly efficient NHS Direct and replaced by a for-profit NHS111 service that botched its initial launch (evidence)

64. 78% of the NHS111 staff who process 111 calls have no clinical expertise. This has caused all sorts of pressures, including additional admissions at A&E (evidence) Excel file

65. It has been reported that there have been 22 deaths or serious injuries which were caused by failures in the launch of NHS 111 (evidence)

66. A piloted study of NHS111 showed 40,000+ waiting longer than 1 minute for their call to be answered (evidence)

NHS Finances

67. The Tories broke their manifesto promise (page 45) to deliver real terms increases in NHS Spending every year, says the UK Statistics Authority (evidence) Internet required

68. The Tories have delivered the tightest budget arrangements for the NHS since 1979. They are on course to cut NHS Spending per patient by 9.1% by 2018-9. Spending as a proportion of GDP has shrunk considerably (evidence, evidence, evidence and evidence)
Internet required

69. ¼ of NHS Trusts are now in deficit. 44 new trusts moved into deficit in 2013-14. The total deficit for NHS Trust more than doubled from £297m to £743m in 2013-4 (evidence p.6)

Ambulances

70. Ambulance Response Times for Category A (8 minute) calls has dropped from 75% to 69% in just 3 years (evidence)

71. Ambulance Trusts have made large cuts to their staff and fleet since April 2010. For example, EMAS has cut staff by 13% and its fleet size by 100 (evidence)

72. At the same time as Ambulance Response times have been worsening, the Tories have oversaw the axing of 60+ stations
(here, here, here, here, here, here, here, here, here, here)

Internet required

73. Expenditure on Private Ambulances for use in the NHS has doubled in 3 years an investigation revealed (evidence)

A Crisis in Mental Health Provision

74. 1,876 Mental Illness Beds have been axed in little since Q1 2010. At least 7 mental health patients have taken their own lives as a result (evidence & evidence)
Excel file

75. 228,000 have spent up to 12 hours in A&E during the past year. This number has more than doubled in 3 years (evidence) Internet required

76. Mental Health Nursing has suffered severe cuts. To explain, there has been an 8,737 reduction in the number of Specialist Nurses in Maternity, Disability, Psychiatric and Community services since 30 April 2010. This is only partly explainable in the re-designation of 4,854 nurses into Neo-Natal services. It still leaves a shortfall of c4k staff with Mental Health being the worse affected (evidence)
Excel file

Social Care Crisis

77. The number of people self-financing their social care has jumped 36% since 2006. This is a failing of both recent governments. 1 million people have had to sell their own homes to pay for elderly care in the last 5 years, thus this a problem that began under Labour but continues to worsen under the Tories (evidence & evidence)

78. In 1 year 530,000 patient admissions of over 65s, 390,000 of whom were over 75s could have been avoided say the CQC. Nuffield trust also say that avoidable admissions are at a record high (1 in 5). Cuts to GP funding (£0.9bn) & Social Care funding (£1.8-£2.8bn

funding) are putting causing unnecessary discomfort to elderly patients (evidence & evidence) Internet required

79. There has been a 311,000 cut in the number of adults in receipt of Social Care since 2010 (evidence & evidence)
Internet required

80. Funding for elderly Social Care has decreased 10% in real terms since 2010 & Council spend on Social Care has been cut £2.8bn in real terms (evidence) Internet required

81. Elderly users of Social Care are paying £588 more for care than they were in 2010. Some outlets argue the rise has been even higher at £2,400 (evidence & evidence)
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82. George Osborne ignored Andrew Dilnot's plea to fund his Dilnot Report recommendations from a separate pool to NHS funding. The resultant consequence is that an already stretched NHS is being stretched further still and is failing to meet Social Care costs (evidence & evidence)

83. Social Care funding for nursing homes, residential care and community care has been cut by £160m, £331 and £559 respectively from 2010 to 2013. Further cuts are still to come (evidence) Internet required

84. At a time when Dual Energy Bills are up 30%, David Cameron scrapped the Warm Homes Health People Fund despite a report's conclusion that it saved lives (evidence)

NHS Treatment, Rationing & Cuts

85. In the early years of this Tory Government, spending on Cancer Services declined 3.6% in real terms under the Tories (evidence) Internet requied

86. An early report into the life of this government shows that Funding for Clinical Networks on Chest, Heart & Stroke were cut by 12%+ (evidence) Internet required

87. 56% of CCGs are restricting some NHS Treatments for patients who smoke or have a high BMI found the NAO (Page 29) Internet required

88. An NHS, free at the point of use, does not exist for many patients. At least 20+ treatments are no longer free at the point of use for patients in 60+ parts of England's NHS (evidence, evidence)
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89. 52,000 patients were denied patients due to cost considerations in just 1 year. This is just one of several examples where the concept of an NHS free at the point of use is in jeopardy (evidence)

90. In 2014, 42% of Maternity Units shut their doors to the public at least once. This is an increase from 28% in 2012 (evidence & evidence)
Internet required

91. There is a 2,300 shortage of Midwives according to the National Audit Office. This could explain why 42% of Maternity Wards closed their doors last year (evidence)
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92. Of the 27 EU Countries, the UK now has one of the worst Bed to Citizen Ratios in the EU (evidence & evidence)

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93. 9,746 NHS Beds have been axed since 2010 (Q1) (evidence)

Excel file

Patient Safety & Satisfaction

94. Labour left an NHS with rising, indeed record, patient satisfaction. Under the Tories it suffered a record fall, and then stabilised a little. We await the most recent year's data (evidence & evidence)

95. The number of Clinical Negligence Claims made against the NHS has risen 80% since March 31st 2010 & the value of pay-outs has risen £397m (evidence, evidence & evidence)
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96. At a time when more is being asked of the CQC it was naïve to cut their staff numbers by 18%, since 2010 (evidence & evidence) Internet required

97. It is difficult to make any strong conclusions about Never Events because the definition of a never event changed, and the method of collecting and reporting the data has also changed. What we can say is that there is no sign of them falling. NHS 'Never Events' rose from 57 (2009), to 139 (2010), to 294 (2011) (evidence). There were 329 never events in 2012-13 (evidence). There were 338 never events in the NHS during 2013/14 (evidence). There have been 197 never events in the 8 months of this year so far (evidence)
Excel file

98. There has been a 73% increase in written complaints against the NHS in 4 years. 101k complaints occurred in 2009-10, and this rose to 178k by 2013-14 (evidence & evidence)

99. All of the main Private Health Firms have had reported shortcomings from CQC inspections on at least 1 of the NHS premises that they gained control of under this Tory government. This can be confirmed by using the CQC search bar and typing in the firm's name and then checking the CQC reports for the NHS premises for which they are responsible (start here) Internet required

100. Tory Privatisation has failed to deliver safer and more cost efficient healthcare. Several private health firms have walked away from NHS Contracts because they do not provide them with the profits they had hoped. The very same Private Health firms have then been allowed to rebid for more NHS contracts (evidence, evidence). Some firms have also been found to have overcharged the NHS (evidence). Contracts were also ended in cases where the private care was so bad it was endangering the health of patients (evidence & evidence)

Royal College of General Practitioners

Over 500 surgeries at risk of closure as GP workforce crisis deepens

Publication date: 02 October 2014

RCGP figures show surgeries could be forced to close in the next year

Up to 543 GP practices in England – potentially rising to nearly 600 across the UK – could be forced to close within the next year because of a deepening crisis in GP recruitment and retention, which is leaving many practices unable to replace family doctors who are retiring from the profession.

New figures released by the Royal College of General Practitioners show that over 90% of the GPs working in these practices are now aged over 60.

Unless drastic action is taken to make sure that there are enough doctors to take their place, thousands of patients could be forced to travel miles to their nearest GP practice or be left stranded with no family doctor at all.

The alarm bells for the future of patient care will be sounded by Dr Maureen Baker, Chair of the RCGP – the UK's largest network of 50,000 family doctors – in her inaugural speech to the College's national conference in Liverpool this Thursday.

Addressing an expected audience of over 2,000 GPs and health professionals, Dr Baker will warn that the crisis in the GP workforce is now so severe that the number of people entering the profession is falling drastically short of the number of GPs who are leaving in their droves to take early retirement, work abroad or pursue entirely different careers.

So desperate has the situation become that the RCGP estimates that:

- More than 1,000 GPs will be leaving the profession on an annual basis by 2022
- Around 22% of GPs in London could step back from front line patient care within the next 5 years (with 41% of London GPs being over 50)
- The number of unfilled GP posts has nearly quadrupled in the last three years (2.1% in 2010 to 7.9% in 2013)

Meanwhile, it was estimated in March that applications to undertake GP training had dropped by 15%, with only 40% of medical graduates choosing to enter general practice training – as opposed to training for other specialties – despite a national target to ensure that by 50% of medical graduates go into general practice.

Dr Baker will demand a rescue package – a 'new deal' – for general practice that includes cutting back on the bureaucracy that currently prevents qualified GPs from returning to work after a career break, and specific incentives to encourage more doctors into deprived areas, that are currently under-doctored.

The North West and North East regions are the most under-doctored regions of England, with 63.4 and

63.6 GPs per 100,000 population respectively.

The College estimates that with a growing and ageing population, in which increasing numbers of people have multiple long-term conditions, the GP workforce needs 8,000 more FTEs by 2020.

While the RCGP estimates that England needs nearly 40,100 full-time equivalent GPs in order to meet increasing patient demand, there are in fact just 32,075 family doctors. In 2009, there were 32,110 GPs.

Overall, she will reiterate the RCGP's call to all four governments of the UK to increase the share of the NHS budget for general practice – currently at an historic low of just over 8% – to 11% by 2017.

Every day, GPs and their teams carry out 1.4m consultations and over 90% of patient contacts within the NHS are managed in general practice.

GPs and their teams are now seeing 370m patients a year – nearly 60m more than even five years ago – with many GPs now routinely working 11 hour days and seeing 60 patients in a day to try and meet demand.

Comparing general practice to the 'walls of a dam' that prevents the rest of the NHS being flooded, Dr Baker will say:

"So far much of the damage to the dam wall has been hidden from the public – they see the flooding downstream in accident and emergency departments and in hospital pressures, but they haven't been aware that GPs, nurses and practice teams have been absorbing that pressure by trying to do more and more with less and less.

"But if we let that situation continue we will see whole chunks of the dam fall apart when practices have to shut their doors.

"Every practice closed is a loss to a local community. Not only do patients lose out, but it piles more pressure on neighbouring practices, swelling patient lists already bursting at the seams

"We all know about the 98 practices in England, identified by NHS bosses that are at risk of closure due to the removal of the minimum price income guarantee.

"Today I can reveal new estimates from the College that 543 practices in England are at risk of closure if something isn't done.

"There are practices that have over 90% of GPs over the age of 60, when the average retirement age of GPs is 59 – this is shocking.

"With a growing, ageing population, not to mention a baby boom, we need to increase capacity in general practice, not take it away.

"If this was a business it would be expanding to meet demand – not shutting down services and closing branches.

She added:

"Most worryingly, in the face of relentless workload pressures and constant attacks from the media, we are not attracting enough new doctors and nurses into general practice, or doing enough to retain the highly skilled workforce we have.

"All of these developments result in further weakening of the dam. Colleagues, the wall of the dam – the service of general practice – is under huge pressure and unless urgent action in taken to repair and restore the dam, it could burst with terrible consequences for our patients in general practice and indeed for the whole of the NHS.

"Let's continue to make our voices heard and demand a new deal for general practice.

"And a new deal for every single patient in Wales, in Northern Ireland, in Scotland and England."

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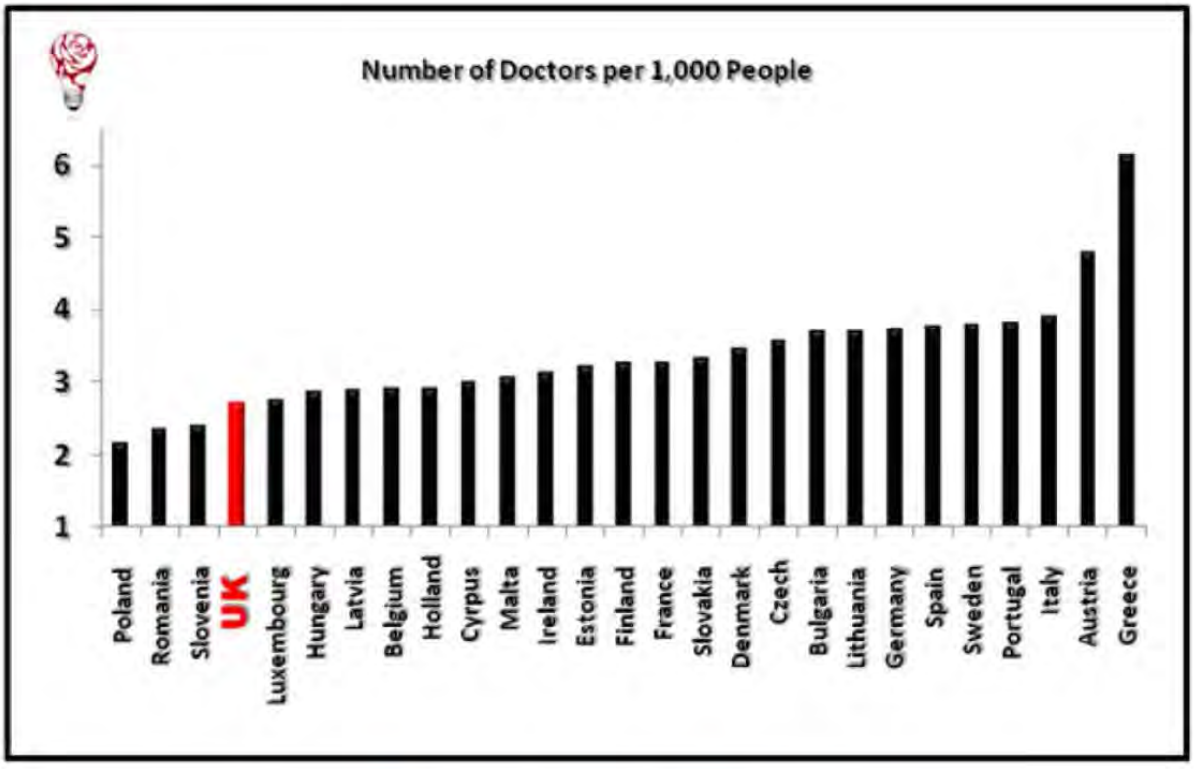

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5:00 PM - 4 Jan 2014

Reply to @EvidenceUK

Wyn Tingley @wyntingley · 4 Jan 2014
@EvidenceUK thank goodness for socially funded healthcare or we'd have far too many doctors charging fees. Good graph, thanks.

1

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Serco to pull out of UK clinical services market

Outsourcing company Serco has announced plans to pull out of the clinical health services market in the UK.

This follows extensive losses of £17.6 million on three of its NHS contracts.

“The group has revised upwards the estimate of the costs of running the contracts to term, resulting in an additional non-cash exceptional charge of £3.9 million in the period (year ended 31 December 2013: £17.6 million),” it explained in its 2014 half year results.

Serco’s GP out-of-hours contract in Cornwall and clinical services contract at Braintree Community Hospital, were cancelled prematurely. The third contract at Suffolk Community Health will continue until its agreed end in 2015.

Previously in May 2013, the company had said it expected to make a profit on its Suffolk contract.

Serco explained that it had continued to monitor its performance in the UK’s clinical health operations. It concluded that “an onerous contract provision was made in the prior year” which resulted in its intentions to “withdraw from the UK clinical health market” completely.

Valerie Michie, former managing director at Serco’s healthcare business, formerly denied claims that the firm’s £140 million bid for the Suffolk contract was unrealistic.

On the announcement of the contract losses, she previously said: “We had to take the difficult decision to end these two contracts early, but this does not undermine our commitment to the healthcare market, which is undiminished.”

A Serco spokesman told the *HSJ* that it would make the decision on whether to rebid for the Suffolk contract “in due course”.

Related articles:

- Serco appoints new local government division CEO
- Serco to make £17.6m losses on NHS contracts

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A private company is exiting [illegible] GP practice contract early

May 03, 2014 06:40

By **Helen Rae**

Private company Care UK has announced that it will exit its five-year contract for Grainger GP Practice in Newcastle early

Paul Baker (beard) and Martin Manasse who are part of the patient group, Keep our NHS Public North East, campaigning against NHS reforms

A private company that runs a Newcastle GP practice will end its contract more than two years early.

Grainger GP Practice at Elswick Health Centre was controversially taken over by Care UK in September 2012 and was committed to run the service until the end of August 2017.

The move sparked fierce opposition from health professionals and campaign groups as they claimed the company did not have a record of delivering high-quality GP care in deprived areas.

Now Care UK has announced it will exit its five-year contract halfway through its tenure and depart at the end of January next year. The company refused to give reasons as to why the contract was ending early.

Doctor Leah McAleer left Grainger GP Practice following the appointment of Care UK, and campaign group Keep Our NHS Public North East has always had concerns about the private company.

Martin Manasse, a member of the campaign group said: “It is shameful that Care UK is exiting their contract early, but I believe it was predictable. We said when

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the company took over that the money available from their bid was not enough for what they claimed they were going to do with the GP practice."

Approximately 7,000 patients are registered with Grainger GP Practice and health chiefs have insisted that patients do not need to register elsewhere as they remain confident an alternative provider can be secured without any disruption.

The announcement by Care UK comes just weeks after nearby Scotswood GP practice was told that it is under threat following a recent contract review of its provider.

Newcastle Central MP Chi Onwurah said: "Patients deserve continuity of care if we are going to overcome health inequalities. Patients need to have trust in GP services and that comes by building up a relationship with those who run services. If care providers come in and exit for unknown reasons then that damages services."

Patients registered with the doctors' practice in Elswick have received a letter informing them of the changes.

A Care UK spokesperson said: "Since being chosen to run the Grainger Medical Practice we have worked hard to improve the service for local people.

"However, after reviewing our business strategy and having conversations with the commissioner, it was decided that Care UK will not run the service past January 2015. We are committed to working closely with the commissioner and whoever is chosen to run the service after us to ensure the practice's 7,000 patients are not affected in any way by a change of provider."

The Cumbria, Northumberland, Tyne and Wear area team of NHS England is responsible for commissioning GP services in the local area and will seek the views of patients.

Dr Mike Prentice, medical director for the team, said: "We recognise the need for a GP practice in the area and are confident that an alternative provider can be secured in this time frame, and that there will be no disruption to patients.

"We have written to all patients to let them know about this change. There is no need to re-register with another GP, though patients do have that option if they wish.

"This is a good opportunity for people to let us know if there are things we can do to improve the service, and we will be contacting patients again in the near future

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to ask for their views.

"Ensuring continuity of access to high quality care and services remains our top priority."

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EXCLUSIVE: Services provider established by outsourcing giant Serco overcharged NHS by millions

RICHARD WHITTELL , EMILY DUGAN

Wednesday 27 August 2014

Outsourcing giant Serco is embroiled in a fresh misuse of public funds scandal after a company it set up overcharged NHS hospitals millions of pounds, The Independent can reveal.

Internal documents leaked to Corporate Watch indicate Britain's biggest pathology services provider, which was established by

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Serco in partnership with Guy's and St Thomas' hospitals, overcharged the NHS for diagnostic tests.

The venture - first called GSTS and now trading under the name Viapath - has also been dogged by allegations of cost-cutting and clinical failings. Internal documents show increasing concern amongst senior consultants who claimed that staff cuts and a lack of investment since privatisation left some laboratories close to disaster.

In internal emails clinicians said the company had an "inherent inability... to understand that you cannot cut corners and put cost saving above quality." The trust and Viapath say the problems have now been resolved. But this only happened after the intervention of senior medical staff and changes to the structure of the joint venture that reduced Serco's role.

A 2013 internal audit by the trust into three of the 15 laboratories run by Viapath found its invoicing and billing systems were "unreliable" and contained "material inaccuracies", amounting to an overcharge of £283,561 over a sample three month period. The auditors found invoices included double-counting of tests charged to the hospitals, with both samples and patients included in bills, and that the Trust had been "indirectly providing a free pathology service" to other NHS bodies by being billed for outside work done. They estimated this could represent approximately £1 million in 2012 alone.

The full scale of the over-charging is not known because a full audit has never been conducted.

But The Independent has also seen documents highlighting concerns raised by senior NHS managers over the accuracy of billing from other laboratories. One department raised a dispute over £1 million in 2011 due to what they said were errors including the suggestion that two different labs were charged for the same tests.

Margaret Hodge, chair of the Public Accounts Committee said: "After a series of high profile failures, Government claims it has a grip on contracts with private companies to deliver our public services. Clearly it hasn't. This is not just about ripping off the taxpayer, but about a failure to provide acceptable quality in a service that is vital for diagnosing what it many cases are serious or even life-threatening illnesses.

"It is also not the first time that serious concerns have been raised about Serco and its track record, including in other parts of the NHS where last year our Committee reported on substandard service and data manipulation in a contract to provide GP out-of-hours services."

Chair of the Commons Public Accounts Committee, Margaret Hodge (Getty)

Pathology laboratories are central to the NHS, with blood and tissue analysis used in 70 per cent of all patient diagnoses. Viapath – a joint venture between Serco and Guy's and St Thomas' hospital trust and King's College hospital – is the largest pathology service provider in the UK, processing more than 22 million tests a year in London and Bedford.

Viapath declared it would combine the hospitals' "clinical and scientific excellence" with the "service and business excellence" of outsourcing giant Serco when it was founded in 2009.

The joint venture was supposed to have reformed the Trust's commercial practices in the early stages of the contract, signed in 2009. However, a promised reform of charging has still not been introduced.

Serco had a controlling, 51 per cent voting share in the partnership, which made a £3.8 million profit last year. However after several failings the hospitals renegotiated the contract to an equal three-way split in 2012.

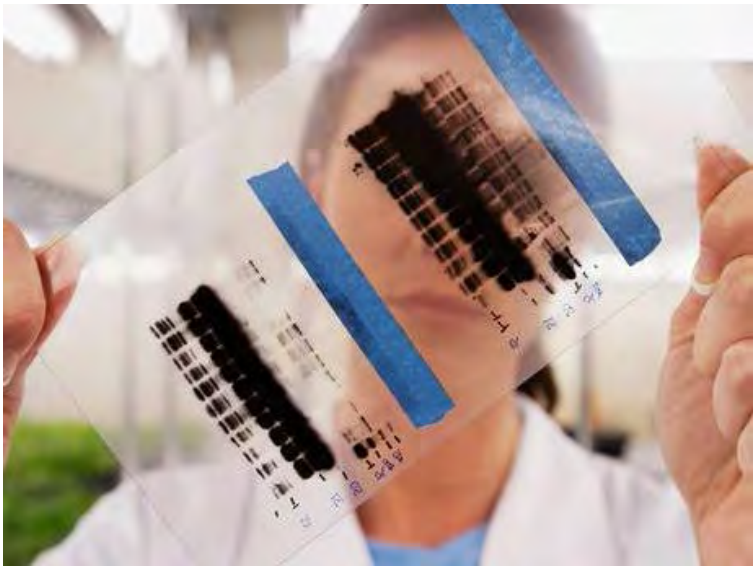
In a review of its first four years, marked "strictly confidential", CEO Richard Jones admitted that it had "achieved much less than hoped" and that "initial attempts at transformation were

badly handled and ended up costing money rather than saving it".

An NHS commercial manager close to the contract told the Independent: "When you're taking over a contract of this complexity it's unreasonable to expect to fix the problem on day one. But the contract was set up on the basis that they had a year to turn things around and get things in proper shape. When they were unable to do it the trust should have ended the contract."

They added: "They haven't improved efficiency. Going into a service like this and making it more efficient and ensuring that people are billed properly - that's where you think the private sector will add value. Serco know the public sector behaves this way and they take advantage. They use the ambiguity and inefficiency of the public sector that they're meant to be improving on to take advantage of that inherited incompetence."

Senior consultants have raised concerns over the effects of the "financial squeeze" by Viapath on some Guy's and St Thomas' labs. In June last year senior clinicians in the histopathology laboratory – which tests tissue samples for disease - made a complaint to Viapath. They claimed that their policy "over the last three years of either not replacing leavers or downgrading them has left us with a department that cannot cope with the technical complexity of our workload. This is now resulting in errors, poor turnaround times and now, an inability to perform quality control" for gynaecologic tests.



Auditors found double-counting of lab tests and that Guy's and St Thomas' had been indirectly providing a free pathology service to other bodies (Alamy)

Consequences alleged included delays in scanning for the HPV virus, too few staff to book in samples for processing and quality

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A Clinical Director at the hospitals described it as “yet another lab in distress and part of a recurring pattern.” In a document written in August 2013 entitled “[Viapath]: the Great Leap Backwards”, Professor Tony Wierzbicki, the clinical lead for Blood Sciences said Viapath has not made the necessary investment into one of the “very few departments in the hospital whose failure can cause the whole institution to close”.

The review accused Viapath of ignoring consultants' concerns, “inadequate” investment and haemorrhaging experienced staff by introducing “a large pay cut with no improvement in working conditions”. It claimed disaster was avoided “only just” in 2013, and that the rate of “near miss 'never' events has climbed dramatically”, with new chemistry analysers brought in by Viapath apparently unable to read barcodes on a quarter of specimens and too slow to cope with peak demand compounding staff shortages.

The clinician also claimed that “minor events are often not recorded as the culture of [Viapath] means staff know the practical consequences of honesty.”

The service previously came under fire after it emerged that more than 400 clinical “incidents” had happened with its tests in 2011 – including losing or mislabelling patients’ blood and cell samples. Its first year performance review by the hospital's management said there appeared to be an increase in the number of these incidents since Viapath became involved.

Further mistakes in 2012 included a patient given the wrong blood after the system did not flag their medical history - and a patient’s kidney damage results showing up incorrectly after a “software fault”.

In a statement sent to The Independent by the trust’s press office, Professor Wierzbicki said: “I raised concerns 12 months ago during the internal review process. My concerns at that time have been resolved and there has been significant investment in staff and equipment. This has led to shorter waiting times for blood tests and a quicker turnaround time of services to key departments such as A&E.”

Guy’s and St Thomas’ Trust said in a statement that a September 2013 internal review commissioned by the Trust’s Audit Committee, including interviews with Viapath staff and frontline

clinicians, concluded that: “notwithstanding some early challenges during the first years of Viapath, the new management team at Viapath was making good progress in transforming pathology services in terms of quality and value for money.”

The Trust said “there are no disputed invoices between Guy’s and St Thomas’ and Viapath. Billing arrangements are governed by a contract which is monitored regularly with data shared in an open and transparent way. If activity data errors or anomalies are identified, these are resolved on a case by case basis at monthly finance meetings and adjustments are made to subsequent invoices. Such adjustments have amounted to only 0.4 per cent of the cumulative contract value over the last five years.”

Richard Jones, Viapath chief executive, said he welcomed the trust’s statement and added: “Viapath had a difficult start but the partners have worked together to deliver ongoing improvements in service delivery and investment in innovation which is now yielding benefits for patients and our many NHS users. Our scientists and clinicians are world class and I am proud of the service we are delivering for the NHS.”

A Department of Health spokesman said: “All providers of services to NHS patients, whether independent or NHS healthcare providers, are required to meet the same high standards on both patient care and strong financial control. The responsibility for holding accountable any company or provider which breaches conditions of its contract lies with the relevant NHS commissioning body.”

Serco: a history in scandals

Serco earns over £1 billion from its public sector contracts every year but it has been hit by a series of scandals over the past two years.

It is currently under investigation by the Serious Fraud Office for overcharging the Government for the electronic tagging of offenders, some of whom were found to be dead, back in prison or overseas. Serco agreed to repay the government £68.5m at the end of last year.

Last year the company agreed to the early termination of its contract for out-of-hours GP services in Cornwall after falsifying performance data, failing to meet national standards and having a ‘bullying’ culture.

The Serco-run prison, HMP Doncaster, came under heavy criticism from the prison inspectorate last year after it emerged it had locked up inmates in cells without water or electricity for more than two days.

NHS faces legal bill as dozens suffer problems after private eye operations

Half of patients left with complications from cataract operations carried out by Vanguard for Musgrove Park hospital in Taunton

Steven Morris

The Guardian, Thursday 14 August 2014 17.58 BST

Jump to comments (750)

A man undergoes an eye test. Vanguard Healthcare carried out the cataract operations to reduce a backlog at Musgrove Park. Photograph: Martin Godwin

Dozens of people have been left with impaired vision, pain and discomfort after undergoing operations provided by a private healthcare company at an NHS hospital.

One 84-year-old man claimed he has lost his sight and his family is calling for a full independent inquiry after it emerged that half of the 60 patients who underwent surgery suffered complications.

The routine cataract operations were carried out by the private provider in May to help to reduce a backlog at Musgrove Park hospital in Taunton, Somerset. But the hospital's contract with Vanguard Healthcare was terminated only four days after 30 patients, most elderly and some frail, reported complications, including blurred vision, pain and swelling. Some of those who suffered complications, including the 84-year-old man, have contacted lawyers to discuss seeking compensation, which raises the prospect of an NHS hospital picking up the bill for procedures done by a private health company.

The trust refused to talk in detail about what happened pending the conclusion of its own investigation. It also refused to discuss who would

pick up any bill for compensation or details of its contract with Vanguard.

But, when the problems surfaced, a senior member of staff at Musgrove Park appeared to concede that the hospital would be liable for any payments. Dr Colin Close, Musgrove Park's medical director, acknowledged compensation claims could be made and was quoted in a local paper saying: "Any financial responsibility would rest with us."

The hospital now claims that Close was misquoted.

The son of the 84-year-old patient, who asked not to be named, said his father was referred for the cataract surgery by his GP. The retired salesman, from the Somerset Levels, did not consider he needed the operation but agreed to the treatment.

The son said the procedure took 15 minutes and his father felt it was "very rushed". The man suffers from mild dementia but the family said staff told his wife she could not be present as space was limited.

After the operation the man's vision was impaired. He thought it would return and went home but Musgrove Park contacted him to say there had been "complications" and he should return to hospital. He had another operation but his family said he had been told only a cornea transplant would restore his sight.

"My father is traumatised and depressed with the loss of his eyesight. Previous pleasures of gardening and watching sport on the TV have been taken away from him. This could have been prevented if the welfare of the patients had been thought about, rather than this urgency of getting people through," the man's son said.

Among the questions the family want addressed in an independent inquiry is whether Vanguard was brought in to save the trust from paying a financial penalty because of the backlog. They also want to know exactly when the hospital was made aware there was a problem.

Laurence Vick, a medical negligence lawyer who has been approached by some of the victims, said the case highlighted the "uneasy relationship" between the NHS and the private sector.

He said the question of who paid when outsourced NHS treatment failed was of growing importance as more services were handed over to the private sector.

Vick, the head of the clinical negligence team at Michelmores solicitors in Exeter, said: "We don't know what arrangements are in place for Musgrove to recoup their outlay and losses on this contract from Vanguard. From the taxpayer's point of view, it would be totally unreasonable for Vanguard to walk away from this scandal with only their reputation, and not their investment, damaged.

"The failings at Musgrove Park have once again uncovered the uneasy relationship between the NHS and the private sector, and it is crucial that an episode of this kind is not dismissed as an anomaly – a hybridised, public-private NHS will need to be wary of similar issues in future."

Musgrove Park approached Vanguard to help clear a backlog of cataract procedures. Vanguard surgeons began work at the start of May in a mobile unit. But patients quickly reported problems and the procedures were halted.

Musgrove Park said: "Due to the ongoing nature of our investigations it would be inappropriate for us to comment on the sequence of events surrounding the unfortunate complications experienced by our patients receiving cataract surgery with Vanguard Healthcare in their mobile theatre onsite at Musgrove Park hospital.

"Our first and foremost concern has always been our patients, and particularly those who have experienced complications. We have been in very close contact with them since the incident to ensure they are fully

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Frontline staff are working flat out, but the system simply can't cope with the number of patients

informed with our progress and receive the highest quality aftercare and treatment. We will want to discuss the outcomes of our investigations with them first, once they have reached conclusion."

Ian Gillespie, chief executive of Vanguard Healthcare Solutions, said: "Patient care is our number one priority and we're working closely with the trust to understand and fully investigate the root causes of any complications.

"This investigation is still ongoing, making it inappropriate to comment on specific issues or on individual patient cases. Operations were carried out in Vanguard's operating theatre by highly qualified surgeons, approved by the hospital, and with many years' experience of working in the NHS."

Gillespie said Vanguard was not conducting the same procedures elsewhere in the UK, he added.

Who is Vanguard Healthcare?

Founded in 1999, Vanguard boasts that it has the single largest fleet of mobile surgical facilities in the world. It has 40 such units with which it serves the NHS and other healthcare providers.

Surgery and endoscopy services, complete with equipment and staff if required, are carried out in the facilities, allowing hospitals across the UK to address temporary fluctuations in demand or capacity.

The Vanguard website claims that almost 195,000 procedures have been performed in its facilities and that 100% of its customers surveyed last year said they would use its services again.

It says it is the only provider of temporary mobile/modular healthcare solutions to be registered with the Care Quality Commission (CQC), the independent regulator of health and social care services in England. Last year, the CQC said Vanguard had met all required standards, observing: "Care and treatment were planned and delivered in a way that was intended to ensure people's safety and welfare."

Haroon Siddique

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2 August 2013 Last updated at 11:35

Lister Surgicentre: Facility bought by NHS for £53m

A privately-run NHS hospital where three patients died after routine surgery is to come under NHS control, clinic bosses have confirmed.

Three people died at Surgicentre following routine surgery

The Surgicentre, based at the Lister Hospital in Stevenage, provides routine operations.

It will be bought by the Department of Health for £53m and services will transfer to East and North Hertfordshire NHS Trust.

Hospital operators Carillion said the transfer was by "mutual agreement".

Services at the Surgicentre are currently provided and managed by a subsidiary of building company Carillion called Clinicenta.

It provides routine surgery in areas such as ear, nose and throat, trauma, orthopaedics, gynaecology and ophthalmology for NHS patients referred there.

In April last year, Care Quality Commission (CQC) inspectors failed the centre in four out of five areas and the following August, GPs were told not to refer patients to the eye department because of worrying waiting times.

Three people undergoing routine surgery for joint conditions died unexpectedly, sparking investigations by Hertfordshire NHS and the CQC.

'No break'

NHS Central Eastern Commissioning Support Unit said the decision to transfer services was an agreement between the Department of Health, East and North Hertfordshire Clinical Commissioning Group (CCG), NHS England and Clinicenta.

"There will be no break in service during the transfer and patients who are currently receiving treatment at the Surgicentre should continue to attend their appointments in the usual way," a statement said.

The NHS said its priority was to "ensure patient care is not affected".

Carillion would not comment on losing the contract but in a statement confirmed an agreement had been made.

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Clinicenta managing director, Mike Hobbs, said: "There will be no break in service provision and the NHS will retain the Lister Surgicentre buildings and equipment for continued use."

He added staff would now be consulted about how the transfer should proceed and the impact of the changes.

The transfer is likely to take place over the next few weeks on a date to be finalised.

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Data on Written Complaints in the NHS - 2009-10 [NS]

Publication date: August 25, 2010

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Summary

Please note: As from 30 September 2010 the publication, Data on Written Complaints in the NHS 2009-10, has been revised. The original version contained a number of outdated organisation names. These have now been updated. Please note, this does not affect the data for each organisation. A list of changes to names is included in the 'revised organisation names' document above.

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2009 and 31 March 2010.

Key facts

- **Hospital and Community Health Services (HCHS)**
  The number of written complaints about hospital and community health services has increased by 13.4 per cent from 89,139 in 2008-09 to 101,077 in 2009-10. This is the largest increase since data was first published annually (1997-98).

  The previous largest increase was 10.6 per cent between 1999-00 and 2000-01. Complaints have seen decreases (by as much as 4.5 per cent in 2006/07 and 2007/08) as well as increases over the years, with an overall average annual increase of 1.1 per cent since 1997-98.
- **Family Health Services**
  There has been an increase (4.4 per cent or 2,158) in the number of written complaints about general practice (including dental) health services from 48,597 in 2008-09 to 50,755 in 2009-10. This compares to last year's increase which was 10.6 per cent.

Resources

- Data on Written Complaints in the NHS - 2009-10: Overview [.pdf]
- Data on Written Complaints in the NHS - 2009-10: Tables [.xls]
- Data on Written Complaints in the NHS - 2009-10: Revised organisation names [.pdf]
- Data on Written Complaints in the NHS - 2009-10: Pre-release access list [.pdf]

Coverage

Date Range: April 01, 1997 to March 31, 2010

Geographical coverage: England
Geographical granularity: Strategic Health Authorities
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- Hospital Estates and Facilities Statistics
- Indicator Portal
- MyHSCIC
- MHMDS Online
- National Adult Social Care Intelligence Service
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- NHS Safety Thermometer

Data on Written Complaints in the NHS - 2013-14 [NS]

Publication date: August 28, 2014

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Summary

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2013 and 31 March 2014 and also includes experimental information on upheld complaints.

For Information: The HSCIC is currently consulting on proposed changes to the range and the frequency of collection of, data used to produce the NHS Complaints statistical publication. The consultation closes on the 5 September 2014. Details of the proposed changes and how to respond to the consultation are available here: http://www.hscic.gov.uk/complaintsconsultation

Key facts

Main findings in 2013-14:

Total complaints (Hospital and Community Health Services and Family Health Services)

- Total number of all written complaints reported in 2013-14 was 174,872 the equivalent of more than 3,300 written complaints a week over the year.

Hospital and Community Health Services (HCHS)

- Total number of all HCHS written complaints reported has increased by 4,992 (4.6 per cent) from 109,316 in 2012-13 to 114,308 in 2013-14.
- The biggest proportion of HCHS written complaints by profession were for the Medical profession (which includes hospital doctors and surgeons) with 45.6 per cent (52,123) of all HCHS reported written complaints. Nursing, Midwifery and Health Visiting accounted for the second biggest at 21.7 per cent (24,793). For 2012-13 the proportions were 47.1 per cent and 22.1 per cent respectively.
- 45.6 per cent (52,330) of all HCHS written complaints reported are for the subject area All aspects of clinical treatment. This is a slightly lower proportion than last year's figure of 46.2 per cent (51,071).

Family Health Services (GP & Dental)

- Total number of all FHS written complaints reported in 2013-14 was 60,564. We are unable to provide comparisons with previous years.
- 40.3 per cent (24,405) of all FHS written complaints reported were for the Medical service area. We are unable to provide comparisons with previous years.
- 36.3 per cent (22,202) of all FHS written complaints reported are for the subject area Clinical. We are unable to provide comparisons with previous years.

Resources

- Data on Written Complaints in the NHS - 2013-14: Overview [.pdf]
- Data on Written Complaints in the NHS 2013-14 Tables [.xls]
- Data on Written Complaints in the NHS - 2013-14: CSV files [.zip]
- Data on Written Complaints in the NHS 2013-14 Upheld Tables [.xls]

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Data on Written Complaints in the NHS - 2013-14: Pre-release access list [.pdf]

Coverage

Date Range: April 01, 2008 to March 31, 2014

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Patient care compromised as funding for general practice slumps across the UK

Publication date: 16 November 2013

New figures published by the RCGP and the National Association for Patient Participation (N.A.A.P) show funding for general practice at nine year low.

The proportion of NHS funding spent on general practice has slumped across Great Britain over the last nine years to the lowest percentage on record - according to new figures published today (Saturday 16 November) by the Royal College of General Practitioners (RCGP) and the National Association for Patient Participation (N.A.P.P).

In 2004-2005, 10.33% of the British NHS budget was spent on general practice. By 2011-2012, this figure had declined by almost two percentage points to 8.4% - even lower than previously thought.

When Northern Ireland is factored in, the percentage share of the NHS budget spent on general practice across the UK has fallen as low as 8.39%.

GPs say the slump in funding is compromising the standard of care they can offer patients, leading to longer waiting times, and increasing pressure on hospitals.

The decline in funding for general practice comes despite the fact that general practice carries out 90% of all contacts across the NHS.

In England, 10.55% of the NHS budget was spent on general practice in 2004-2005. By 2011-2012, this had fallen to 8.5%.

In Scotland, 9.47% of the NHS budget was spent on general practice in 2004-2005. By 2011-2012, this had fallen to 7.78%.

In Wales, 8.58% of the NHS budget was spent on general practice in 2004-2005. By 2011-2012, this had fallen to 7.77%.

Figures are not available for Northern Ireland for 2004-2005, However, by 2011-2012, the figure for the country was down to 8.1% from 8.22% the previous year.

The reductions in funding across the UK have been so severe that, according to two recent opinion polls of GPs

commissioned by the RCGP:

- 70% of GPs fear that waiting times will worsen over the next two years;
- 80% of GPs say they no longer have the resources to provide high-level patient care; and
- 47% of GPs say they have had to withdraw some patient services.

In response to the continued slump in funding the RCGP and NAPP are today launching a new campaign, Put Patients First, Back General Practice, which is calling for the Westminster and Devolved Governments to increase the percentage of NHS spending on general practice across the UK to 11% by 2017.

GPs say this increase would protect patients from further cuts and lead to:

- Shorter waiting times for appointments;
- More flexible opening hours;
- More online services;
- Longer consultations and better continuity of care - especially for those with long-term conditions;
- Improved care co-ordination and planning for the frail elderly and those with complex care needs; and
- The ability to access more services close to home, without the need to travel to hospital.

New Chair of the RCGP Dr Maureen Baker said:

"During the last nine years, GPs across the country have had to cope with a growing and an ageing population, in which more and more people have been affected by multiple, serious long-term conditions – and yet funding for general practice has been slashed.

"On the one hand, the people who run the NHS across the UK say they want more people to be cared for in the community. On the other, resources have relentlessly drifted away from community-based health services towards more expensive hospital-based care.

"The flow of funding away from general practice has been contrary to the rhetoric and has happened in the absence of any overall strategy as to how we spend the NHS budget.

"The share of the NHS budget spent on general practice has slumped to the lowest point on record. The various NHS bodies and governments who decide how we divide the NHS funding cake in the UK have inadvertently allowed a situation to develop in which funding for general practice is being steadily eroded. With services now at breaking point, it's time to come up with a plan to turn the tide."

She added: "We need to increase our investment in general practice as a matter of urgency, so that we can take the pressure off our hospitals, where medical provision is more expensive, and ensure that more people can receive care where they say they want it - in the community.

"The governments of the UK must end this crisis by increasing spending on patient care in general practice to 11% of the total NHS budget across the UK by 2017."

President and Chair of the National Association for Patient Participation, Patricia Wilkie, said:

"We believe that there needs to be increased investment in patients and GP care in order to improve and sustain the high standards of quality in patient care that patients need and GPs want to give."

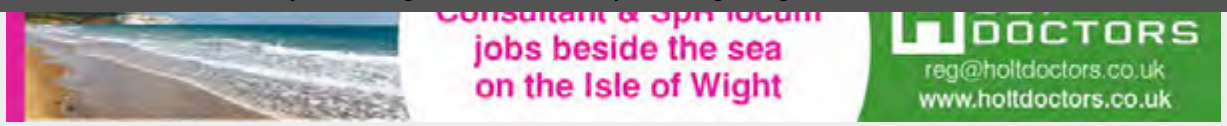
ENDS

Further Information

RCGP Press office: 020 3188 7574/7575/7581
Out of hours: 0203 188 7659
press@rcgp.org.uk

Notes to editor

The Royal College of General Practitioners is a network of more than 50,000 family doctors working to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on education, training, research and clinical standards.



Hundreds of GP surgeries no longer offer extended opening hours

Authors: Helen Jaques

Publication date: 27 Jul 2012

The number of general practices in England offering evening and weekend appointments has dropped by 5.7% in 2011-12 from the 2010-11 f gure, research by the Labour Party has found.

Of the 91 primary care trusts (PCTs) that responded to a request made under freedom of information legislation, more than half (56%) reported a decrease from 2010-11 in the number of surgeries that offered extended opening hours.

A total of 234 (5.7%) of the practices covered by these 91 trusts no longer offered extended opening hours in 2011-12, the f rst fall since extended hours were introduced in 2008.

If extrapolated across the 8316 practices in England this decrease would be equivalent to 477 surgeries opting out of evening and weekend opening hours.

Only a tenth (11%) of primary care trusts reported an increase in the number of general practices in their area offering extended opening hours. A third (32%) reported no change in the number of surgeries opening late and at weekends.

Trusts in Hartlepool, Newcastle, and Haringey in north London reported the biggest drop in practices offering extended hours, with falls of 31.3%, 25%, and 24.3%,

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respectively.

The majority of general practices in England are contractually required to offer patient appointments in the core hours of 8:00am to 6:30pm Monday to Friday. Practices can chose to open outside of these hours and at weekends if they opt in to a direct enhanced service that acts as an add on to the core contract.

Andy Burnham, Labour's shadow health secretary, said, "The prime minister promised that patients would be able to get evening appointments with their GP, but our f gures show things are heading in the opposite direction—with almost 500 more surgeries now shutting earlier.

"The government's calamitous decision to reorganise the NHS has taken eyes off the ball and allowed the system to drift. Its decision to stop the national monitoring of GP opening hours sent out the wrong signal to the NHS, and now patients are paying the price."

Given the increase in practice expenses, GP surgeries might f nding that the cost of offering extended hours is exceeding the amount they are being paid and that offering longer opening hours is no longer f nancially viable, said Richard Vautrey, deputy chairman of the BMA's General Practitioners Committee.

"Also in many areas, in particular rural areas, there is no great need for extended hours," he said. "I think practices will make a decision about how best to serve their patients but in many areas providing extended hours isn't something that large numbers of patients are asking for."

Helen Jaques *news reporter* BMJ Careers

hjaques@bmj.com

Cite this as *BMJ Careers* ; doi:

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Almost 6% of GPs cut extended hours services

Extended GP services have been reduced under the Coalition despite Conservative promises to maintain opening hours in the evenings and weekends, Labour says.

The party conducted research which shows that half of 91 PCTs reported a decrease in extended services, with 5.7% of GPs, or 477 practices, having scrapped the surgeries in the last year.

The worst falls were found inHartlepool, where 31% of surgeries are operating a reduced service.Newcastleand Haringey PCTs reported that a quarter of practices are reducing opening hours.

Labour suggested that this was increasing pressure on A&E departments, with 21.5 million visits in 2011-12 compared with 20.5 million in 2010-11.

Shadow health secretary Andy Burnham said: “There is a cumulative impact here of a range of government policies that is beginning to create markedly inferior service for the public, be it a GP service, be it in an A&E, or be it looking for a walk-in service that doesn't exist anymore. People are then turning up at A&E sicker, and then you get fewer staff in A&E to deal with them.”

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In a pre-election promise, Cameron stated that patients would be able to see a GP in their area until 8pm, seven days a week.

Burnham continued: “David Cameron ruthlessly used the NHS before the election to pose as a different kind of Tory and made a series of promises to get intoDowning Street– but day by day his words appear increasingly hollow. The prime minister promised patients would be able to get evening appointments with their GP, but our figures show things are heading in the opposite direction – with almost 500 more surgeries now shutting earlier.”

A Conservative spokesman responded: “It is more than a bit rich for the Labour party to lecture this government on access to GPs out of hours when it was their disastrous GP contract which meant that 90% of surgeries stopped offering this service altogether.

“Our plans to put doctors back in charge of the NHS, which were opposed by Labour, will mean that local doctors will once again be responsible for caring for their patients out of hours and will offer patients a real choice of which GP surgery to go to.”

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New analysis confirms government target missed as A&E waiting times hit nine-year high

4 Jun 2013

New analysis of data for the final quarter of 2012/13 shows that nearly 6 per cent of patients waited four hours or longer in A&E departments, the highest level since 2004.

The **latest quarterly monitoring report from The King's Fund** shows that 313,000 patients (5.9 per cent) spent four hours or more in A&E in the period January to March 2013, an increase of more than a third on the previous three months and nearly 40 per cent on the same quarter in 2011/12. This means that, across the quarter as a whole, the government's target that no more than 5 per cent of patients should wait longer than four hours in A&E was missed for the first time since the Prime Minister pledged to keep A&E waiting times low in June 2011.

Nearly 40 per cent of trusts (98) reported breaches in the target, an increase of 50 per cent on the previous quarter. Data also shows that the proportion of patients waiting longer than four hours before being admitted from A&E to hospital – so-called trolley waits – rose to almost 7 per cent, also the highest level since 2004. While more recent data shows that A&E and trolley waits have since fallen back to pre-winter levels, this analysis confirms the severe strain on emergency care in early 2013 and the risk that performance could deteriorate again next winter.

The growing pressure on hospitals is also reflected in a survey of NHS finance directors carried out for the report. This suggests that, although the NHS will end 2012/13 in a healthy financial position, the outlook for the next two years is bleak, with the majority expecting the NHS to fail to meet its

Contact the press team

T: 020 7307 2585
M: 07584 146035
E: mediaoffice@kingsfund.org.uk

Patrick South
Assistant Director, Communications (External Affairs)

Saskia Kendall
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target to deliver £20 billion in productivity improvements by 2015. The main findings from the survey of 51 finance directors were:

- 90 per cent (46) expect to end the 2012/13 financial year in surplus with only 4 per cent (2) expecting a deficit
- more than 40 per cent (21) said that the quality of patient care in their area had got worse over the previous 12 months
- more than two-thirds (35) indicated that the government's reforms had a negative impact on performance
- while nearly half (24) met their productivity target in 2012/13, less than 40 per cent (19) are confident of doing so in 2013/14, a reduction in confidence compared to previous surveys
- more than 90 per cent (49) estimate the risk of the NHS failing to meet its £20 billion productivity target as 50/50 or worse.

The pessimistic outlook reflects growing financial pressure on the NHS. So far, a large proportion of savings have been the result of an ongoing pay freeze for staff, reductions in prices paid to hospitals and cuts in management costs. With these savings increasingly difficult to sustain, further productivity improvements will become harder to deliver without changes to services. The pressure will be exacerbated by cuts in funding for social care - more than two-thirds of finance directors (34) identified reductions in local authority funding as affecting their trust last year.

Despite the pressures in emergency care, other NHS performance measures are continuing to hold up well. Waiting times for referral to treatment in hospital, the number of health care-acquired infections and delays in transferring patients out of hospital all remain stable.

Commenting on the report, **John Appleby**, Chief Economist at The King's Fund, said: 'Emergency care acts as a barometer for the NHS. The worryingly high number of patients waiting longer than four hours in the last quarter of 2012/13 is a clear warning sign that the health system is under severe strain. The pressures in emergency care will not be relieved by focusing on a single aspect of the problem in isolation – it requires a co-ordinated response across the whole health system.

'While the NHS is in a healthy financial position overall, efficiencies are becoming harder to deliver as one-off savings such as cuts in management costs start to slow. This is compounded by the need to maintain staffing levels following the shocking failures of care highlighted by the Francis report. With staff costs making up the bulk of the NHS budget, this will leave little room for manoeuvre - significant changes to services will be required if the NHS is to meet its target of delivering £20 billion in efficiency savings.'

More on quarterly monitoring

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Pressures on A&E services »

John Appleby looks at the facts behind A&E attendances.

How is the health and social care system performing? is the eighth of The King's Fund's regular quarterly monitoring reports and was published on 4 June 2013. For further information or to request an interview with John Appleby, please contact the Press and Public Affairs team on 020 7307 2585 (if calling out of hours, please ring 07584 146035).

The survey of finance directors was carried out online between 16 April 2013 and 29 April 2013. Of 136 finance directors contacted, 51 responded to the survey, 26 of whom worked in acute or combined acute and community trusts, with the remainder from mental health, ambulance and specialist trusts. The survey aims to provide a snapshot of opinion and is not intended to be a representative sample.

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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The list of 66 A&E and maternity units being hit by cuts

We reveal the dozens of maternity and A&E units which have been closed or downgraded since 2010 and the dozens more now under threat

Dozens of maternity and A&E units which have been closed or downgraded since 2010 Photo: PA

By Laura Donnelly, Health Editor
6:00AM GMT 26 Oct 2014

2 Comments

Research by The Telegraph shows that dozens of NHS maternity and Accident & Emergency units have been closed or downgraded since the last election, with even more under threat. Here, details of the changes which have taken place, and the changes facing decisions in the coming months:

Accident & Emergency closures and downgrades since May 2010

Downgraded:

Hammersmith, west London September 2014

Central Middlesex Hospital, north London, September 2014

Chase Farm, north London December 2013

Wycombe Hospital, Buckinghamshire downgraded from an emergency medical

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centre which took some ambulance cases to a minor injuries unit, October 2012

Trafford Hospital, Greater Manchester, November 2013.

Queen Elizabeth II, Welwyn Garden City, A&E services reduced to 12 hours a day in January 2012, with minor injuries service overnight. From Oct 1 2014, no A&E but 24-hour urgent care centre dealing with minor injuries and illnesses.

Queen Mary's Sidcup, south east London, temporarily closed winter 2010, officially downgraded in October 2013

Cheltenham Hospital, Gloucestershire July 2013

St Cross Hospital, Rugby, September 2013

Stafford Hospital, closed overnight, December 2011.

Newark Hospital, Nottinghamshire, April 2011

Rochdale Infirmary, Greater Manchester, April 2011

Maidstone Hospital, Kent, September 2011

Downgrades agreed but not yet implemented

Wansbeck Hospital, Northumbria, due mid 2015

North Tyneside Hospital, North Shields, due mid 2015

King George's Hospital, Ilford, due 2015

Dewsbury Hospital, west Yorkshire due 2017

City Hospital, Birmingham, due 2017-18

Sandwell Hospital, Birmingham, due 2017-18

Closed:

University Hospital of Hartlepool August 2011, urgent care centre opened elsewhere in the town

A&E downgrades or closures now planned or under consideration

Calderdale Royal Hospital, Halifax, west Yorkshire, preferred option was to close A&E earlier this year - public consultation delayed

Bedford or Milton Keynes; decision on preferred option to scale back could come this month

North Manchester Hospital, Fairfield Hospital, and Tameside Hospitals - proposals to close emergency surgery, so A&E patients likely to require it will be diverted to more major centres

Two or three of four hospitals - Wythenshaw, Stepping Hill, Royal Bolton and Royal Albert Edward Infirmary, Wigan – are proposed to lose emergency surgery

Lincoln, Grantham and Boston hospitals, Lincolnshire; plans to reduce the number of sites with full A&E

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5. A&E in crisis: a special report

Basingstoke Hospital, Hampshire and Royal Hampshire County Hospital, Winchester; proposals to centralise services – possibly at a new hospital – will be consulted on later this year

Royal Shrewsbury Hospital and Telford Hospital – proposals under discussion could lead to loss of full A&E from one of the hospitals

Alexandra Hospital, Redditch, proposals still to go to public consultation, but officials seeking to downgrade to an emergency centre, with major emergencies diverted to Worcestershire Royal Hospital and an emergency centre at the Alexandra Hospital.

Ealing, no decision taken, timetable likely to mean changes in 2017/18, if agreed

Charing Cross no decision taken, timetable likely to mean changes in 2017/18, if agreed

Maternity closures and downgrades since May 2010

Consultant-led units closed:

King George's Hospital, Ilford, March 2013

Chase Farm, North London, November 2013

Rochdale, Greater Manchester June 2011

Salford, Greater Manchester, November 2011, replaced with midwife-led unit which may now be closed

Bury, Greater Manchester, March 2012

Queen Mary's Sidcup, Kent, temporary closure September 2010, became permanent October 2013

QEII Hospital, Welwyn, October 2011

Consultant-led units replaced by midwife-led units:

Sandwell Hospital, Birmingham, January 2011,

Solihull Hospital, Birmingham, temporary closure in April 2010, midwife led unit set up in July 2010

Eastbourne District General Hospital, temporarily from May 2013, decision not to reopen taken in June 2014 .

Maidstone Hospital, Kent, September 2011

Friarage, Northallerton, North Yorkshire, consultant-led unit closed October 6, being replaced with midwife led unit

Midwife-led units closed:

Darley Birth Centre, Matlock, Derbyshire, July 2012

Corbar Birth Centre in Buxton, Derbyshire, July 2012

Canterbury Hospital, Kent, May 2012

Buckland Hospital, Dover, Kent May 2012

Castle Hill Hospital, Cottingham, near Hull closed temporarily in 2011, permanently, January 2012

Grantham Hospital, Lincolnshire, February 2014.

Heatherwood Hospital, Ascot, Berkshire – closed temporarily September 2011, permanently in February 2012

Maternity unit downgrades or closures now planned or under consideration

Bishop Auckland Hospital's midwife-led unit, Country Durham, closed on safety grounds since July 2013, future uncertain

Salford Royal midwife-led unit, under review

North Tyneside midwife-led unit planned for closure

Proposals to replace consultant-led units with midwife led units:

Stafford Hospital

Dewsbury and District Hospital, West Yorkshire

Alexandra Hospital, Redditch, Worcestershire

Bedford or Milton Keynes, Buckinghamshire

Pilgrim Hospital, Boston or Lincoln, Lincolnshire

University Hospital Lewisham

Ealing

Basingstoke

Royal Hampshire County, Winchester

Mayday Hospital, Croydon; Kingston, south west London; St George's, south London; and St Helier, Sutton – proposals which could lead to fewer consultant-led units and more

Research and analysis

NHS walk-in centre services in England: review

From:	Monitor
First published:	19 February 2014
Part of:	Procurement, choice and competition in the NHS: documents and guidance, NHS patients: about your local NHS foundation trust and Monitor's role and + others
Applies to:	England

The findings of Monitor's review of the provision of NHS walk-in centre services in England.

Documents

Final report and recommendations

PDF, 1.17MB, 110 pages

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Detail

This review looked into how closing NHS walk-in centres affects patients, whether commissioning arrangements for walk-in centres are working well for patients, and whether payment mechanisms related to walk-in centres and general practice services are generating benefits for patients.

Published:

19 February 2014

From:

Monitor

Part of:

Procurement, choice and competition in the NHS: documents and guidance

NHS patients: about your local NHS foundation trust and Monitor's role

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Media briefing note - winter pressures

Contents

All media enquiries to be directed to Michelle Kane
NHS England media team
nhsengland.media@nhs.uk

0207 972 2805 or 07768 901 293

Introduction

- The NHS has pulled out all the stops to prepare for this winter. We are determined to protect the good standards of service that the public have come to expect and frontline workers have worked tirelessly to deliver, despite the very considerable pressures that we anticipate over the winter months.

- As a result, planning started earlier than ever before (May) with hospitals, GPs, social services and other health professionals coming together to work out the best way of responding in every area of the country.

- Some £250m has been injected to help support the NHS over the period. A&E departments that will benefit most have been identified with £221m going to 53 trusts. A further £15m will be used to increase the capacity of NHS 111 to help deal with demand. Latest statistics show that 92 per cent of callers are satisfied with the service.

- The money will be used to support different initiatives, decided at local hospital level, tailored to local needs. The money is given with conditions. Hospitals will have to show how they have made improvements with these funds.

- NHS England, Monitor and the NHS Trust Development Authority will monitor developments with great care so that action can be taken quickly. Importantly we want to publish more information and analysis for the public so they can see how the NHS is getting on, being more transparent than ever before.

- A further £150m will be distributed around England to help local systems maintain standards and reduce pressures on A&Es caused by cold weather. The additional money will come from NHS England's expected surplus for the current financial year. It will be distributed among local communities based on the number of people they serve.

- It is important the public know what they need to do so we will be taking action to ensure the information they need is readily available. Local campaigns will help people look after themselves and to find the right place to get care when needed.

- Whatever happens this winter, the urgent care system has reached the point where it needs radical change so it can continue to meet the needs of the public.

- Above all, we must ensure the public can get the right care, in the right place, first time, every day of the week. We plan, on behalf of the public, to develop a shared vision of the future and the clinical models of care that will make that vision a reality.

The context

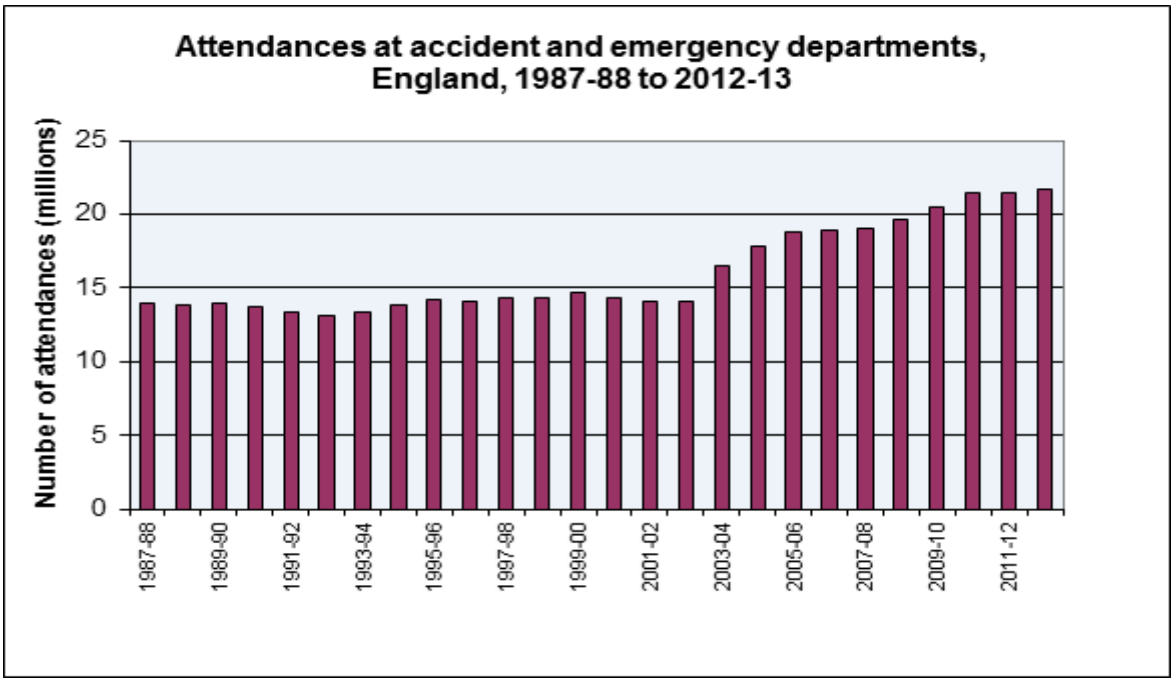
Demand on NHS hospital resources has increased dramatically over the past 10 years, with a 35 per cent increase in emergency hospital admissions and a 65 per cent increase in secondary care episodes for those over 75 years.

- Last year, there were over 21 million visits to A&E or nearly 60,000 attendances every day
- There were 6.8 million attendances at walk in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since these data were first recorded a decade ago
- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008
- Last year, there were 51.4 million GP appointments, one in five due to minor ailments such as coughs, colds and hair lice
- Attendances at hospital A&E departments have increased by more than two million over the last decade
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13

A combination of factors, such as an ageing population, out-dated management of long-term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand over time.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6 per cent per year.

The chart below shows the year on year increase of A&E attendance which has gone up by nearly eight million since 1987, and over seven and a half million in the last decade.



The delivery of the A&E standard across England throughout winter remains a key priority for NHS England and our partners. Since the A&E Improvement Plan was introduced by NHS England in May 2013, Urgent Care Working Groups (UCWGs) have been working locally to support the delivery of the delivery of the 4 hour A&E operational standard, which continues to be met nationally.

UCWGs have plans in place for winter which are also subject to assurance by regional tripartite panels. £250m of non-recurrent funding has been made available in 2013-14, £221m of which has been targeted in support of those local systems, identified by NHS England, the NHS Trust Development Authority and Monitor, which will benefit the most from the extra funding. This money has been given by NHS England to lead Clinical Commissioning Groups to distribute in line with locally agreed plans.

What is happening with trolley waits?

The number of trolley waits is monitored across the country. Everyone Counts has set out that no patients should wait more than 12 hours on a trolley in an A&E department – a requirement that did not exist under the previous system – and CCGs are empowered to take action against providers that breach this condition.

Preparations for winter

Preparations started earlier than in previous years. This section sets out what has happened.

To deliver patients' rights under the NHS Constitution, the NHS must meet the operational standard of 95 per cent of A&E patients being seen and discharged within four hours. Last winter the NHS found it harder than usual to meet the standard. Analysis did not reveal a single trend or factor to explain this dip in performance, but increased numbers of patients arriving at A&E, increased admission rates and acuity of admissions, prolonged spells of cold weather, and underperforming NHS 111 have all been cited as factors.

Action Taken

- **Planning**

NHS England wrote to the health service on 9 May regarding the delivery of the 4 hour A&E operational standard. The accompanying A&E Improvement Plan asked local systems to establish Urgent Care Working Groups (UCWGs) to oversee emergency care services and begin early preparations for this winter.

As a result, local system leaders started to plan for this winter earlier than they have before.

- **Financial support for the NHS locally**

NHS England, Monitor and the TDA have worked closely with the local NHS to identify those A&E departments that will benefit most from extra support. In September, we announced that £221m has been allocated to 53 Trusts. The money will be used to support different initiatives, decided at local hospital level, tailored to local needs. The money is given with conditions. Hospitals will have to show how they have made improvements with these funds. The NHS 111 service is part of the solution to alleviating pressure on accident and emergency departments. Around £15m will be spent on increasing the capacity of NHS 111 to help it to deal with the extra pressures winter brings.

NHS England will also distribute an additional £150m to those communities that are not deemed the most at-risk to bolster and enhance their existing plans to maintain services and reduce the pressure on A&Es caused by cold weather. The additional money will come from NHS England's expected surplus for the current financial year. It will be distributed among local communities based on the number of people they serve.

- **NHS staff flu vaccination programme**

NHS Trusts have been asked to vaccinate 75 per cent of their staff this year. Trusts will not be eligible for a potential allocation from winter monies in 2014/15 if the 75 per cent standard is not met, except in exceptional circumstances where they can prove to the TDA, Monitor and NHS England they have robust plans in place to ensure they will do so next year.

All NHS England Area Teams reported on their state of readiness for implementation of the flu programme in August 2013, outlining the preparedness of providers, vaccine supply and data

flows. There are seven pilot sites which have already started testing the future roll-out of the programme to older primary aged children.

- **Role of Urgent Care Working Groups**

The role of UCWGs is to bring partners together from across the health and care system, including primary care, secondary care, social and community care. The groups provide an important forum of mutual accountability for all partners in the local urgent care system to implement local urgent care plans through winter.

UCWGs do not replace the formal mechanisms of accountability within and between organisations towards improving the delivery of the A&E standard.

Each UCWG was asked to produce an A&E improvement plan that would include preliminary preparation to support delivery of A&E performance over winter. UCWGs developed winter management arrangements by the end of September, and the arrangements were self-assured at system-wide local level, and assured by regional tripartite groups comprising the Trust Development Authority, Monitor and NHS England.

A total of 147 Urgent Care Working Group Assurance Plans have now been reviewed and assured in detail. Working as part of the tripartite, NHS England, will continue to work with UCWGs to keep their plans under review, particularly those considered most challenged.

- **What is the £250m winter funding been used for?**

The Government agreed £250 million of non-recurrent funding for 2013/2014 to be targeted at local health and care systems which will benefit the most. NHS England, Monitor and the NHS Trust Development Authority have worked together to identify 53 systems who will share £221 million. The targeted winter pressures funding was allocated to the frontline at the end of September and is making an impact.

Each of these systems has agreed how they will use their share. Examples include:

- additional experienced senior clinical staff in A&E over the weekends;
- an integrated urgent care centre in A&E;
- pathway improvements for long term conditions requiring urgent care;
- providing support in A&E for mental health and substance misuse patients;
- additional primary care capacity;
- integration of health and social care teams to facilitate discharge and prevent readmission; and an intensive support programme for high referring care homes.

A total of £15m will also be spent on improving the capacity of NHS 111 to enable it to deal with the pressures winter brings. The remaining £14 million is being held as a contingency and the national tripartite group is considering how this might best be used.

The table below provides examples of how the money is being spent. It is important to note the figures are an early sample of the overall allocation.

Category	% of spend	Examples of how funding will be used	How this relates to root causes of pressures on A&E	Examples of progress
Acute Capacity	28	Additional experienced senior clinical staff in A&E over the weekends along with an integrated urgent care centre in A&E	Addressing staffing issues in A&E	Redesign of frail elderly pathway in Ealing. Specialist physician due in post, working in A&E from 1 December. Seven day working fully implemented in North Bristol.
Acute Pathway redesign	23	Pathway improvements for long term conditions requiring urgent care, while providing support in A&E for mental health and substance misuse patients	Addressing the changing case-mix and increased complexity of patients	Senior psychiatric liaison doctor identified to work with North West London A&E. Arrangements for on-site psychiatric assessment unit in hand.
Primary Care	11	Additional primary care capacity to provide urgent response for home visits for patients at imminent risk of admission	Hospital capacity has reduced, so reducing demand to match this will support improved performance	Investment in primary care capacity in Horsham and Mid-Sussex to improve access at weekends. Care plans to be routine for frail elderly and people with complex needs.
Community Care	26	Strengthen community end of life and hospice services to reduce palliative care admissions through A&E	Admitted patients are driving A&E breaches – taking pressure off reduced hospital capacity should support improved performance	Recruitment underway of additional carers and nurses to support specialist palliative care team in community in Dartford.
Social Care	7	Integrate health and social care teams to facilitate discharge and prevent readmission; intensive support programme for high referring care homes	Supports capacity in hospitals – we know that delayed discharge is a localised problem	Recruitment underway of additional social worker, to be based in Brighton Rapid Discharge Team. Investment in Hostels

				Hospital Discharge Project to improve flow for homeless.
Other	5	Hospital Ambulance Liaison Officers to ensure handover/turnaround delays are minimised; first responder tele-care system to assess minor injuries remotely	Demand management to relieve overall input pressures on A&E	Investment in liaison officers in Kent to facilitate handovers. Supported conveyance pilot in Brighton & Hove.

System allocations

Below is a full list of all NHS Trusts and NHS Foundation Trusts who have received extra support this year.

Region	System as identified by NHS Trust/NHS FT	Amounts (£000s)
London	Barking, Havering & Redbridge University Hospitals NHS Trust	£7,000
London	Barnet & Chase Farm Hospitals NHS Trust	£5,120
London	Barts Health NHS Trust	£12,800
London	Croydon Health Services NHS Trust	£4,500
London	Ealing Hospital NHS Trust	£2,900
London	North Middlesex University Hospital Trust	£3,800
London	North West London Hospitals NHS Trust	£6,400
London	South London Healthcare NHS Trust	£7,700
London	Whittington Health NHS Trust	£2,960
London	West Middlesex University Hospital NHS Trust	£2,300
Midlands and East	Basildon and Thurrock NHS FT	£2,490
Midlands and East	Bedford Hospital NHS Trust	£3,734
Midlands and East	Derby Hospitals NHS FT	£4,487
Midlands and East	Heart Of England NHS FT	£9,289
Midlands and East	Kettering General Hospital NHS FT	£3,919
Midlands and East	Mid Essex Hospital Services NHS Trust	£2,869
Midlands and East	Mid Staffordshire NHS FT	£3,747
Midlands and	Milton Keynes Hospital NHS FT	£2,763
Midlands and East	Northampton General Hospital NHS Trust	£4,000
Midlands and East	Peterborough and Stamford NHS FT	£5,050
Midlands and East	Sandwell and West Birmingham Hospitals NHS Trust	£4,218

Midlands and East	Shrewsbury and Telford Hospital NHS Trust	£4,000
Midlands and East	The Queen Elizabeth Hospital, King's Lynn. NHS FT	£3,990
Midlands and East	The Princess Alexandra Hospital NHS Trust	£5,700
Midlands and East	United Lincolnshire Hospitals NHS Trust	£8,000
Midlands and East	University Hospital Coventry and Warwickshire NHS Trust	£4,000
Midlands and East	University Hospital Of North Staffordshire NHS Trust	£3,460
Midlands and East	University Hospitals Of Leicester NHS Trust	£10,000
Midlands and East	Worcester Acute Hospitals Trust	£1,000
North	Aintree University Hospital NHS FT	£1,520
North	Airedale NHS FT	£1,450
North	East Lancashire Hospitals NHS Trust	£1,403
North	Lancashire Teaching Hospitals NHS FT	£914
North	Leeds Teaching Hospitals NHS Trust	£1,890
North	Northern Lincolnshire and Goole Hospitals NHS FT	£1,044
North	North Cumbria University Hospitals NHS Trust	£2,292
North	Southport & Ormskirk Hospital NHS Trust	£4,042
North	Stockport NHS FT	£1,530
North	Tameside Hospital NHS FT	£2,475
North	University Hospitals Of Morecambe Bay NHS FT	£1,257
North	York Teaching Hospital NHS FT	£2,061
South	Brighton and Sussex University Hospitals NHS Trust	£2,326
South	Dartford and Gravesham NHS Trust	£4,080
South	East Sussex Healthcare NHS Trust	£2,300
South	Hampshire Hospitals NHS FT	£3,302
South	Heatherwood and Wexham Park Hospitals NHS FT	£6,644
South	Medway NHS FT	£6,120
South	North Bristol NHS Trust	£5,900
South	Oxford University Hospitals NHS Trust	£10,207
South	Plymouth Hospitals NHS Trust	£5,500
South	Portsmouth Hospitals NHS Trust	£1,427
South	Royal United Bath Hospitals NHS Trust	£4,426
South	Weston Area Health Trust	£4,800

- **What about the additional £150m?**

A further £150 million will be distributed around England to help hospitals maintain their A&E services over winter.

This is in addition to the £250 million targeted to the most at-risk areas in September. The distribution of the extra £150 million will include those communities that are not deemed the most at-risk, to bolster and enhance their existing plans to maintain services and reduce the pressure on A&Es caused by cold weather.

The additional money will come from NHS England's expected surplus for the current financial year. It will be distributed among local communities based on the number of people they serve.

The money will be paid as an additional allocation to 157 Clinical Commissioning Groups (CCGs), the GP-led groups now responsible for the planning and purchasing of most hospital and community services in their own local areas.

Decisions on how the money will be spent will be taken by Urgent Care Working Groups – the new collaborative groups of hospital, community and primary care clinicians responsible for ensuring A&E services meet four-hour standards and provide high-quality care.

As with the funding announced by the Department of Health in September, health services can use this additional money to improve other services away from A&E to reduce unnecessary visits and avoidable emergency admissions, as well as boosting individual A&E departments.

Local initiatives could include:

- minimising A&E attendances and hospital admissions from care homes by appointing specialists in charge of joining up services for the elderly
- Improved access to out-of-hours social work, increased hours at walk-in centres, increased intermediate care beds and extension to pharmacy services to ease pressures on A&E departments
- consultant reviews of all ambulance arrivals in A&E so that a senior level decision is taken on what care is needed at the earliest opportunity

Details of the CCG allocations will be available on the NHS England website later today.

NHS 111

An efficient and effective NHS 111 service will play a very large part in helping to manage winter pressures by offering expert health advice.

The NHS 111 service has been introduced as part of the wider revisions to the urgent care service to make it easier for the public to access the right services, first time. The new NHS 111 service makes it easier for the public to access healthcare services when they need medical help fast, but it's not a life-threatening situation.

NHS 111 assesses callers' symptoms, gives them the healthcare advice they need or directs them straightaway to the right local service. NHS 111 is available 24 hours a day, seven days a week and is free to call from landlines and mobile phones.

NHS 111 can also help to take the pressure off the 999 emergency service and local A&E departments, which many people turn to if they don't know where else to go for the urgent help they need.

The latest data for September 2013 shows NHS 111 continues to provide a good service to the public and more people are getting access to the service -93 per cent of the population of England now have access to NHS 111.

The data also shows that even more calls were answered promptly with 97.1 per cent of callers answered within 60 seconds and of all calls offered only 0.7 percent were abandoned after waiting longer than 30 seconds . More people than ever called the NHS 111 service – 585,305 calls were made to the service in September and levels of satisfaction remain high. In the last survey into satisfaction levels, 92 per cent of people using the service were satisfied or highly satisfied with it.

NHS England has been working with commissioners, and the South Central Ambulance Service NHS Trust (SCAS), to plan for additional capacity to handle the significant additional demand on NHS 111 services which is anticipated over the winter and Christmas periods. NHS England has allocated an additional £15m funds to support NHS 111 through the forthcoming winter period which will enable SCAS to provide additional contingency support for over an additional 9,000 calls per week from 27 November 2013.

This additional money will also be used to provide a suite of other NHS 111 contingency measures such as the extension of the 0845 4647 NHS Direct service in some areas, and funding for commissioners to improve the quality of their local Directories of Service.

NHS England Winter Health Check

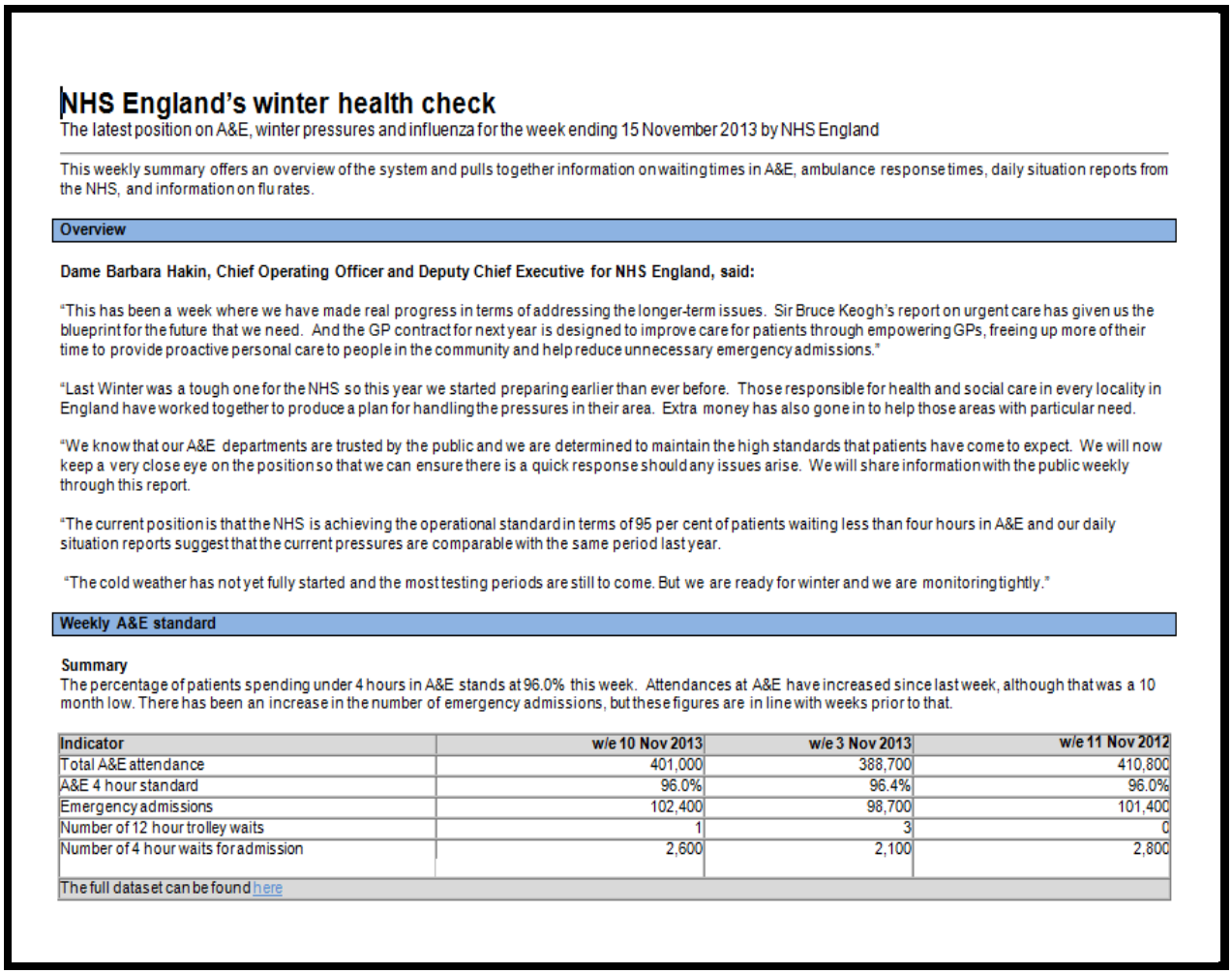
Starting 15 November, NHS England will publish a Winter Health Check, a weekly round-up of data that tell us about the impact of winter on the health and care system at **9:30am every Friday**.

The round-up draws together a range of datasets covering waiting in A&E, ambulance response times, daily situation reports from the NHS in every part of the country, and will link with Public Health England's weekly report on rates of flu, norovirus and other diseases, to give a clear and accurate overview of what is happening.

As well as containing the latest information from the previous week, the round-up will include time series data on a number of indicators to enable accurate historical comparisons.

All statistics used in the report can be found here on the NHS England website and a copy of the NHS England Winter Health Check report can be found here.

An example of the report can be seen below:



NHS England's winter health check

The latest position on A&E, winter pressures and influenza for the week ending 15 November 2013 by NHS England

This weekly summary offers an overview of the system and pulls together information on waiting times in A&E, ambulance response times, daily situation reports from the NHS, and information on flu rates.

Overview

Dame Barbara Hakin, Chief Operating Officer and Deputy Chief Executive for NHS England, said:

"This has been a week where we have made real progress in terms of addressing the longer-term issues. Sir Bruce Keogh's report on urgent care has given us the blueprint for the future that we need. And the GP contract for next year is designed to improve care for patients through empowering GPs, freeing up more of their time to provide proactive personal care to people in the community and help reduce unnecessary emergency admissions."

"Last Winter was a tough one for the NHS so this year we started preparing earlier than ever before. Those responsible for health and social care in every locality in England have worked together to produce a plan for handling the pressures in their area. Extra money has also gone in to help those areas with particular need.

"We know that our A&E departments are trusted by the public and we are determined to maintain the high standards that patients have come to expect. We will now keep a very close eye on the position so that we can ensure there is a quick response should any issues arise. We will share information with the public weekly through this report.

"The current position is that the NHS is achieving the operational standard in terms of 95 per cent of patients waiting less than four hours in A&E and our daily situation reports suggest that the current pressures are comparable with the same period last year.

"The cold weather has not yet fully started and the most testing periods are still to come. But we are ready for winter and we are monitoring tightly."

Weekly A&E standard

Summary

The percentage of patients spending under 4 hours in A&E stands at 96.0% this week. Attendances at A&E have increased since last week, although that was a 10 month low. There has been an increase in the number of emergency admissions, but these figures are in line with weeks prior to that.

Indicator	w/e 10 Nov 2013	w/e 3 Nov 2013	w/e 11 Nov 2012
Total A&E attendance	401,000	388,700	410,800
A&E 4 hour standard	96.0%	96.4%	96.0%
Emergency admissions	102,400	98,700	101,400
Number of 12 hour trolley waits	1	3	0
Number of 4 hour waits for admission	2,600	2,100	2,800

The full dataset can be found here

Case studies

7 day GP care in Durham to ease A&E

GPs in the North East are working a seven day week to make sure people can get an appointment locally at weekends.

The region's 31 practices are opening at the weekends so patients will be able to call and book routine appointments with a GP, but are also be able to go to their local surgery for urgent, but not emergency, treatment.

All practices will be taking any patients who need treatment, not just those on their own lists, with the local NHS 111 service making appointments for all practices. This initiative has been driven by local doctors, nurses and other healthcare professionals.

County Durham and Darlington NHS Foundation Trust
Simon Clayton, North of England Commissioning Support (NECS), 07826 531333
simonclayton@nhs.net

'Virtual Winter Ward' to help keep patients in their own homes

A virtual ward has been set up for patients in Middlesbrough so that they can receive care in their own homes instead of hospital. As well as benefits to the patient, such as receiving car and treatment in your own home and reduced risk of infection from seasonal flu or norovirus, the virtual ward also free up inpatient beds and visits to A&E.

The South Tees Hospital in Middlesbrough has also set up a 30 bed winter ward to meet the expected increase in patients over the winter period, investing an extra £650k in doctors and nurses.

South Tees NHS Trust
Amanda Marksby, Head of Communications, 01642 854343 Amanda.Marksby@stees.nhs.uk

Dedicated children's nursing team working at PACE

A dedicated team of specialist children's nurses in Birmingham has been set up to give a rapid response to parents worried about their child while in hospital.

The PACE team, who ward nurses or doctors can call if they or even the parents think that there is 'something not quite right', is just one of the measures Birmingham Children's Hospital has in place this winter to keep standards high and relieve pressure on the Emergency Department and wards.
Any parent worried can ask the nurses to alert the PACE team and the team have received over 1,000 referrals from doctors, nurses, anaesthetists and parents alike, since the scheme launched in January 2013.

Work is also under way to add a dedicated phone line that parents can call if they are particularly worried that their child is getting sicker.

The Trust, which achieved the 95% A&E target last year seeing 97.9 per cent of their 12,234 patients in under four hours from January to March this year, has also invested in extended A&E consultant cover.

Extra weekend working in the labs has also been put on to make sure samples can be sent off that day and families can get quicker results and go home sooner freeing up beds.

Birmingham Children's Hospital
Contact: NHS England media team 07768 901 293

Sustainable, all year acute care for older patients

The Emergency Multidisciplinary Unit (EMU) run by Oxford Health NHS Foundation Trust aims to deliver an acute care pathway for frail older patients that does not rely on bed-based care yet can still provide appropriate medical, nursing and therapist treatments within an individually tailored care plan as close to the patient's home as possible. It delivers an innovative service to the community by changing pathways of care focussing on patients' needs for rapidly responsive and local services by changing the culture of 'silo-working' among healthcare professionals to a more integrated approach supported by technological innovation.

A comprehensive assessment (supported by point of care diagnostics for laboratory tests and basic imaging) enables acute medical diagnosis and treatment with on-going care to support patients and carers during episodes of acute illness without acute hospital admission. It has a dedicated ambulance and driver to ensure rapid transfer to and from EMU and the team on the unit consists of nurses, health care assistants, physiotherapists, occupational therapists, social workers and the medical team contains elderly care physicians and general practitioners.

A key aim of the unit is to allow patients to stay safely at home in a familiar and secure environment during acute illness by providing care that is high quality in terms of medical decision making, monitoring and appropriate therapeutic interventions coupled with therapist assessment and intervention. A pool of five beds is available for short term use (<72 hours) for patients who are not suitable for ambulatory care but continuity of the clinical team is maintained by using these beds rather than transfer to the large acute hospital. There is also the availability of the 'hospital at home' nursing team who can support the EMU in delivering therapeutic interventions in patients' homes.

Oxford Health NHS Foundation Trust
Contact: Alistair Duncan, Communications Manager
Alistair.Duncan@oxfordhealth.nhs.uk

Guy's and St Thomas' Home ward and Enhanced Rapid Response service

The Home ward and Enhanced Rapid Response service have helped more than 1,200 local residents in Lambeth and Southwark to be treated at home rather than in hospital.

Launched as pilot schemes in January 2012, both services have recently been extended to support patients in all parts of the two local boroughs with a range of chronic diseases including diabetes, heart disease and severe breathing problems.

Nurses, physiotherapists, social workers and GPs work together to provide patients with the care they need to stay out of hospital and in their own homes. Patients can be referred to the service by their GP or hospital doctor.

Guy's and St Thomas' NHS Foundation Trust
Megan Elliott, Senior Media Officer, 0207 118 8523

Key contacts

NHS England is working with colleagues across the NHS and the Department of Health to ensure that the system is prepared ahead of the winter period. Below are the roles and responsibilities of each organisation key to ensuring the system provides high quality urgent and emergency care for patients and the public this winter.

- **NHS England**

NHS England is responsible for overall oversight of the NHS.

Enquiries about NHS England, NHS 111 and national issues should be directed to Michelle Kane at michellekane@nhs.net or nhsengland@nhs.net 0207 972 2805 or 07768 901293

- **Department of Health**

The Department of Health is a ministerial department who lead across health and care by creating national policies and legislation, providing the long-term vision and ambition to meet current and future challenges.

Enquiries about the Department of Health should be directed to Sarah Weaver sarah.weaver@dh.gsi.gov.uk 020 7210 5962

- **Monitor**

Monitor is the regulator for health services in England and is charged with protecting and promoting the interests of patients by ensuring that the whole sector works for their benefit. Monitor exercise a range of powers granted by Parliament, including making sure public sector providers are well led and essential NHS services continue if a provider gets into difficulty. More information about Monitor's role can be found here.

Enquiries about NHS Foundation Trusts should be directed to:
press.office@monitor.gov.uk 020 3747 0800

- **Trust Development Authority**

The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts. The range of services provided by NHS Trusts covers the entire spectrum of healthcare, from acute hospitals to ambulance services through to mental health and community providers; the size of organisation varies from very small providers through to some of the largest organisations in the NHS, and therefore each Trust has a set of unique challenges.

Any enquiries about NHS Trusts should be directed to:

ntda.communications@nhs.net 0207 932 1967

- **Public Health England**

Public Health England are responsible making the public healthier by encouraging discussions, advising government and supporting action by local government, the NHS and other people and organisations.

Enquiries about public health issues, including flu, immunisation, norovirus and health protection should be directed to:
phe-pressoffice@phe.gov.uk 020 7654 8400

- **NHS Trusts/NHS Foundation Trusts**

NHS Trusts and NHS Foundation Trusts are commissioned by CCGs to provide hospital services for the local community and by directly NHS England to provide specialist services that are commissioned at a national level.

Enquiries about issues affecting individual NHS Trusts and NHS Foundation Trusts should be directed to them in the first instance. A full list of trusts can be found here

- **Clinical Commissioning Groups**

CCG are responsible for commissioning most local health and care services on behalf of patients, including planned hospital care and accident and emergency.

Enquiries about the performance or issues of individual Trusts or health and care systems should be directed to the relevant CCG as commissioner of the service.

- **NHS Ambulance Trusts**

The UK Ambulance Service is comprised of ten individual NHS Ambulance Trusts and are commissioned and funded by local Clinical Commissioning Groups, often through a "lead commissioner" arrangement.

Enquiries about the performance of individual ambulance services should be directed to the appropriate ambulance trust. A full list of providers can be found here.

Spokespeople

The NHS England team available for broadcast bids include:

- Dame Barbara Hakin, Deputy Chief Executive and Chief Operating Officer
- Professor Sir Bruce Keogh, National Medical Director
- Jane Cummings, Chief Nursing Officer
- Professor Keith Willett, National Clinical Director for Acute Episodes of Care

- Professor Jonathan Benger, National Clinical Director for Urgent Care
- Liz Redfern, Deputy Chief Nursing Officer

The following NHS England National Clinical Directors will be available for interview on condition specific issues.

Condition	**National Clinical Director**
Respiratory	Professor Mike Morgan
Diabetes	Dr Jonathan Valabhji
Long Term Conditions	Mr Martin McShane
Dementia	Professor Alistair Burns
Integration and Frailty	Professor John Young
Acute Episodes of Care	Professor Keith Willett
Children	Dr Jacqueline Cornish
Urgent Care	Professor Jonathan Benger
Rural and Remote Care	Dr Lesley Boswell
Cardiac	Huon Gray

Regional and local NHS England leaders are also available for media bids. All bids should go through the NHS England regional media teams.

Area/Contact	**Spokesperson**
North	Dr Mike Bewick, Medical Director Gill Harris, Director of Nursing
Midlands and East	Dr David Levy, Medical Director Ruth May, Director of Nursing
London	Dr Andy Mitchell, Medical Director Caroline Alexander, Director of Nursing
South	Dr Nigel Acheson, Medical Director Liz Redfern, Director of Nursing

STATISTICAL PRESS NOTICE
NHS REFERRAL TO TREATMENT (RTT) WAITING TIMES DATA
OCTOBER 2014

Data are published on consultant-led Referral to Treatment (RTT) waiting times for patients who were treated during October 2014 and patients waiting to start treatment at the end of October 2014.

Main Findings

- During October 2014, 89.0 % of admitted patients and 95.2% of non-admitted patients started treatment within 18 weeks. For patients waiting to start treatment (incomplete pathways) at the end of October 2014, 93.2% were waiting up to 18 weeks.

- 330,247 RTT patients started admitted treatment and 933,443 started non-admitted treatment during October 2014. The number of RTT patients waiting to start treatment at the end of October 2014 was just over 3.0 million patients.

- The average (median) time waited for patients completing an RTT pathway in October 2014 was 9.3 weeks for admitted patients and 5.4 weeks for non-admitted patients. For patients waiting to start treatment at the end of October 2014, the median waiting time was 5.8 weeks.

- For patients waiting to start treatment (incomplete pathways) at the end of October 2014, 381 were waiting more than 52 weeks.

The following Trusts did not submit any (admitted, non-admitted and incomplete) RTT pathway data for October 2014:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Barts NHS Health Trust
- Heart of England NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- Walsall Healthcare NHS Trust

The following Trust did not submit data on incomplete RTT pathways for Oct 2014:

- Tameside Hospital NHS Foundation Trust

Royal Free London NHS Foundation Trust did not submit any data for the former Barnet and Chase Farm Hospitals NHS Trust with whom it merged from 1st July 2014.

Factoring in estimates based on the latest data submitted for each missing Trust suggests the total number of RTT patients waiting to start treatment at the end of October 2014 may have been just over 3.2 million patients. See section 5 of Notes to Editors for details of the latest data submitted by missing Trusts.

Detailed tables of waiting times by treatment function (specialty), commissioner and provider are available at:
http://www.england.nhs.uk/statistics/rtt-waiting-times/

Table 1 – October 2014 Referral to Treatment (RTT) waiting times by treatment function, England

	Admitted Pathways		Non-Admitted Pathways		Incomplete Pathways	
Treatment function	Total (all)	% within 18 weeks	Total (all)	% within 18 weeks	Total (all)	% within 18 weeks
General Surgery	40,402	88.0%	66,242	95.0%	261,221	92.0%
Urology	20,447	88.8%	34,575	94.3%	147,565	91.8%
Trauma & Orthopaedics	62,289	86.0%	98,690	94.6%	413,545	91.8%
ENT	17,139	85.0%	72,054	95.1%	201,698	93.0%
Ophthalmology	45,305	89.5%	89,923	95.6%	309,134	94.3%
Oral Surgery	18,521	86.3%	34,094	92.3%	132,389	93.2%
Neurosurgery	2,519	83.6%	5,042	91.6%	26,680	89.1%
Plastic Surgery	12,590	90.2%	10,384	96.0%	49,163	90.7%
Cardiothoracic Surgery	2,082	87.0%	1,080	95.4%	7,392	89.7%
General Medicine	3,404	97.9%	18,188	96.7%	45,971	95.4%
Gastroenterology	14,879	97.3%	30,705	92.7%	132,582	93.7%
Cardiology	10,322	91.0%	42,307	95.6%	131,693	93.6%
Dermatology	7,975	91.8%	67,004	94.8%	173,629	94.5%
Thoracic Medicine	1,827	98.4%	20,876	95.2%	56,675	93.9%
Neurology	1,227	95.3%	25,490	92.4%	92,034	93.1%
Rheumatology	2,078	97.3%	23,920	96.5%	57,029	96.0%
Geriatric Medicine	134	98.5%	10,967	98.7%	18,424	97.5%
Gynaecology	24,024	91.7%	67,034	97.7%	177,623	95.0%
Other	43,083	89.6%	214,868	95.4%	571,459	93.3%
England	**330,247**	**89.0%**	**933,443**	**95.2%**	**3,005,906**	**93.2%**

Table 2 – Referral to Treatment (RTT) waiting times, England

	Admitted pathways			Non-Admitted pathways			Incomplete pathways		
Month	Median wait (weeks)	95th percentile (weeks)	% within 18 weeks	Median wait (weeks)	95th percentile (weeks)	% within 18 weeks	Median wait (weeks)	95th percentile (weeks)	% within 18 weeks
March 2007	18.8	52+	48.3%	-	-	-	-	-	-
August 2007	15.6	52+	56.0%	7.4	52+	76.1%	14.3	52+	57.2%
March 2008	8.1	27.3	87.1%	3.9	21.8	93.4%	9.8	52+	66.0%
March 2009	7.7	20.0	93.0%	3.8	15.6	97.4%	5.6	29.8	87.6%
March 2010	8.0	21.2	92.0%	3.9	15.4	97.8%	5.2	23.3	91.1%
March 2011	7.9	23.4	89.6%	3.7	15.8	97.3%	5.5	25.4	89.4%
March 2012	8.1	22.2	91.1%	3.6	15.8	97.4%	5.2	20.2	93.3%
March 2013	8.2	21.5	92.1%	3.9	16.0	97.6%	5.5	18.9	94.2%
April 2013	8.5	21.9	91.6%	5.1	16.1	97.2%	5.6	18.8	94.5%
May 2013	8.7	22.4	92.1%	4.8	15.9	97.5%	5.6	18.2	94.8%
June 2013	8.7	21.9	91.7%	5.2	16.3	97.4%	5.7	18.5	94.6%
July 2013	8.6	21.4	92.1%	5.0	16.3	97.2%	5.6	18.7	94.4%
August 2013	8.6	21.4	92.2%	5.2	16.4	97.2%	6.2	18.8	94.2%
Sept 2013	9.1	21.9	91.5%	5.7	16.8	96.8%	6.0	19.0	94.2%
October 2013	9.0	21.9	91.4%	5.1	16.9	96.7%	5.6	18.9	94.2%
Nov 2013	8.7	22.1	91.0%	5.1	17.0	96.5%	5.7	19.2	94.0%
Dec 2013	8.3	21.9	91.5%	4.9	16.6	96.8%	6.3	19.9	93.6%
Jan 2014	9.4	23.3	90.4%	5.8	17.1	96.3%	6.2	19.8	93.5%
Feb 2014	9.5	23.4	89.9%	4.7	17.1	96.3%	5.4	19.7	93.4%
Mar 2014	8.8	24.0	89.4%	4.8	17.1	96.3%	5.5	19.5	93.7%
Apr 2014	8.6	23.5	90.0%	5.0	16.9	96.3%	5.9	19.7	93.7%
May 2014	9.1	24.3	90.1%	5.5	16.9	96.5%	6.2	19.4	93.7%
June 2014	9.4	23.9	89.5%	5.4	17.2	96.2%	5.8	19.5	93.7%
July 2014	8.9	23.8	89.3%	5.2	17.4	95.9%	5.9	19.8	93.3%
August 2014	8.9	24.6	87.9%	5.5	17.7	95.5%	6.5	20.6	92.9%
Sept 2014	9.5	24.5	88.3%	6.0	17.9	95.2%	6.2	19.8	93.5%
October 2014	9.3	23.8	89.0%	5.4	17.9	95.2%	5.8	19.9	93.2%

Notes:

1. Median and 95th percentile times are calculated from aggregate data, rather than patient level data, and therefore are only estimates of the position on average waits.
2. Where the 95th percentile falls in the over 52 week time band, the estimates are less accurate. Hence, such figures are shown as "52+" weeks.
3. Admitted RTT pathways are waiting times for patients whose treatment started during the month and involved admission to hospital.
4. Admitted (unadjusted) RTT data were first published in March 2007. Admitted RTT data on an adjusted basis were first published in March 2008.
5. Adjustments are made to admitted RTT pathways for clock pauses, where a patient had declined reasonable offers of admission and chosen to wait longer.
6. Non-admitted RTT pathways are waiting times for patients whose treatment started during the month and did not involve admission to hospital.
7. Incomplete RTT pathways are waiting times for patients still waiting to start treatment at the end of the month.
8. Non-admitted and Incomplete RTT data were first published in August 2007.

Notes to Editors

For admitted patients, adjusted data (allowing for legitimate pauses of the RTT clock) is used to measure waiting times.

Statistical Notes

5. National Statistics

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

2. Referral to Treatment "pathways" and "clock stops"

Patients referred for non-emergency consultant-led treatment are on Referral to Treatment (RTT) pathways. An RTT pathway is the length of time that a patient waited from referral to start of treatment, or if they have not yet started treatment, the length of time that a patient has waited so far.

The following activities end the RTT pathway and lead to the RTT clock being stopped:

- first treatment – the start of the first treatment that is intended to manage a patient's disease, condition or injury in a RTT pathway
- start of active monitoring initiated by the patient
- start of active monitoring initiated by the care professional
- decision not to treat – decision not to treat made or no further contact required
- patient declined offered treatment
- patient died before treatment

3. Operational waiting time standards

Patients continue to have a legal right under the NHS Constitution to access services within maximum referral to treatment waiting times, or for the NHS to take all reasonable steps to offer them a range of alternative providers if this is not possible.

The waiting time standards set the proportion of RTT pathways that must be within 18 weeks. These proportions leave an operational tolerance to allow for patients for who starting treatment within 18 weeks would be inconvenient or clinically inappropriate. These circumstances can be categorised as:

- Patient choice – patients choose not to accept earliest offered appointments along their pathway or choose to delay treatments for personal or social reasons

- Co-operation – patients who do not attend appointments along their pathways
- Clinical exceptions – where it is not clinically appropriate to start a patient's treatment within 18 weeks

The waiting time operational standards for 2014/15 are set out in Everyone Counts: Planning for Patients 2014/15 to 2018/19. These are:

- 90% of admitted patients and 95% of non-admitted patients to start treatment within a maximum of 18 weeks from referral
- 92% of patients on incomplete pathways to have been waiting no more than 18 weeks from referral

Admitted pathways are the waiting times for patients whose treatment started during the month and involved admission to hospital. These are also often referred to as inpatient waiting times, but include the complete time waited from referral until start of inpatient treatment.

Non-admitted pathways are the waiting times for patients whose treatment started during the month and did not involve admission to hospital. These are also often referred to as outpatient waiting times, but they include the time waited for patients whose RTT waiting time clock either stopped for treatment or other reasons, such as a patient declining treatment.

The Department of Health introduced the incomplete pathways operational standard from April 2012 onwards. Incomplete pathways are the waiting times for patients waiting to start treatment at the end of the month. These are also often referred to as waiting list waiting times and the volume of incomplete RTT pathways as the size of the RTT waiting list.

NHS England introduced a zero tolerance of any referral to treatment waits of more than 52 weeks in 2013/14, with contractual penalties for each such wait.

4. Referral to Treatment waiting times data collection

Referral to Treatment (RTT) data is collected from NHS providers (NHS Trusts and other providers) and signed off by commissioners.

The data measures RTT waiting times in weeks, split by treatment function. The treatment functions are based on consultant specialties. The length of the RTT pathway is reported for patients whose RTT clock stopped during the month.

The Department of Health published the RTT Rules Suite on 28 November 2007. This document was updated in April 2014 and can be found at:
https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

Other guidance documents relating to RTT can be found at:
http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/

The data return includes all patients whose RTT clock stopped at any point in the reporting period. A column has been provided to enter data for patients whose length of

RTT period is unknown, i.e. patients who have had a clock stop during the month but where the clock start date is not known.

For admitted patients, the RTT time is measured on an *adjusted* basis – from the date the RTT clock starts to the date that the RTT clock stops, allowing for legitimate pauses as described in the above RTT Rules Suite.

For non-admitted patients, the RTT time is measured on an *unadjusted* basis – from the date the RTT clock starts to the date that the RTT clock stops, as detailed in DSCN 17/2006.

For patients on incomplete pathways, the RTT time is measured on an *unadjusted* basis. Incomplete pathways represent those patients who have been referred on to consultant-led referral to treatment pathways, but whose treatment had not yet started at the end of the reporting period. These patients will be at various stages of their pathway, for example, waiting for diagnostics, an appointment with a consultant, or for admission for a procedure.

5. Data Availability

Data for admitted patients (patients whose RTT clock stopped with an inpatient/ day case admission) have been published each month since January 2007 on an unadjusted basis.

Data for admitted patients (patients whose RTT clock stopped with an inpatient/ day case admission) have been published each month since March 2008 on an adjusted basis.

Data for non-admitted patients (patients whose RTT clock stopped during the month for reasons other than an inpatient/day case admission) and incomplete RTT times for patients whose RTT clock is still running have been published each month since August 2007.

RTT waiting times data are published to a pre-announced timetable, roughly 6 weeks after the end of the reference month. Publication occurs on a Thursday and is always on or after the 26th working day after the end of the reporting month.

Seven Trusts did not submit data on incomplete RTT pathways for October 2014. Additionally, Royal Free London NHS Foundation Trust (RAL) did not submit any data for the former Barnet and Chase Farm Hospitals NHS Trust with whom it merged from 1st July 2014. Factoring in estimates based on the latest data submitted for each of these missing Trusts suggests the total number of RTT patients waiting to start treatment at the end of October 2014 may have been just over 3.2 million patients. The latest figures submitted by missing Trusts are shown in the table below.

Trust	Latest available incomplete RTT pathway data (rounded to nearest hundred)	Month incomplete pathway data last submitted
Barking, Havering and Redbridge University Hospitals NHS Trust	20,700	Nov-13
Former Barnet and Chase Farm Hospitals NHS Trust	24,400	Sep-13
Barts NHS Health Trust	75,600	Aug-14
Heart of England NHS Foundation Trust	34,000	June-14
Royal Berkshire NHS Foundation Trust	28,800	June-14
Tameside Hospital NHS Foundation Trust	26,000	Feb-14
The Princess Alexandra Hospital NHS Trust	10,200	June-14
Walsall Healthcare NHS Trust*	13,800	Feb-14

Note: * Walsall Healthcare NHS Trust submitted August 2014 data on incomplete pathways, however, the Trust has since informed NHS England that it does not consider this data to be an accurate reflection of the true position and therefore the data for August 2014 will be revised at a future date. The latest available data for the Trust prior to the August 2014 submission is for February 2014.

6. Average (median) waiting times

The median is the preferred measure of the average waiting time as it is less susceptible to extreme values than the mean. The median waiting times is the middle value when all patients are ordered by length of wait. This is the midpoint of the RTT waiting times distribution. For completed pathways, 50% of patients started treatment within the median waiting time, and for incomplete pathways 50% of patients were waiting within the median waiting time.

It should be noted that median times are calculated from aggregate data, rather than patient level data, and therefore are only estimates of the position on average waits.

7. Interpretation of RTT waiting times

Care should be taken when making month on month comparisons of these figures. Measures of waiting time performance are subject to seasonality. For example, the presence of bank holidays or the number of weekends in a calendar month both affect the number of working days. Similarly, adverse weather may result in emergency pressure and impacts upon the health service's ability to preserve elective capacity. These factors can affect waiting times and should be considered when making comparisons across time.

9. Feedback welcomed

We welcome feedback on the content and presentation of RTT statistics within this Statistical Press Notice and those published on the NHS England website. If anyone has any comments on this, or any other issues regarding RTT data and statistics, then please email RTTdata@dh.gsi.gov.uk

Additional Information

For press enquiries, please e-mail the NHS England media team at nhsengland.media@nhs.net or call 0113 825 0958 or 0113 825 0959.

The Government Statistical Service (GSS) statistician responsible for producing these data is:

Debbie Moon
NHS Operations
NHS England
Room 8E28, Quarry House, Quarry Hill, Leeds LS2 7UE
Email: RTTdata@dh.gsi.gov.uk

9 March 2012 Last updated at 15:59

NHS risk register: Ministers lose Freedom of Information appeal

Ministers have been ordered to publish a risk assessment of the NHS shake-up under Freedom of Information laws.

The risk register was compiled ahead of the introduction of the Health and Social Care Bill

The Department of Health had appealed against an FOI ruling that the transition risk register, requested by Labour MP John Healey, be published.

But it lost, despite civil servants' warnings that to publish confidential advice could have a "chilling effect".

Mr Healey said the ruling gave "strong legal support to a full and open debate" about NHS plans for England.

"The judgement backs the public's right to know about the risks the government is taking with its NHS plans," he said - accusing the government of having "dragged out" the process for 15 months.

Section 35 defence

The government still has the option of a further appeal to the "upper tribunal".

Meanwhile the controversial Health and Social Care Bill, which introduces an overhaul of the way the NHS is run in England, is in the final stages of its passage through Parliament.

The government had used the "section 35" defence under the Freedom of Information Act, which exempts information used in policy formulation and development from having to be released.

But it must be weighed against the balance of public interest - and in an earlier ruling the information commissioner had said in this case, that was "very strong".

'Insidious' effect

A two-day hearing in central London this week heard evidence from Labour MP and former shadow health secretary Mr Healey, Una O'Brien - the top civil servant at the Department of Health - and Lord O'Donnell, who until recently was the UK's top civil servant before retiring as cabinet secretary.

Ms O'Brien told the tribunal that civil servants,

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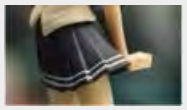
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who compile the risk register, needed a "safe space" to be able to advise ministers on controversial policies in "frank" language.

She argued that publishing the information would ultimately have an "insidious" effect as people would hold back in what they were prepared to write down.

- List of risks associated with a policy or programme
- Includes estimates of the likelihood of it occurring and its potential impact via the RAG (red, amber green) traffic light system
- Also sets out proposed action to deal with risk
- Usually seen by officials rather than ministers

'No real evidence'

Lord O'Donnell argued that the document itself was unbalanced - focusing more on the negatives than positive outcomes - and predicted the way they would be compiled in future would change, if they were published.

But the Information Commissioner's QC told the tribunal that there was "no real evidence" that previous FOI rulings on internal government documents had had a similar effect.

And he said this case was exceptional - because of the scale of changes being made, the controversy around them and the inherent risks in the nature of the reforms.

A spokesman for the Information Commissioner's office welcomed the tribunal's ruling and said they would "consider the full details of the tribunal's decision once it has been made available".

And it was welcomed by the Royal College of Nursing - which is among medical professionals' groups calling for the Health and Social Care Bill to be withdrawn.

Crossbench peer Lord Owen said Lib Dem peers should not now "go along with any attempt by the coalition government to continue with the third reading of this bill" in the Lords, until they have had time to consider the risk register.

The government's appeal against the broader "strategic risk register" requested by Evening Standard journalist Nicholas Cecil - was upheld by the committee.

The government has accused Labour of "rank opportunism" - because shadow health secretary Andy Burnham blocked the publication of a strategic risk register. But Mr Burnham argues there are "crucial differences" between the two documents.

A Department of Health spokesman said: "We are still awaiting the detailed reasoning behind this decision.

"Once we have been able to examine the judgement we will work with colleagues across government and decide next steps."

> **Once we have been able to examine the judgement we will work with colleagues across government and decide next steps”**
>
> Department of Health spokesman

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BMJ investigation finds GP conflicts of interest “rife” on commissioning boards

(Published 12 March 2013)

More than one in three GPs who will buy patient services have financial links to private providers

More than a third of general practitioners on the boards of new clinical commissioning groups (CCGs) have a conflict of interest due to directorships or shares held in private companies, reveals a *BMJ* investigation today.

It provides the clearest evidence to date of the conflicts many doctors will have to manage from April 1, when the GP-led groups are handed statutory responsibility for commissioning around £60bn of NHS healthcare.

The *BMJ* used Freedom of Information requests and CCG websites to analyse the registered interests of

almost 2,500 board members across 176 of the 211 commissioning groups in England.

It found 426 (36%) of the 1,179 GPs in executive positions had a financial interest in a for-profit private provider beyond their own GP practice – a provider from which their CCG could potentially commission services.

These ranged from senior directorships in local for-profit firms - set up to provide services such as diagnostics, minor surgery, GP out of hours and pharmacy - to shareholdings in large private sector health firms providing care in conjunction with local doctors, such as Harmoni and Circle Health.

In some cases, the majority of GPs on the CCG governing body had financial interests in the same private healthcare provider.

Although some doctors have relinquished interests in private enterprises because of their new roles as commissioners, the *BMJ* found that in total, 555 (23%) of 2,426 governing body members – including all clinical, lay, and managerial representatives – have a financial stake in a for-profit company.

Last week, the BMA’s UK Consultants’ Committee passed a motion at their conference expressing concern at “the clear conflict of interest of GP commissioners who run their own private companies”, and calling on GP commissioners to “be barred from being involved in companies that they are giving contracts to.”

The NHS Commissioning Board has issued a code of conduct to CCGs stating that board members must remove themselves from decisions that they could materially benefit from. But doctors’ leaders have expressed concern that clinical input into commissioning decisions may become diluted if too many doctors are forced to remove themselves from particular decisions.

All of the CCGs found to have notable conflicts told the *BMJ* they had robust systems in place for managing potential conflicts, including publishing conflict of interest policies, and regularly updating members’ declarations of interest.

But Michael Dixon, chair of NHS Alliance and interim president of NHS Clinical Commissioners, warned placing too much emphasis on the issue may prevent clinical commissioners from bringing more care into community settings.

The NHS Commissioning Board said it was reviewing its existing guidance and would shortly be publishing “final, comprehensive guidance on managing conflict of interest”

The Department of Health has also acknowledged that concerns about conflicts needed addressing, and pledged to strengthen Monitor’s power to act where conflicts “may affect the integrity of a commissioner’s decision."

Dr Fiona Godlee, editor in chief of the *BMJ*, said: “This is the first time the full extent of the involvement of CCG GP board members in private health companies has been revealed.

“These conflicts will make the commissioning of some services difficult. Although board members can excuse themselves from meetings when conflicts arise, this could mean some decisions are made by a group of predominantly lay people.

“Some of these conflicts of interest are too great to be ‘managed’. We think that those GPs who have positions at executive board level in private provider companies need to choose between their competing interests and, if need be, step down from the commissioning boards.”

Contact (from Wed 13 March):
Gareth Iacobucci, News Reporter, BMJ, London, UK
Tel: +44 (0)207 874 0738
Email: giacobucci@bmj.com

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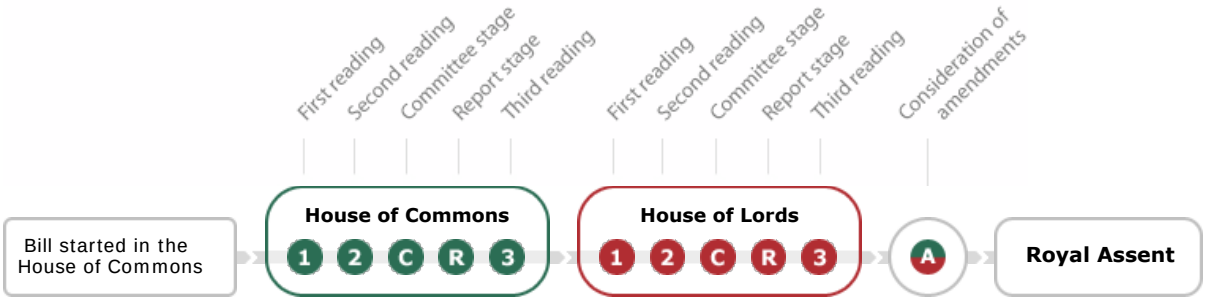
Freedom of Information (Private Healthcare Companies) Bill 2013-14

Type of Bill: Private Members' Bill (under the Ten Minute Rule, SO No 23)

Sponsor: Grahame M. Morris

Progress of the Bill



Last event

1 1st reading: House of Commons 8 October, 2013 | 08.10.2013

All previous stages of the Freedom of Information (Private Healthcare Companies) Bill 2013-14

Latest Bill

This Bill is being prepared for publication.

All Bill documents

Latest news on the Freedom of Information (Private Healthcare Companies) Bill 2013-14

The Bill failed to complete its passage through Parliament before the end of the session. This means the Bill will make no further progress.

Summary of the Freedom of Information (Private Healthcare Companies) Bill 2013-14

A Bill to amend the Freedom of Information Act 2000 to apply to private healthcare companies; and for connected purposes.

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UK Statistics Authority
1 Drummond Gate
London
SW1V 2QQ

Telephone: 0845 604 1857
E-mail: authority.enquiries@statistics.gsi.gov.uk
Website: www.statisticsauthority.gov.uk

Chair of the UK Statistics Authority, Sir Andrew Dilnot CBE

Rt. Hon. Andy Burnham MP
House of Commons
LONDON
SW1A 0AA

29 July 2014

Dear Mr Burnham

WAITING TIMES IN ACCIDENT AND EMERGENCY DEPARTMENTS

Thank you for your letter dated 4 July 2014 regarding the Prime Minister's statements in Prime Minister's Questions on 2 July 2014 referring to average waiting times in accident and emergency departments in England. You asked the UK Statistics Authority to review the following statements by the Prime Minister:

> *"Let me tell the right hon. Gentleman exactly how long people are waiting. When the shadow Secretary of State was Secretary of State for Health, the average waiting time was 77 minutes; under this Government, it is 30 minutes."*[1]

> "*The average waiting time is down by more than half. That is better."*[2]

In addition, you asked us to review the Secretary of State for Health's statement:

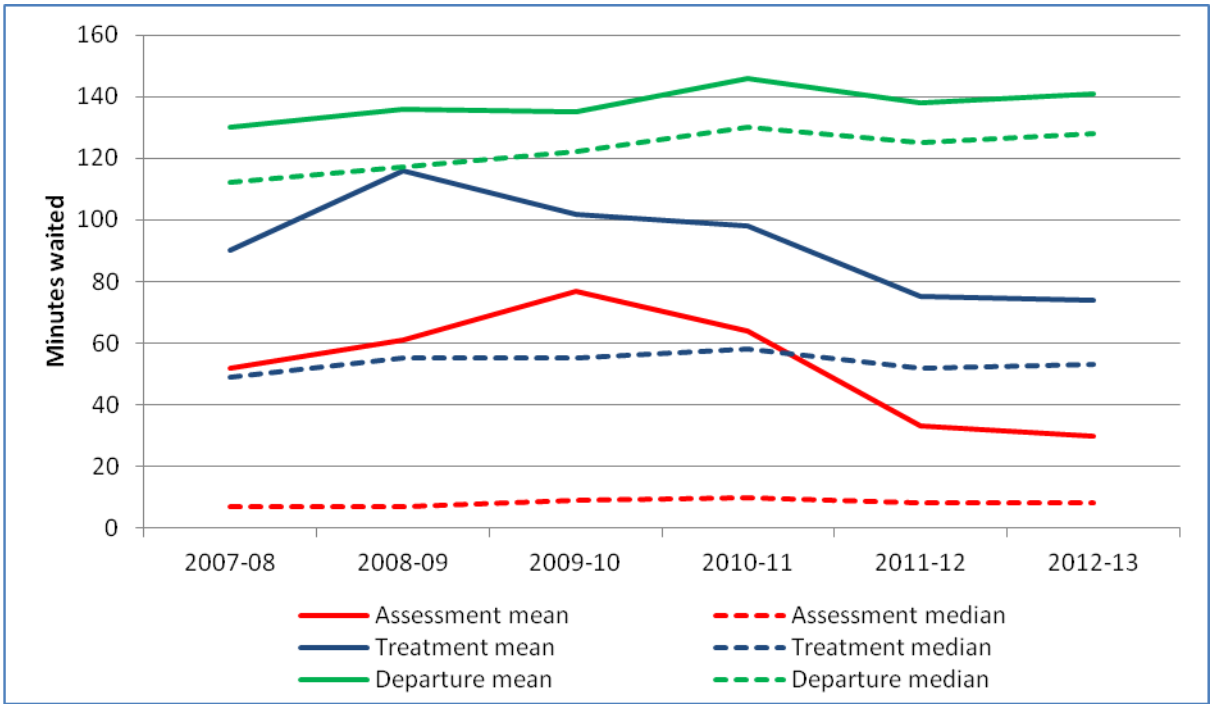
> *"NHS staff are working incredibly hard to see and treat these patients within four hours, and it is a tribute to them that the median wait for an assessment is only 30 minutes under this Government, down from 77 minutes under the last Government."*[3]

Table 1 in the attached annex is extracted from data in the Health and Social Care Information Centre (HSCIC) Hospital Episode Statistics (HES) database, which were passed as management information to the Department of Health in November 2013, and subsequently published on the HSCIC website as ad hoc official statistics in July 2014 following a request by the King's Fund. These data show provisional time to assessment, treatment and departure of all patients from 2007-08 to 2012-13. The *mean* time to assessment in 2012-13 was 30 minutes, and in 2009-10 the corresponding figure was 77 minutes. I note that the Secretary of State for Health referred to this figure being the *median* time to assessment; and that the published official statistics report this, instead, as 9 minutes in 2009-10, and 8 minutes in 2012-13. The Secretary of State may wish to take advice on whether it is necessary to correct the parliamentary record.

[1] HC Deb 02.07.2014, c883
[2] HC Deb 02.07.2014, c883
[3] HC Deb 09.06.2014, c288

Accident and emergency waiting times data is complex, with both the median and mean published in the HES official statistics. Three different lengths of time are presented: time to assessment, time to treatment, and time to departure. In addition, official statistics that track performance against the NHS England standard[4] are published (shown in Table 2 in the attached annex). Taken together these sources provide a useful indication about patient experience in accident and emergency departments in England, although HSCIC has told us that it generally supplies the 'duration to departure' measure when asked to provide data to respond to Parliamentary Questions as this is closest to the NHS England standard. The *mean* duration to departure time in 2009-10 was 135 minutes and in 2012-13 it was 141 minutes. The *median* duration to departure in 2009-10 was 122 minutes, and 128 minutes in 2012-13. The chart below shows the recent trends in mean and median times to assessment, treatment and departure.

Activity in English NHS Hospitals and English NHS commissioned activity in the independent sector



Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre

Statistics are often described in abbreviated terms, particularly during public debate, and caveats are not always repeated or indeed possible. However, it is important for statistics to be described carefully. Where possible, time periods should be specified, the source data should be identified, and particular care should be taken if the mean and median are substantively different.

Tables 1 and 2 in the attached annex are different ways of presenting information about the same phenomenon. When summarising a distribution that is skewed, such as this, the mean and median differ. We think that it would be helpful if HSCIC were to publish more

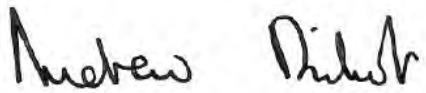
[4] The NHS England standard, according to the NHS Constitution, is that 95 per cent of people attending an accident and emergency department in England should be admitted, transferred or discharged within four hours of their arrival. During 2009-10 the target was 98 per cent.

information on the distribution of these data, to better illustrate the range of waiting times which patients experience in accident and emergency departments.

The Authority notes that the denominators used to calculate the mean and median times to assessment, treatment and departure differ in each year. For example, according to the estimates for 2012-13, 16 million people were assessed, 16.6 million people were treated, and 18 million people departed from accident and emergency departments. HSCIC told us that the likely reason for this discrepancy is that not all patient information is captured at each stage. The particular fields in question are not mandatory fields that the data providers must supply. HSCIC advised that the time to departure estimate is likely to be the most complete.

I am copying this letter to the Prime Minister, the Secretary of State for Health, the National Statistician, and the Cabinet Secretary.

Yours sincerely



Sir Andrew Dilnot CBE

ANNEX

Table 1: Activity in English NHS Hospitals and English NHS commissioned activity in the independent sector

Year	*Assessment*			*Treatment*			*Departure*		
	Denominator (millions)	Mean	Median	Denominator (millions)	Mean	Median	Denominator (millions)	Mean	Median
2007-08	9.1	52	7	9.9	90	49	11.5	130	112
2008-09	10.4	61	7	11.1	116	55	13.0	136	117
2009-10	12.1	77	9	12.9	102	55	15.0	135	122
2010-11	13.0	64	10	13.6	98	58	15.8	146	130
2011-12	15.3	33	8	15.9	75	52	17.2	138	125
2012-13	16.0	30	8	16.6	74	53	18.0	141	128

Notes:

1. Duration to Assessment

The total amount of time in minutes between the patient's arrival and their initial assessment in the Accident and Emergency department. This is calculated as the difference in time from arrival at A&E to the time when the patient is initially assessed.

2. Duration to Treatment

The total amount of time in minutes between the patient's arrival and the start of their treatment. This is calculated as the difference in time from arrival at A&E to the time when the patient began treatment.

3. Duration to Departure

The total amount of time in minutes spent in the Accident and Emergency department. This is calculated as the difference in time from arrival at A&E to the time when the patient is discharged from A&E care. This includes being admitted to hospital, died in the department, discharged with no follow up or discharged - referred to another specialist department.

4. Assessing growth through time (Accident & Emergency)

HES figures are available from 2007-08 onwards. Changes to the figures over time need to be interpreted in the context of improvements in data quality and coverage and changes in NHS practice. For example, changes in activity may be due to changes in the provision of care.

Source: Health and Social Care Information Centre, Hospital Episode Statistics (HES), Accident and Emergency in England. The mean and median duration (in minutes) to assessment, treatment and departure by year, 2007-08 and 2012-13, July 2014, available at:
http://www.hscic.gov.uk/media/14745/Accident-and-Emergency-Attendances---England-2007-08-to-2012-13-provisional---National-Summary/doc/Accident_and_Emergency_Attendances_-_England_2007-08_to_2012-13_(provisional)_-_National_Summary.docx

Table 2: Accident and emergency attendances more than 4 hours from arrival to admission, transfer or discharge: England

Year	Quarter	Type 1 Departments - Major A&E	Type 2 Departments - Single Specialty	Type 3 Departments - Other A&E/Minor Injury Unit	Percentage in 4 hours or less (type 1)	Percentage in 4 hours or less (all)
2009-10	Q1: Apr – Jun	71,918	339	2,436	98.0%	98.6%
	Q2: Jul - Sep	64,026	257	1,740	98.1%	98.7%
	Q3: Oct - Dec	108,800	251	1,687	96.8%	97.8%
	Q4: Jan - Mar	100,028	221	1,914	96.9%	97.9%
2010-11	Q1: Apr – Jun	84,418	400	1,854	97.7%	98.4%
	Q2: Jul - Sep	104,395	436	1,968	97.0%	98.0%
	Q3: Oct - Dec	180,940	431	2,892	94.7%	96.5%
	Q4: Jan - Mar	176,052	485	2,843	94.8%	96.6%
2011-12	Q1: Apr – Jun	159,256	868	2,224	95.6%	97.0%
	Q2: Jul - Sep	142,246	499	2,098	95.9%	97.3%
	Q3: Oct - Dec	189,038	451	2,431	94.5%	96.3%
	Q4: Jan - Mar	222,749	424	2,659	93.7%	95.8%
2012-13	Q1: Apr - Jun	184,483	511	2,758	94.9%	96.6%
	Q2: Jul – Sep	165,139	444	2,338	95.4%	96.9%
	Q3: Oct - Dec	228,920	545	2,504	93.5%	95.7%
	Q4: Jan – Mar	310,035	729	3,005	91.1%	94.1%
2013-14	Q1: Apr – Jun	237,553	816	2,916	93.4%	95.7%
	Q2: July - Sep	202,551	600	2,648	94.4%	96.3%
	Q3: Oct – Dec	227,400	336	2,756	93.5%	95.6%
	Q4: Jan – Mar	257,815	551	3,244	92.7%	95.2%
2014-15	Q1: Apr - Jun	279,517	656	4,541	92.6%	95.1%

Source: NHS England, A&E Quarterly activity statistics, NHS and independent sector organisations in England, July 2014, available from: http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2014/04/Quarterly-time-series-2004-05-onwards-with-Annual.xls

31 July 2013 Last updated at 17:04

Jeremy Hunt's Lewisham hospital cuts plan quashed at High Court

Campaigners celebrated at the Royal Courts of Justice following the ruling, but will the jubilation last? Jane Dreaper reports

Health Secretary Jeremy Hunt has had his decision to reduce services at a major hospital declared unlawful and quashed by the High Court.

Mr Justice Silber ruled Mr Hunt acted outside his powers when he announced casualty and maternity units at Lewisham Hospital would be downgraded.

He said the Secretary of State had breached provisions of the National Health Services Act 2006.

The judge gave him permission to appeal against the decision.

Mr Justice Silber said recommendations of the Secretary of State had to have regard to, or be supported by, GP commissioners.

It was quite clear that the Lewisham GP commissioners did not give support to the proposals, said the judge.

'Incredible day'

He went on: "On the contrary, they strongly opposed them although those GP commissioners in a number of surrounding but different areas were happy with them.

"I considered that it was the absence of support from the local GP commissioners which constituted an additional reason why the decision of the Secretary of State cannot stand."

The challenge was brought by Save Lewisham Hospital and the London Borough of Lewisham.

Dr Louise Irvine, a local GP who chairs the Save Lewisham Hospital campaign, said: "This is an incredible day.

"We are delighted for every single person who has supported the campaign and those who will now continue to benefit from this extraordinary hospital."

Rosa Curling, a lawyer with solicitors' firm Leigh Day acting for the campaigners, described it as a "tremendous victory".

She said: "This judgment should serve as a warning to the government that, if they try to do this, local communities will fight back to ensure

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Analysis

Karl Mercer
Political Correspondent, BBC London

There were cheers and tears in Court 76 as Mr Justice Silber gave hospital campaigners the news they had hoped for.

He ruled that Jeremy Hunt and the administrator he appointed to South London Healthcare had acted outside their powers when they decided to reduce services at Lewisham hospital.

He ruled that local GPs had not supported the plans and therefore they should not be allowed to go ahead.

Today's ruling comes six months to the day since Jeremy Hunt announced the downgrading of services like the A&E and maternity units at Lewisham.

Campaigners had argued it was being made to

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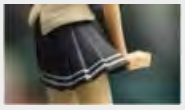

Lolita complex
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Gradual recovery
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their healthcare services remain in place."

Mayor of Labour-run Lewisham Council, Sir Steve Bullock, said justice had been delivered to a hospital "well-managed, highly-respected and financially solvent".

In January Mr Hunt told MPs that the cuts were necessary because neighbouring South London Healthcare NHS Trust has been losing more than £1m every week.

A spokesman said Mr Hunt's department was "disappointed by the decision" and would consider the judgment carefully.

He said: "This judgment applies to one aspect of a package of changes which we believe are in the best long-term interests of patients and the public across south-east London.

"We expect to continue other elements of that package of changes, including the dissolution of the South London Healthcare NHS Trust, planned for October 1 - although there are a number of steps to go before that can take place."

The other changes expected to go ahead are King's Health Partners taking over Princess Royal Hospital and the merger of Queen Elizabeth Hospital and Lewisham Hospital trusts.

suffer because of the failings of the neighbouring South London Healthcare Trust which is £65m in deficit.

This was the first time the Trust Special Administrator regime had ever been used.

The government has been given permission to appeal.

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29 October 2013 Last updated at 13:44

Lewisham Hospital: Appeal Court overrules Jeremy Hunt

The health secretary had claimed the cuts would improve patient care

The Court of Appeal has ruled Health Secretary Jeremy Hunt did not have power to implement cuts at Lewisham Hospital in south-east London.

During the summer, a High Court judge ruled Mr Hunt acted outside his powers when he decided the emergency and maternity units should be cut back.

The government turned to the Court of Appeal on Monday in an attempt to get the decision overruled.

Mr Hunt had previously claimed the move would improve patient care.

'Vital services'

Following the ruling, Mr Hunt said: "I completely understand why the residents of Lewisham did not want any change in their A&E services, but my job as health secretary is to protect patients across south London - and doctors said these proposals would save lives.

"We are now looking at the law to make sure that at a time of great challenge the NHS is able to change and innovate when local doctors believe it is in the interests of patients."

At the High Court in July, Mr Justice Silber said Mr Hunt's decision was unlawful as he lacked power and breached the National Health Services Act 2006.

It was said the cuts would also mean local people having "to travel a long, long way further to get access to vital services".

Under government policy Mr Hunt had appointed a trust special administrator (TSA) to the South London Healthcare Trust, which went into administration after losing more than £1m a week.

To help ease the problem, the TSA recommended cuts at the Hospital.

At the Court of Appeal on Monday Rory Phillips QC, for the Health Secretary and the TSA, argued they had not acted outside their powers.

They challenged Mr Justice Silber's findings that the TSA was not entitled to recommend the changes and that Mr Hunt was not entitled to implement them.

Referring to the 2006 Act, Mr Phillips said its "wording, statutory context and purpose" should have led Mr Justice Silber "to conclude that they were entitled so to act, consistently with Parliament's evident intention".

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This expensive waste of time for the government should serve as a wake up call that they cannot ride roughshod over the needs of the people"

Rosa Curling

Save Lewisham Hospital

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The decision was described as a "humiliation" for Jeremy Hunt by the shadow health secretary

The challenge against the government was brought by Save Lewisham Hospital and the London Borough of Lewisham.

'Squandered' money

Rosa Curling, who represented the campaign group, said: "We are absolutely delighted with the Court of Appeal's decision.

"This expensive waste of time for the government should serve as a wake up call that they cannot ride roughshod over the needs of the people.

"The decision to dismiss the appeal also reaffirms the need for judicial review, a legal process by which the unlawful decisions of public bodies, including the government, can be challenged by the public."

Andy Burnham, Labour's shadow health secretary, described the decision as a "humiliation" for Mr Hunt that "raises major questions about his judgment".

He said: "Instead of graciously accepting the first court ruling, he has squandered thousands of [pounds of] taxpayers' money trying to protect his own pride and defend the indefensible.

"Today, the secretary of state must accept this decision, apologise unreservedly to the people of Lewisham and give an unequivocal commitment that their A&E will not now be downgraded."

Mayor of Lewisham Sir Steve Bullock said: "This is a great result. I was confident of our case but I am still very relieved.

"This is another victory for each and every individual who signed a petition, who wrote to the secretary of state and who marched through the streets of Lewisham."

The decision was made by Lord Dyson, Lord Justice Sullivan and Lord Justice Underhill.

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13 September 2014 Last updated at 07:05

Trade talks 'must include healthcare'

By Hugh Pym
BBC health editor

Pharmaceutical companies' interests need to be protected, say ministers

Major trade talks between the US and EU must not exclude healthcare, a UK health minister has said.

The Transatlantic Trade and Investment Partnership talks, known as TTIP, are currently being negotiated.

Campaigners say any deal which allows US health firms to compete more freely in the UK will undermine the NHS.

But Earl Howe says exempting health would not be in the interest of British pharmaceutical firms, which currently face trade barriers in the US.

TTIP aims at removing trade barriers in a wide range of economic sectors to make it easier to buy and sell goods and services between the EU and the US.

Supporters argue a deal will boost growth and job creation in the UK and the rest of the European Union.

And they say removing trade barriers will allow British exporters of goods and services to expand sales in the American market.

'Bad news'

Earl Howe told the BBC it would not be in the interest of British pharmaceutical and medical technology companies, currently subject to trade barriers, to seek an exemption for health in the talks between

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Public services are always exempted - there is no problem about exemption"

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European and America negotiators.

"The potential for them is immense - it would be highly unwise and detrimental in our view to exclude health," he said.

Opponents of TTIP say that it is a vehicle for boosting multinational corporations' profits and that it will not help workers in Europe.

There have been accusations of a lack of transparency and accountability. Protests and demonstrations have been mounted.

Campaigning group 38 Degrees has been leafleting on the streets of the UK claiming that there is a threat to the health service.

David Babbs, the group's executive director, argues that a trade deal "would open up Britain to the US health industry and how could letting US health giants in be anything but bad news for our National Health Service".

What is TTIP?

- It is a trade agreement being negotiated between the European Union and the United States
- It aims at removing trade barriers in a wide range of economic sectors to make it easier to buy and sell goods and services between the EU and the US
- Discussions will look at areas including trade tariffs and technical regulations
- The TTIP negotiations will also look at opening both markets for services, investment, and public procurement. They could also shape global rules on trade

Source: European Commission

This week there was a call at the TUC Congress for the government to seek a formal exemption for the NHS from the trade talks.

Earl Howe says excluding health would be harmful for British companies

Argument 'abused'

Gail Cartmail, assistant general secretary of Unite, argued that trade liberalisation could pave for the way for legal challenges over NHS contracts by US health companies.

She said: "The government had no mandate to privatise our health service anyway - they certainly don't have a mandate to make it irreversible. We say to Cameron, use your veto."

Earl Howe said there had been "scaremongering" about the agreement and the government was not planning wholesale privatisation of the health service.

EU Trade Commissioner Karel de Gucht, leading the European negotiating team, has denied there is a hidden agenda and that the NHS might be undermined.

He said: "Public services are always exempted - there is no problem about exemption. The argument is abused in your country for political reasons but it has no grounds."

However, as the newly appointed European commissioners are yet to take up their posts and mid-term congressional elections in the US, a TTIP

deal is not likely in the near future.

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PART 3 continued **CHAPTER 2** continued

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(7) The reference in subsection (6) to the old Health Research Authority is a reference to the Special Health Authority called the Health Research Authority (and abolished by section 108).

114 Establishment by the HRA

(1) The HRA may establish research ethics committees which have the following functions—

(a) approving research of the kind referred to in section 112(1);

(b) giving such other approvals as enactments require.

(2) The HRA must ensure that a research ethics committee established under this section complies with the requirements set out in the REC policy document.

(3) The HRA may abolish a research ethics committee established under this section.

115 Membership of the United Kingdom Ethics Committee Authority

In regulation 5 of the Medicines for Human Use (Clinical Trials) Regulations 2004 (S.I. 2004/1031S.I. 2004/1031) (United Kingdom Ethics Committee Authority)—

(a) in paragraphs (1), (2) and (3), for "the Secretary of State for Health", in each place it appears, substitute "the Health Research Authority", and

(b) in paragraph (2), for "the Secretary of State" substitute "the Health Research Authority".

Patient information

116 Approval for processing confidential patient information

(1) The Health Service (Control of Patient Information) Regulations 2002 (S.I. 2002/1438) are amended as follows.

(2) In regulation 5 (the title to which becomes "Approval for processing information")—

(a) the existing text becomes paragraph (1), and

(b) in sub-paragraph (a) of that paragraph, for "both the Secretary of State and a research ethics committee" substitute "the Health Research Authority".

(3) After paragraph (1) of that regulation insert—

"(2) The Health Research Authority may not give an approval under paragraph (1)(a) unless a research ethics committee has approved the medical research concerned."

(4) After paragraph (2) of that regulation insert—

"(3) The Health Research Authority shall put in place and operate a system for reviewing decisions it makes under paragraph (1)(a)."

(5) In regulation 6 (registration requirements in relation to information), in paragraph (1)—

(a) before "the Secretary of State" insert "the Health Research Authority or", and

(b) before "he" insert "it or".

(6) In paragraph (2)(d) of that regulation, before "the Secretary of State" insert "the Health Research Authority or (as the case may be)".

(7) In paragraph (3) of that regulation, for the words from the beginning to "in the register" substitute "The Health Research Authority shall retain the particulars of each entry it records in the register, and the Secretary of State shall retain the particulars of each entry he records in the register,".

(8) For paragraph (4) of that regulation substitute—

"(4) The Health Research Authority shall, in such manner and to such extent as it considers appropriate, publish entries it records in the register; and the Secretary of State shall, in such manner and to such extent as he considers appropriate, publish entries he records in the register."

CHAPTER 3

CHAPTERS 1 AND 2: SUPPLEMENTARY

Miscellaneous

117 Transfer orders

(1) An order under section 95 (establishment of Health Education England) or section 108 (establishment of the Health Research Authority) (a "transfer order") may make provision for rights and liabilities relating to an individual's contract of employment.

(2) A transfer order may, in particular, make provision the same as or similar to provision in the Transfer of Undertakings (Protection of Employment) Regulations 2006 (S.I. 2006/246S.I. 2006/246).

(3) A transfer order may provide for the transfer of property, rights or liabilities—

(a) whether or not they would otherwise be capable of being transferred;

(b) irrespective of any requirement for consent that would otherwise apply.

(4) A transfer order may create rights, or impose liabilities, in relation to property, rights or liabilities transferred.

(5) A transfer order may provide for things done by or in relation to the transferor for the purposes of or in connection with anything transferred to be—

(a) treated as done by or in relation to the transferee or its employees;

(b) continued by or in relation to the transferee or its employees.

(6) A transfer order may in particular make provision about continuation of legal proceedings.

General

118 Chapters 1 and 2: interpretation and supplementary provision

(1) For the purposes of Chapters 1 and 2

, an expression in the first column of the following table is defined or otherwise explained by the provision of this Act specified in the second column.

Expression	*Provision*
Appointment criteria	Section 103
Commissioner of health services	Section 104
Devolved authority	Section 124
Devolved legislature	Section 124
Direct or direction	Subsection (2) below
Enactment	Section 124
Financial year	Section 124
Health care workers	Section 96
Health research	Section 109
The health service	Section 124
Health services	Section 98
HEE	Section 95
The HRA	Section 108
LETB	Section 102
Social care research	Section 109

(2) A power under Chapter 1 or 2 to give a direction—

(a) includes a power to vary or revoke the direction by a subsequent direction, and

(b) must be exercised by giving the direction in question in writing.

(3) The amendments made by sections 115 and 116 and Schedule 8 to provisions of subordinate legislation do not affect the power to make further subordinate legislation amending or revoking the amended provisions.

CHAPTER 4

TRUST SPECIAL ADMINISTRATION

119 Powers of administrator etc.

(1) In section 65O of the National Health Service Act 2006 (Chapter 5A of Part 2:

interpretation) (the existing text of which becomes subsection (1)) at the end insert—

"(2) The references in this Chapter to taking action in relation to an NHS trust include a reference to taking action, including in relation to another NHS trust or an NHS foundation trust, which is necessary for and consequential on action taken in relation to that NHS trust.

(3) The references in this Chapter to taking action in relation to an NHS foundation trust include a reference to taking action, including in relation to another NHS foundation trust or an NHS trust, which is necessary for and consequential on action taken in relation to that NHS foundation trust."

(2) In section 65F of that Act (administrator's draft report), in subsection (1), for "45 working days" substitute "65 working days".

(3) After subsection (2C) of that section insert—

"(2D) Where the administrator recommends taking action in relation to another NHS foundation trust or an NHS trust, the references in subsection (2A) to a commissioner also include a reference to a person to which the other NHS foundation trust or the NHS trust provides

services under this Act that would be affected by the action."

(4) After subsection (7) of that section insert—

"(8) Where the administrator recommends taking action in relation to another NHS foundation trust or an NHS trust, the references in subsection (5) to a commissioner also include a reference to a person to which the other NHS foundation trust or the NHS trust provides services under this Act that would be affected by the action."

(5) In section 65G of that Act (consultation plan), in subsection (2), for "30 working days" substitute "40 working days".

(6) After subsection (6) of that section insert—

"(7) Where the administrator recommends taking action in relation to another NHS foundation trust or an NHS trust, the references in subsection (4) to a commissioner also include a reference to a person to which the other NHS foundation trust or the NHS trust provides services under this Act that would be affected by the action."

(7) In section 65H of that Act (consultation requirements), in subsection (4)—

(a) after "trust special administrator must" insert "—

(a)", and

(b) at the end insert ", and

(b) in the case of each affected trust, hold at least one meeting to seek responses from staff of the trust and from such persons as the trust special administrator may recognise as representing staff of the trust."

(8) In subsection (7) of that section, after paragraph (b) (but before paragraph (ba) inserted by section 84(10)(a) of this Act) insert—

"(bza) any affected trust;

(bzb) any person to which an affected trust provides goods or services under this Act that would be affected by the action recommended in the draft report;".

(9) In subsection (9) of that section—

(a) after "trust special administrator must" insert "—

(a)",

(b) after "subsection (7)(b)," (but before the insertion made by section 84(10)(b) of this Act) insert "(bzb),", and

(c) at the end insert ", and

(b) hold at least one meeting to seek responses from representatives of each of the trusts from which the administrator must request a written response under subsection (7)(bza)."

(10) After subsection (11) of that section, insert—

"(11A) In this section, "affected trust" means—

(a) where the trust in question is an NHS trust, another NHS trust, or an NHS foundation trust, which provides goods or services under this Act that would be affected by the action recommended in the draft report;

(b) where the trust in question is an NHS foundation trust, another NHS foundation trust, or an NHS trust, which provides services under this Act that would be affected by the action recommended in the draft report.".

(11) In subsection (12)(a) of that section, after "subsection (7)(b)", insert "and (bzb)".

(12) In section 65N of that Act (guidance), after subsection (1) insert—

"(1A) It must, in so far as it applies to NHS trusts, include guidance about—

(a) seeking the support of commissioners for an administrator's recommendation;

(b) involving the Board in relation to finalising an administrator's report or draft report."

(13) In section 13Q of that Act (public involvement and consultation by NHS Commissioning Board), at the end insert—

"(4) This section does not require the Board to make arrangements in relation to matters to which a trust special administrator's report or

draft report under section 65F or 65I relates before the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be)."

(14) In section 14Z2 of that Act (public involvement and consultation by clinical commissioning groups), at the end insert—

"(7) This section does not require a clinical commissioning group to make arrangements in relation to matters to which a trust special administrator's report or draft report under section 65F or 65I relates before the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be)."

(15) In section 242 of that Act (public involvement and consultation by NHS trusts and foundation trusts), in subsection (6)—

(a) for "65I, 65R or 65U" substitute "or 65I", and

(b) for the words from "the decision" to the end substitute "the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be)."

(16) In Schedule 14 to the Health and Social Care Act 2012 (abolition of NHS trusts in England: consequential amendments)—

(a) after paragraph 4 insert—

"4A In section 13Q(4) (public involvement and consultation by Board), omit "makes a decision under section 65K(1),".

4B In section 14Z2 (public involvement and consultation by clinical commissioning groups), omit "makes a decision under section 65K(1),".",

(b) in paragraph 15, after sub-paragraph (3) insert—

"(3A) In subsection (2D), omit "or an NHS trust" and "or the NHS trust.",

(c) in that paragraph, after sub-paragraph (7) insert—

"(8) Omit subsection (8).",

(d) in paragraph 16 (the text of which becomes sub-paragraph (1)) at the end insert—

"(2) In subsection (7) of that section, omit "or an NHS trust" and "or the NHS trust".",

(e) in paragraph 17, in sub-paragraph (2)(a), for "paragraph (b)" substitute "paragraphs (b) and (bzb)",

(f) in that paragraph, after sub-paragraph (4) insert—

"(4A) In subsection (11A)—

(a) omit paragraph (a), and

(b) in paragraph (b), omit "where the trust in question is an NHS foundation trust," and ", or an NHS trust,".",

(g) in paragraph 24, after sub-paragraph (2) insert—

"(2A) Omit subsection (1A).",

(h) after that paragraph insert—

"24A In section 65O (interpretation)—

(a) omit subsection (2), and

(b) in subsection (3), omit "or an NHS trust".", and

(i) in paragraph 35, omit the "and" preceding paragraph (d) and after that paragraph insert ", and

(e) in subsection (6), omit "makes a decision under section 65K(1),"."

Part 4

Integration Fund

120 Integration of care and support with health services etc: integration fund

(1) At the end of section 223B of the National Health Service Act 2006 (funding of the National Health Service Commissioning Board) insert—

"(6) Where the mandate specifies objectives relating to service integration, the requirements that may be specified under section 13A(2)(b) include such requirements relating to the use by the Board of an amount of the sums paid to it under this section as the Secretary of State considers it necessary or expedient to impose.

(7) The amount referred to in subsection (6)—

(a) is to be determined in such manner as the Secretary of State considers appropriate, and

(b) must be specified in the mandate.

(8) The reference in subsection (6) to service integration is a reference to the integration of the provision of health services with the provision of health-related services or social care services, as referred to in sections 13N and 14Z1."

(2) After section 223G of that Act (meeting expenditure of clinical commissioning groups out of public funds) insert—

"**223GA Expenditure on integration**

(1) Where the mandate includes a requirement in reliance on section 223B(6) (requirements relating to use by the Board of an amount paid to the Board where mandate specifies service integration objectives), the Board may direct a clinical commissioning group that an amount (a "designated amount") of the sums paid to the group under section 223G is to be used for purposes relating to service integration.

(2) The designated amount is to be determined—

(a) where the mandate includes a requirement (in reliance on section 223B(6)) that designated amounts are to be determined by the Board in a manner specified in the mandate, in that manner;

(b) in any other case, in such manner as the Board considers appropriate.

(3) The conditions under section 223G(7) subject to which the payment of a designated amount is made must include a condition that the group transfers the amount into one or more funds ("pooled funds") established under arrangements under section 75(2)(a) ("pooling arrangements").

(4) The conditions may also include—

(a) conditions relating to the preparation and agreement by the group and each local authority and other clinical commissioning group that is party to the pooling arrangements of a plan for how to use the designated amount (a "spending plan");

(b) conditions relating to the approval of a spending plan by the Board;

(c) conditions relating to the inclusion of performance objectives in a spending plan;

(d) conditions relating to the meeting of any performance objectives included in a spending plan or specified by the Board.

(5) Where a condition subject to which the payment of a designated amount is made is not met, the Board may—

(a) withhold the payment (in so far as it has not been made);

(b) recover the payment (in so far as it has been made);

(c) direct the clinical commissioning group as to the use of the designated amount for purposes relating to service integration or for making payments under section 256.

(6) Where the Board withholds or recovers a payment under subsection (5)(a) or (b)—

(a) it may use the amount for purposes consistent with such objectives and requirements relating to service integration as are specified in the mandate, and

(b) in so far as the exercise of the power under paragraph (a) involves making a payment to a different clinical commissioning group or some other person, the making of the payment is subject to such conditions as the Board may determine.

(7) The requirements that may be specified in the mandate in reliance on section 223B(6) include requirements to consult the Secretary of State or other specified persons before exercising a power under subsection (5) or (6).

(8) The power under subsection (5)(b) to recover a payment may be exercised in a financial year after the one in respect of which the payment was made.

(9) The payments that may be made out of a pooled fund into which a designated amount is transferred include payments to a local authority which is not party to the pooling arrangements in question in connection with the exercise of its functions under Part 1 of the Housing Grants, Construction and Regeneration Act 1996 (disabilities facilities grants).

(10) In exercising a power under this section, the Board must have regard to the extent to which there is a need for the provision of each of the following—

(a) health services (see subsection (12)),

(b) health-related services (within the meaning given in section 14Z1), and

(c) social care services (within the meaning given in that section).

(11) A reference in this section to service integration is a reference to the integration of the provision of health services with the provision of health-related services or social care services, as referred to in sections 13N and 14Z1.

(12) "Health services" means services provided as part of the health service in England.".

PART 5
GENERAL

121 Power to make consequential provision

(1) The Secretary of State may by order make provision in consequence of a provision of this Act.

(2) An order under this section may amend, repeal, revoke or otherwise modify an enactment.

(3) The power conferred by this section is not restricted by any other provision of this Act.

(4) A saving or a transitional or transitory provision in an order under this section by virtue of section 123(7) may, in particular, modify the application of a provision made by the order pending the commencement of—

(a) another provision of the order,

(b) a provision of this Act, or

(c) any other enactment.

(5) Before making an order under this section that contains provision which is within the legislative competence of a devolved legislature, the Secretary of State must consult the relevant devolved authority.

(6) A reference to an enactment includes a reference to an enactment passed or made after the passing of this Act.

122 Power to make transitional etc. provision

(1) The Secretary of State may by order make transitional, transitory or saving provision in connection with the commencement of a provision of this Act.

(2) An order under this section may modify the application of a provision of this Act pending the commencement of—

(a) another provision of this Act, or

(b) any other enactment (including one passed or made after the passing of this Act).

123 Regulations and orders

(1) A power to make regulations under this Act is exercisable by the Secretary of State.

(2) Regulations and orders under this Act must be made by statutory instrument.

(3) Subject to subsections (4) and (5), a statutory instrument containing regulations or an order under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.

(4) A statutory instrument which contains (whether alone or with other provision) any of the following may not be made unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament—

(a) regulations under section 13(7) (the eligibility criteria);

(b) regulations under section 15(4) (the cap on care costs) other than those made in discharge of the duty under section 16(1);

(c) the first regulations under section 15(8) (the amount attributable to an adult's daily living costs);

(d) regulations under section 22(2)(b) (services or facilities which a local authority may not provide or arrange);

(e) regulations under section 35(9) or 36(3) (deferred payment agreements and loans and alternative financial arrangements) which include provision that amends or repeals a provision of an Act of Parliament;

(f) the first regulations under section 52(12) (meaning of references to business failure);

(g) the first regulations under section 53(1) (criteria for application of market oversight regime);

(h) the first regulations under section 53(4) (disapplication of market oversight regime in particular cases);

(i) the first regulations under section 62(2) (exercise of power to meet child's carer's needs for support);

(j) an order under section 78(9) (delegation of local authority functions);

(k) regulations under section 91 (offence of supplying etc false or misleading information);

(l) an order under section 121 (consequential provision) which includes provision that amends or repeals a provision of an Act of Parliament;

(m) regulations under paragraph 17 of Schedule 7 (fees chargeable by the HRA).

(5) Subsection (3) does not apply to—

(a) an order under section 95 (transfer order to new HEE);

(b) an order under section 108 (transfer order to new HRA);

(c) an order under section 122 (transitional etc. provision);

(d) an order under section 125 (commencement).

(6) A power to make regulations or an order under this Act—

(a) may be exercised for all cases to which the power applies, for those cases subject to specified exceptions, or for any specified cases or descriptions of case,

(b) may be exercised so as to make, for the cases for which it is exercised—

(i) the full provision to which the power applies or any less provision (whether by way of exception or otherwise);

(ii) the same provision for all cases for which the power is exercised, or different provision for different cases or different descriptions of case, or different provision as respects the same case or description of case for different purposes of this Act;

(iii) any such provision either unconditionally or subject to specified conditions, and

(c) may, in particular, make different provision for different areas.

(7) A power to make regulations or an order under this Act (other than the power

to make an order under section 122 or 125) includes —

(a) power to make incidental, supplementary, consequential, saving, transitional or transitory provision, and

NHS chief says sorry to Andy Burnham for Tory 'smear' campaign

'Furious' Bruce Keogh apologises to shadow health secretary after government attack on Labour over hospital trust deaths

Daniel Boffey, policy editor

The Observer, Saturday 20 July 2013 22.31 BST

NHS medical director Sir Bruce Keogh is said to be furious about the Conservative 'political operation' concerning his report into deaths at hospital trusts. Photograph: Dave Evitts / Newsteam

The medical director of the NHS, Sir Bruce Keogh, has privately apologised to the shadow health secretary, Andy Burnham, over the Tories' "political operation" to use his report into the death rates at 14 hospital trusts as an attack on Labour's record.

Keogh told Burnham that he was sorry about the smear campaign led by Conservative MPs and officials in the days immediately before and after publication of his report.

It is understood that Keogh was furious that his findings had been used to blame Labour for the unnecessary deaths of 13,000 patients, a figure that he did not recognise. Keogh was overheard apologising to Burnham, the former Labour health secretary at the centre of the attacks, when the two men were at government offices on Millbank, where the Sky and BBC political teams are based.

A source at the offices said Keogh told Burnham, "Andy, I'm so sorry", and appeared to show his disgust at what Keogh described as a "political operation". Burnham was overheard insisting that Keogh had "nothing to apologise for", adding: "It's a good report."

Burnham, who prime minister David Cameron called on Labour leader Ed Miliband to sack over the findings in the Keogh report, declined to comment on "a private conversation". An NHS spokesman said Keogh had been called away on family business and was not contactable.

However, an email exchange between Keogh and an unnamed individual, who criticised newspaper reports claiming that the review had found 13,000 unnecessary deaths, reveals something of the NHS boss's thinking. Keogh wrote: "I agree with your sentiments entirely. Not my calculations, not my views. Don't believe everything you read, particularly in some newspapers."

Labour has been enraged by what it claims is "low politics" inspired by Cameron's controversial strategist Lynton Crosby. Last week the health secretary, Jeremy Hunt, claimed that the mortality figures for 2011-12 published by Keogh made Labour's "darkest moment". Hunt added: "If founding the NHS is considered Labour's proudest achievement, today is their darkest moment as a Labour government is exposed as caring more about its own reputation than our most vulnerable citizens in the NHS."

But the Keogh report into 14 hospitals with high death rates uncovered "mediocrity" rather than a disaster on the scale of the Mid Staffs NHS Trust, where up to 1,200 people are thought to have needlessly died. The report said none of the hospitals investigated was providing "consistently high-quality care to patients", and all 14 trusts have been ordered to act on recommendations set out by health officials. Keogh is understood to have gone out of his way to stress that problems in the NHS were the fault of decades of under-investment, not the actions of one political party or group of ministers.

Evidence
@EvidenceUK

The next time a Tory MP/Spokesperson cites the CQC / Baroness Young to slur Andy Burnham please show them this letter

Baroness Young of Old Scone

The Right Honourable David Cameron MP
10 Downing Street
London
SW1A 2AA

15 July 2013

Dear Prime Minister

Care Quality Commission

I am writing as the former chairman of the Care Quality Commission, from summer 2008 to December 2009.

During Prime Minister's Questions on 27June 2013, you quoted my evidence to the Francis Enquiry and portrayed my words as indicating that "there was a culture under the previous Government of not revealing problems in the NHS."

I am afraid you have been misled as to the context in which my words were spoken and what my evidence in reality meant. My evidence went on to say that any pressure was more often from civil servants and NHS management rather than Ministers and was primarily "because of what we were wanting to do, not so much what we were wanting to say, because I don't think we were really under a lot of pressure not to say things.....So the pressure we were under from the Department was more about what we were going to do, rather than what we were going to say."

I stand by this evidence. During my time as Chairman, CQC was not pressurised by the previous Government to tone down its regulatory judgments or to hide quality failures. Disagreement with Ministers was about the way in which CQC would develop its regulatory systems, not about the content of our reporting or our regulatory findings.

So I am afraid neither my evidence to the Francis Inquiry nor my current recollection of CQC's experience under the previous Government can be interpreted to support the view that, in the words of your answer at PMQs "there was a culture under the previous Government of not revealing problems in the NHS".

How can this misapprehension best be corrected for the record?

Yours sincerely

Barbara Young

Baroness Young of Old Scone

NHS FOR SALE?
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CONFLICTS OF INTEREST?

GOVERNMENT / POLITICIANS

Companies with links to Tories 'have won £1.5bn worth of NHS contracts' (3 October 2014: The Guardian)

Private companies with financial links to Tory politicians have won NHS contracts worth £1.5bn in the past two years, according to research by the UK's largest trade union.

Unite claims that 24 Conservative MPs and peers who voted in favour of the government's health reforms have links to 15 private companies that have won up the contracts since 2012.

[...]

Unite's research includes politicians it says have received donations from organisations linked to private healthcare companies. It also includes others it says have a financial stake in companies that have won contracts since the 2012 Health and Social Care Act.

McCluskey said around £12bn of former NHS services are now being run by the private sector.

"Key clinical services including cancer care, blood analysis and mental health have been sold off or are up for sale," said McCluskey. "It is time to scrap the Health and Social Care Act and save our NHS."

Firm with links to top Tory takes £2.6 million profit from NHS reforms (Daily Mirror: 12 March 2014)

A firm boasting a close advisor to the PM on its board of directors has earnt £2.6 million from the NHS in 10 months by filling vacancies caused by Tory health reforms.Tory MP Nadhim Zahawi – who helped push the controversial GPs' funding system through the Commons – was appointed non-executive director of recruitment firm SThree in 2008. The firm has been staffing new Clinical Commissioning Groups set up under the Health and Social Care Bill, via an arm of its international business

See also:

CLINICAL COMMISSIONING GROUPS/GP SERVICES

ACCOUNTABILITY

MANAGEMENT

MONITOR

Examples of reported conflicts (by company)

GHG Chairman advises Conservatives on public sector savings which may benefit his company

BMI/Netcare

Conservative peer Lord Patten advisor to Bridgepoint Capital, owner of Care UK

Care UK

Care UK founder, John Nash and wife donate over £200,000 to Conservative Party

Harmoni (Care UK)

NHS fairness tsar urged to quit by doctors over 'conflict of interest'

McKesson

- American consultancy McKinsey in conflict-of-interest row

specialising in “Healthcare & Life Sciences sectors” called Real Staffing.

The MP for Stratford on Avon was admitted to David Cameron’s inner circle in October last year when he joined the Number 10 Policy Unit, a close-knit body set up to guide the Prime Minister. An SThree spokesman said: “Nadhim Zahawi is a non-executive director of Real’s parent company SThree and has no executive role in its affairs.

"We strongly refute any suggestion of a link between his political role and the commercial activities of the Group.”

Dr Clive Peedell of the National Health Action Party, said: “It looks like a collosal amount of money going out of the NHS which could be spent on direct patient care instead of going to shareholders.”

Advisor to health secretary has private healthcare links (The Independent: 14 February 2014)

The former Marks & Spencer’s boss appointed by Jeremy Hunt to advise on improving the NHS could “make a fortune” from hospital takeovers by private companies, the country’s biggest union has claimed.

Sir Stuart Rose, who will lead a review of management in the NHS, is also paid to sit on the advisory board of Bridgepoint, an international private equity group, which is the major shareholder of private health firm Care UK.

Care UK is in the running to take over the George Eliot NHS Hospital Trust – one of 14 hospital trusts in Sir Stuart’s review. Rachael Maskell, national officer for health at the Unite union, said Sir Stuart’s appointment represented a “gobsmacking conflict of interest” and called on him to confirm he would not profit personally from Care UK’s bid for the Warwickshire hospital.

A Department of Health spokesperson said that Sir Stuart had “committed to recuse himself from any relevant health discussions at Bridgepoint European Advisory Board meetings”.

MPs see ‘lack of clarity’ in NHS savings spending as reforms pressure health care system (BBC News: 12 February 2014)

There is a lack of clarity over what the money saved in the NHS in England has been spent on, say MPs. The NHS is in the middle of an efficiency drive with savings expected to be reinvested in front-line care and making services more productive. More than £10bn has been saved in the first two years with another £4bn forecast in 2013-14. But the Health Select Committee said there was little evidence it had been used wisely.

The cross-party group of MPs said the plan had been to transform the way services were delivered to make the NHS sustainable in the long-

- The firm that hijacked the NHS

McKinsey

Two Conservative and two Labour peers have shares in Serco

Serco

Jeremy Hunt personally intervenes to encourage Virgin takeover of NHS hospitals

Virgin

Spire employs former Department of Health employee and former Health Secretary

Spire

PRIVATE PROVIDER
IN-DEPTH PROFILES

Recent reports:

Private Health Lobbying
How private for-profit healthcare companies have lobbied and influenced government policy, in order to try and gain greater access to the £100bn NHS budget.

MPs and Lords Financial Interests in Healthcare

Analysis of financial interests MPs and Lords may have in private healthcare, these may include business investments, advisory positions and/or monetary donations.

"If conflicts of interest in CCGs are not managed effectively, the consequences could badly undermine the confidence of regulators, providers and, most importantly, patients, in the system."

Clare Gerada Royal College of GPs March 2013

term. But it said, to date, much of the savings had come from "straightforward" measures such as pay freezes and cutting funding to hospitals. It said as a result, the pressures on the NHS and social care system were now greater than they were a few years ago.

Committee chairman Stephen Dorrell said: "We have not seen the transformation of care on the scale which is needed to meet demand and improve care quality. "The NHS budget is static and the social care budget is falling. In these circumstances, the successful integration of high-quality health and care services represents a substantial and growing challenge."

Revealed: Big Pharma's hidden links to NHS policy, with senior MPs saying medical industry uses 'wealth to influence government' (The Independent: 11 February 2014)

NHS bosses allowed a lobbying company working for some of the world's biggest drugs and medical equipment firms to write a draft report which could help shape future health policy. NHS England commissioned a group called the Specialised Healthcare Alliance (SHCA) to consult with patients' groups, charities and health organisations and produce a report feeding into its future five-year strategy for commissioning £12bn of services. But the SHCA has confirmed to The Independent that it is entirely funded by commercial "members". Its director, John Murray, is also a lobbyist whose company lists some of the world's biggest drug and medical device firms as clients.

NHS hires drugmaker-funded lobbyist (The Guardian: 11 February 2014)

A lobbying organisation with links to some of the world's biggest pharmaceutical companies and medical equipment firms has been asked by NHS bosses to write a report that could influence health policy, it has been reported. NHS England commissioned the Specialised Healthcare Alliance (SHCA) to consult patients' groups, healthcare organisations and charities and produce a report that would be considered as part of its strategy for commissioning specialised services in the future. The Liberal Democrat MP Tessa Munt said the revelation "called into question the integrity and objectivity of NHS England's handling of 143 specialised services for millions of people". But NHS England said the report did not involve a conflict of interest, saying it was "not the final strategy and not NHS England policy".

Labour critical of Tory party donors who are given NHS contracts worth £1.5 billion under health reforms (Daily Mirror: 8 February 2014)

Lessons from the US?

Cherry-picking patients leaves sour taste

Medical professionalism in a commercialized health care market

Share your examples about the impact of NHS changes

Private health care firms with Tory links have been awarded NHS contracts worth nearly £1.5 billion.

Circle Health landed £1.36 billion worth of health service work after several of its investors gifted about £1.5 million to the Conservatives. Care UK has contracts worth another £102.6 million. Its chairman John Nash was made a peer after boosting Tory coffers by £247,250. Labour's research shows Circle Health's parent company, Circle Holdings PLC, is owned by a series of hedge funds. Lansdowne Partners, with a 29.2% stake, was founded by Sir Paul Ruddock, who donated £692,592 to the Tories. David Craigen, who gave the party £59,000, is also involved in Lansdowne. Invesco Perpetual owns 28.7% of Circle Holdings. It was set up by Sir Martyn Arbib, who donated £466,330.

Labour's Shadow Health Secretary Andy Burnham, who uncovered the figures, fumed: "Nobody gave David Cameron permission to sell the NHS to his friends. "It's shocking the same Tory donors who bankrolled the development of their NHS reorganisation policy are now profiting from the sell-off of NHS services."

Privatisation agenda drives Tory policy on NHS, says Andy Burnham (The Independent: 14 January 14 2014)

In an exclusive interview with The Independent, Andy Burnham accused the Coalition of crippling the NHS with competition law and setting it on a path towards charging patients for their care. The Labour frontbencher said that he had "huge reservations" about links between the Conservative party and private health-care companies – arguing that the NHS would be prey to giant American corporations picking off key services for profit if a landmark European Union free trade agreement is reached with the US.

Speaking as negotiations continue for a free trade deal bridging the Atlantic, Mr Burnham said such an agreement could pose fundamental problems. "US health-care companies will be able to say to an NHS clinical commissioning group: 'We have a legal right to bid for that service.' Dragging the NHS down that path will destroy it, it will devour what's precious about the NHS. "All the legal advice I am getting says, while we will just about be able to pull it back at the 2015 election, after that, it will be gone. That's the choice voters face."

Health and Social Care Act - How the EU is making NHS privatisation permanent (New Statesmen: 2 December 2013)

The European Parliament is in the process of enabling a historic shift in world economics with countless, far-reaching consequences. A key part of the TTIP is 'harmonisation' between EU and US regulation, especially for regulation in the process of being formulated. In Britain, the coalition

government's Health and Social Care Act has been prepared in the same vein – to 'harmonise' the UK with the US health system.This will open the floodgates for private healthcare providers that have made dizzying levels of profits from healthcare in the United States, while lobbying furiously against any attempts by President Obama to provide free care for people living in poverty. With the help of the Conservative government and soon the EU, these companies will soon be let loose, freed to do the same in Britain. "[The Health and Social Care Act] effectively enforces competitive tendering, and thus privatisation and liberalisation i.e. opening to transnational bidders - a shift to US-style profit-prioritised health provision."

The TTIP ensures that the Health and Social Care Act has influence beyond UK borders. It gives the act international legal backing and sets the whole shift to privatisation in stone because once it is made law, it will be irreversible. Investor State Dispute Settlement (ISDS) laws, fundamentals of the agreement, allow corporations legal protection for their profits regardless of patient care performance, with the power to sue any public sector organisation or government that threatens their interest. Once these ISDS tools are in place, lucrative contracts will be underwritten, even where a private provider is failing patients and the CCG wants a contract cancelled. In this case, the provider will be able to sue a CCG for future loss of earnings, thanks to the agreement, causing the loss of vast sums of taxpayer money on legal and administrative costs. Even more worrying is that, once the TTIP is enacted, repealing the Health and Social Care Act in the UK will become almost impossible. As Kaucher explains: "Even if outcomes of the NHS changes are disastrous, ISDS will effectively disallow any attempts by any future UK government to reverse the changes."

US private hospital group donates £17K to Tories (This is Jersey: 3 September 2013)

The Hospital Corporation of America (HCA) is the world's largest private hospital group, runs several units in London, and holds contracts to run NHS services. It donated £8,500 to the Conservatives in August 2010 and a further £8,500 in September 2011.

Tory strategist Lynton Crosby in new lobbying row (The Guardian: 21 July 2013)

The lobbying firm founded by the Tories' chief election strategist, Lynton Crosby, advised private healthcare providers on how to exploit perceived "failings" in the NHS, according to a leaked document obtained by the Guardian. The leaked document consists of slides from a presentation which showed that the firm Crosby Textor advised the H5 Private Healthcare Alliance on how to promote themselves amid a highly

sensitive debate on the future of the NHS. Labour warned of a "shocking conflict of interest" involving the man charged with running the Tory general.

The slides state that people believe the NHS provides good healthcare, though they believe it has "failings" and is "too bureaucratic with long waiting lists". Crosby Textor advised its clients that 63% of those questioned in a poll conducted for the presentation believed that "going private frees up the NHS waiting list". Crosby Textor, which conducts polls on behalf of clients to help them develop a "powerful strategy focused on the most persuadable 'swing' targets", found overwhelming support for private healthcare providers in a survey carried out for the H5 Alliance.

Lynton Crosby has also been at the centre of debates over the introduction of plain packaging for cigarettes: David Cameron has refused to give a direct answer about whether he spoke to a Crosby, the Tobacco Company lobbyist, before deciding to delay the introduction of plain packaging for cigarettes.

High Court stops Jeremy Hunt from downgrading Lewisham hospital (Pulse: 31 July 2013)

Health secretary Jeremy Hunt acted unlawfully when he downgraded the A&E department at Lewisham Hospital, found the High Court today.

In today's judgment Justice Silber said that the decision of the Secretary of State must be 'quashed' as he had acted outside his powers as Secretary of State.

The Save Lewisham Hospital (SLH) group, led by local GP Dr Louise Irvine,challenged Mr Hunt's decision to replace Lewisham Hospital A&E with an urgent care centre, which was based on a recommendation by a 'trust special administrator' looking into financial problems at the nearby South London Healthcare Trust.

In his judgment Mr Silber referred to a pledge made by the Prime Minister, David Cameron, in January 2013 to Dame Joan Ruddock, MP for Lewisham Deptfort, that hospital closures or reorganisations would not go ahead 'unless they had support from the GP commissioners'.But Lewisham CCG's opposition to the downgrading of Lewisham Hospital A&E went unheeded by the health secretary, highlighted concerns from CCG leaders that they will not have the freedom they need to shape local services.

Controversy over new Tory health advisor Nick Seddon who called for NHS cuts and charges for GP visits (London Evening Standard: 9 May 2013)

David Cameron's No 10 policy shake-up hit new controversy today when it emerged his new health adviser had advocated deep NHS cuts and

even charges to see a family doctor. Nick Seddon was hired from the right-leaning think tank Reform to advise the Prime Minister on health and social care as part of the new team led by Boris Johnson's brother, Jo Johnson.

Before joining Reform, Mr Seddon worked at private health company Circle, which runs the first NHS hospital to be privately managed.

Labour health spokesman Andrew Gwynne said: "Another revealing appointment in Number 10. After the old Etonians, come the NHS privateers.

The firm that hijacked the NHS: MoS investigation reveals extraordinary extent of international management consultant's role in Lansley's health reforms (Mail on Sunday: 12 February 2012)

This investigation by The Mail on Sunday reveals the extent of the involvement of McKinsey & Company in the Conservative's reforms of the NHS. Many of the bill's proposals were drawn up by the company. One document revealed by the paper says the firm has used its privileged access to 'share information' with its corporate clients – which include the world's biggest private hospital firms – who are now set to bid for health service work. Other revelations include that McKinsey & Company paid for NHS staff, including those now on the regulator Monitor, to go to lavish events.

Blurred boundaries between public service and private interest (The Guardian: 22 October 2012)

What can be done about civil servants who move to the private sector, taking all their insider knowledge with them? This question was prompted by the resignation from the NHS Commissioning Board of Jim Easton to become managing director of the private provider Care UK. He had the task of touring the country telling localities of the need to find £20 billion of savings by working more smartly, including greater outsourcing. Now Mr Seddon's insider knowledge and experience will be put at the disposal of one of the biggest private providers in the country with interests spanning primary care, secondary care, residential care, community care and specialist care.

Compilation of financial and vested interests of MPs and Lords (Social Investigations: February 2012)

According to the campign group, Social Investigations, this list of MPs and Lords interests represents "the dire state of our democracy. The financial and vested interests of our MPs and Lords in private healthcare."

The investigation has highlighted over 200 parliamentarians that have recent past or present financial links to companies involved in healthcare and all of whom were allowed to vote on the Health and Social Care bill, turning it into an Act.

Tory MP forgot he was paid £50K by Circle (BBC News: 12 February 2012)

Conversative MP and ministerial aide Mark Simmonds has apologised for failing to make clear an interest when speaking in favour of the NHS reforms. The MPs' register of interest shows he is paid £50,000 a year as a strategic adviser to Circle Healthcare. Mr Simmonds told MPs he wanted to apologise for "inadvertently" failing to declare his interest.

The firm that hijacked the NHS: MoS investigation reveals extraordinary extent of international management consultant's role in Lansley's health reforms (Mail on Sunday: 12 February 2012)

This investigation by The Mail on Sunday reveals the extent of the involvement of McKinsey & Company in the Conservative's reforms of the NHS. Many of the bill's proposals were drawn up by the company. One document revealed by the paper says the firm has used its privileged access to 'share information' with its corporate clients – which include the world's biggest private hospital firms – who are now set to bid for health service work. Other revelations include that McKinsey & Company paid for NHS staff, including those now on the regulator Monitor, to go to lavish events.

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Government forced to defend McKinsey bill involvement (Health Services Journal: 14 February 2012)

The government has denied that there is a conflict of interest between its health reforms and a management consultant advising on them. Following weekend press reports about McKinsey & Company's role in the Health and Social Care Bill, Labour's leader of the Opposition in the

Lords Baroness Royall raised questions about the firm ahead of debates on the reforms.

NHS reforms: American consultancy McKinsey in conflict-of-interest row. (The Guardian: 5 November 2011)

A global consultancy firm seeking to profit out of the fallout from the shake-up to the NHS is being paid £250,000 a year by the government for advice on the transition towards health secretary Andrew Lansley's vision of the service. The American firm, McKinsey Inc, with estimated revenues of £4.1 billion a year, has been advising the Department of Health on how best to manage the radical changes since March. McKinsey is also one of a group of private consultants that have united to provide paid-for advice to GPs as they prepare for life after the reforms.

David Cameron's adviser says health reform is a chance to make big profits (The Guardian: 14 May 2011)

Mark Britnell, who was appointed to a "kitchen cabinet" advising the prime minister on reforming the NHS, told a conference of executives from the private sector that future reforms would show "no mercy" to the NHS and offer a "big opportunity" to the for-profit sector.

NHS Support Federation
Community Base,
113 Queens Road,
Brighton, BN1 3XG

THE INDEPENDENT WEDNESDAY 07 JANUARY 2015

Tax Special Investigation: Firms running NHS care services avoiding millions in tax

First of a series: companies running care services are among many avoiding millions in tax through a legal loophole

RICHARD WHITTELL , EMILY DUGAN

Monday 21 October 2013

Companies receiving lucrative government contracts to run care services looking after tens of thousands of vulnerable people are avoiding millions of pounds in tax through a legal loophole.

The firms are cutting their taxable UK profits by taking high-

interest loans from their owners through the Channel Islands Stock Exchange, an investigation by Corporate Watch and *The Independent* has found. By racking up large interest payments to their parent companies, they are able to reduce their bottom line and cut their tax bills.

The news will increase concern about NHS reforms that are seeing private companies take more responsibility for services. It also raises questions about the Government's commitment to tackling corporate tax avoidance, which David Cameron has said "corrodes public trust".

Over the course of this week, *The Independent* will reveal how more than 30 UK companies, including some of the UK's most recognisable brands, are benefiting from this legal tax loophole, known as the quoted Eurobond exemption. HMRC considered restricting the use of the loophole in 2012 but never took action.

The care companies known to benefit from the loophole are: Partnerships In Care (several of whose mental health facilities have recently failed inspections), Independent Clinical Services, Priory Group, Acorn Care, Tunstall, Lifeways, Healthcare At Home, Spire Healthcare and Care UK.

Margaret Hodge, chair of the Public Accounts Committee, said: "Companies have a duty to pay their fair share of tax relative to the profits they make in this country. Yet it seems every week brings a new revelation of another business that is using artificial structures to move profits out of the UK, seemingly for no purpose other than to avoid tax.

"The case of these private health companies, which *The Independent* has brought to my attention, I find particularly depressing. These are companies who get their income overwhelmingly from taxpayers' money, for the purpose of providing a vital public service, yet do not appear to be making their fair contribution to the public purse."

One of the companies, Partnerships in Care, managed to turn what would have been a hefty tax bill into a tax credit in 2012, according to accounts filed at Companies House. It owes £321.9m to its owners Cinven, a European investment firm. By paying interest of £29.7m on these borrowings in 2012, it helped to turn a healthy operating profit of £31.7m into a pre-tax loss, leaving the group with a tax credit of £629,000.

Meanwhile, several of the company's secure hospitals for mental health patients have recently received damning inspection reports. A spokeswoman for the company acknowledged that it had recently received two "major warning" notices from the Care Quality Commission but said that in 93 per cent of inspections of their hospitals between July 2012 and August 2013, they were

assessed as compliant or requiring only minor improvement.

Although the interest rate on the loans taken by these care companies is subject to scrutiny by HMRC, they are all significantly higher than the rates they are paying on loans from third parties such as banks – meaning they can reduce their profits and therefore their tax bills, while the parent companies still receive a steady flow of cash back into their accounts.

Tunstall, for example, is paying a 16 per cent interest rate on its borrowings from its owners the Charterhouse and Bridgepoint private equity funds – compared with the 5 per cent average rate on its bank loans.

The company, which provides over-the-phone care services to almost every council in the UK and the new clinical commissioning groups, avoided up to £19m in UK corporation tax in 2012, after £76.1m in interest on the loans from its owners virtually wiped out its operating profit, leaving it with a tax bill of only £548,000.

HMRC would usually deduct a 20 per cent "withholding" tax on interest payments going overseas. But as the loans are issued through the Channel Islands Stock Exchange, the exemption means they leave the UK tax free. If their owners had provided funds to the companies by investing in shares instead of issuing loans, any dividends would be paid after the companies' profits had been taxed. Other operating expenses could also influence their overall tax bill.

Other companies previously found to be using the loophole include Global Radio, owners of radio stations including Classic FM, Capital and Heart, and water companies including Northumbrian, Yorkshire and Thames Water.

British Private Equity and Venture Capital Association director general, Tim Hames, said: "The Quoted Eurobond Exemption is designed to encourage inward investment by global investors, many of them pension funds who are exempt from tax. Those investors who are not exempt pay tax on the interest. Removing the exemption would mean less investment coming into the UK, and into social care providers where it is desperately needed.

HMRC reviewed this matter last year but accepted the investment case for its retention."

Independent Clinical Services did not respond to The Independent's requests for comment and its owners Blackstone declined to comment. A spokesman for Spire and Partnerships in Care said that the arrangements "are common across the private equity industry" and interest levels were "reviewed and agreed with HMRC".

Spokespeople for Healthcare at Home, Lifeways, Priory Group, Care UK and Tunstall pointed out that the companies were fully compliant with UK tax laws. A spokesman for Acorn did not deny using the tax loophole but said the analysis was inaccurate because it was "based on incomplete information".

An HMRC spokesman said: "In March last year we ran a consultation to consider aspects of the taxation of interest including the circumstances in which the exemption from withholding tax on quoted Eurobonds would apply.

"The proposed amendment to the exemption would have applied to companies whether their customers were in the public or the private sector, but in the light of concerns about the possible negative impact on inward investment it was decided to keep this complex area of tax law under review."

Partnerships in Care

Owner: Cinven is a leading European private equity firm. Since the firm was founded in 1977, it has completed transactions valued at more than €70bn (£59bn).

Services: The vast majority of its £171.1m revenue comes from the NHS for specialist hospitals dealing with mental health issues, learning disabilities and substance abuse.

Several of the company's secure hospitals for mental health patients have recently received damning inspection reports, which criticised poor patient safety, critically low staffing and a lack of respect for basic dignity. The Dene, a medium-security psychiatric hospital in West Sussex, failed all seven categories of a recent inspection by the Care Quality Commission and enforcement action was taken. Annesley House, a psychiatric hospital run by the company in Nottingham, failed four out of five areas inspected, with growing numbers of whistleblowers alleging that patients were treated in a "disrespectful" and "degrading" way.

Duty of care: The companies under

Star Wars and James Bond actor collapses and dies during rehearsal for play

Khan Bonfils appeared as a Jedi master in 'Star Wars: Episode 1'

TECH

Swivel chairs and 685 miles per charge, take a look at Mercedes' latest self-driving car

VOICES

'Innocent or guilty, if you're accused of rape then you should not be granted anonymity'

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Sony launches new Walkman - for £949

FOOD + DRINK

Pint of stereotype, please: Study shows drinkers do

scrutiny

Partnerships in Care

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Total owed to owner: £321.9m at 10 per cent

2012 interest to owner: £29.7m

Potential tax avoided in 2012*: £7m

Healthcare at Home

Owner: Vitruvian Partners is a European private equity firm.

Services: Britain's largest home healthcare provider, sending in nurses to people's homes. The vast majority of its £837.6m revenue comes from the NHS.

Total owed to owner: £140.8m at 12 per cent

2012 interest to owner: £11.5m

Potential tax avoided in 2012**: £1.2m (after HMRC disallowed the rest to be deductible)

Independent Clinical Services

Owner: Blackstone is the world's largest manager of alternative

have regional tastes

Scots really do love whiskey and Yorkshire prefers ale

FILM

'The Interview': Coming to a cinema near you soon

Film originally cancelled in the US after threats by hackers to be released in Britain in February

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David Cameron says he likes musician, musician says he feels sick

FILM

'Timid and fawning': Film critic accuses peers

Armond White, who once called Harry Potter the 'dullest franchise in the history of movie franchises,' laments a lack of objectivity and professionalism in a scathing article

TECH

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assets, whose senior executives earn millions of dollars a month.

Services: One of Britain's largest independent providers of nursing staff to the NHS.

Total owed to owners: £144.6m at 10 per cent

2012 interest to owner in 2012: £13.5m

Potential tax avoided in 2012: £3m

Spire Healthcare

Owner: Cinven

Services: Private hospitals

Total owed to owner: £756.7m at 12 per cent

2012 interest to owner: £81.2m

Potential tax avoided in 2012: £20m

Lifeways

Owner: August Equity Partners (taken over by Omers Private Equity, 8 June 2012, after most recent accounting period).

Services: Specialises in supported living and care homes for people with disabilities. Recent inspection reports from the Care Quality Commission show that several homes and services owned by the company have had problems with staffing levels and standards of care.

Total owed to owner (August):

£52m at 12 per cent

2012 interest to owner: £4.4m

Potential tax avoided in 2012: £1m

Priory Group

Owner: Advent International Corporation is one of the world's leading global buyout firms. Services: The group looks after more than 7,000 people, caring for older people and those with learning disabilities. Some 87 per cent of its funding comes from the NHS, or other public funding sources.

Total owed to owner: £222.7m at 12 per cent

2012 interest to owner:

£23.9m

Potential tax avoided in 2012: £6m

Acorn Care

Owner: The Ontario Teachers Pension Plan board is Canada's largest single-profession pension plan with $129.5bn (£78bn) in net assets. It works with 80 local authorities and receives referrals from local authority education, social care and health departments for educating and caring for children with special educational needs. It receives the vast majority of its £110.6m revenue from public bodies.

Total owed to owner: £79m

2012 interest to owner: £16.6m at 16 per cent

Potential tax avoided in 2012**: £4m

Care UK

Owner: Bridgepoint

Services: One of the biggest providers of health and social care services in the UK. It runs GP centres, hospitals and care homes and provides support for people within the community. About 100 elderly and vulnerable people complained about the standard of home care offered since Care UK took over visits to 300 clients in Broadland, Norfolk, in July.

Total owed to owner: £116.1m at 16 per cent

2012 interest to owner: £22.8m

Potential tax avoided in 2012: Up to £5m (depending how much interest HMRC disallowed to be deductible)

Tunstall

Owners: Charterhouse and Bridgepoint

Services: Telehealth support used by many local authorities.

Total owed to owners: £557.8m at 16 per cent

2012 interest to owners: £76.1m

Potential tax avoided in 2012: £19m

* The amount of tax potentially avoided for each company was estimated by applying the rate of corporation tax to the amount of interest paid or accrued on loans from owners, with appropriate deductions where companies have disclosed them. The calculation assumes that the loan amount would be invested as equity by the owners instead.

** These companies made operating losses in 2012 but the additional tax credits from the interest can be offset against future years' tax charges.

Richard Whittell: 'A legitimate

form of investment'... how the exemption works

In 1984 the Government introduced the "quoted Eurobond exemption", a little-known regulatory loophole intended to make UK companies more attractive to foreign lenders looking to minimise their tax bills.

When a UK company pays interest to an overseas lender it would usually have to send 20 per cent straight to HMRC. The exemption allowed banks and other investors to receive the interest without the deduction if they lent their money through a "recognised" stock exchange such as the Channel Islands or the Cayman Islands.

Almost 30 years on, the tax benefits are being enjoyed not only by third-party investors, but by the owners of UK companies, who are using it to spirit profits through tax havens, while minimising – sometimes eliminating – the company's UK tax bill.

The loophole is popular with private equity firms, which manage money given by pension funds and others to buy companies and then sell them off at a profit.

Instead of investing their money in the shares, or "equity", of the companies they buy, they lend the money, often at eye-wateringly high interest rates through offshore stock exchanges.

Their newly acquired companies then take the yearly interest off their profits before they have been taxed in the UK, and reduce their tax bill accordingly. Often, the interest is not paid to the owners immediately but is accrued and added on to the original loan, increasing the amount taken off the next year. If the owners had invested the money in shares, any dividends they received would be paid after the tax had been calculated.

Many companies which use the loophole – and there are lots of them – say this is a legitimate form of investment; and there's no doubt it is legal. HMRC considered restricting the exemption last year.

** Richard Whittell works for Corporate Watch, a not-for-profit journalism, research and publishing group www.corporatewatch.org"*

** Tomorrow: The Independent reveals the company at the heart of British life avoiding tax through the Eurobond loophole – and how HMRC was lobbied not to close it*

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RESEARCH ARTICLE

Medical Tourism: A Cost or Benefit to the NHS?

Johanna Hanefeld, Daniel Horsfall, Neil Lunt, Richard Smith

Published: October 24, 2013 • DOI: 10.1371/journal.pone.0070406

Abstract

'Medical Tourism' – the phenomenon of people travelling abroad to access medical treatment - has received increasing attention in academic and popular media. This paper reports findings from a study examining effect of inbound and outbound medical tourism on the UK NHS, by estimating volume of medical tourism and associated costs and benefits. A mixed methods study it includes analysis of the UK International Passenger Survey (IPS); interviews with 77 returning UK medical tourists, 63 policymakers, NHS managers and medical tourism industry actors policymakers, and a review of published literature. These informed costing of three types of treatments for which patients commonly travel abroad: fertility treatment, cosmetic and bariatric surgery. Costing of inbound tourism relied on data obtained through 28 Freedom-of-Information requests to NHS Foundation Trusts. Findings demonstrate that contrary to some popular media reports, far from being a net importer of patients, the UK is now a clear net exporter of medical travellers. In 2010, an estimated 63,000 UK residents travelled for treatment, while around 52,000 patients sought treatment in the UK. Inbound medical tourists treated as private patients within NHS facilities may be especially profitable when compared to UK private patients, yielding close to a quarter of revenue from only 7% of volume in the data examined. Costs arise where patients travel abroad and return with complications. Analysis also indicates possible savings especially in future health care and social costs averted. These are likely to be specific to procedures and conditions treated. UK medical tourism is a growing phenomenon that presents risks and opportunities to the NHS. To fully understand its implications and guide policy on issues such as NHS global activities and patient safety will require investment in further research and monitoring. Results point to likely impact of medical tourism in other universal public health systems.

Figures

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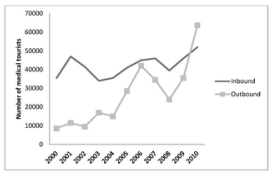

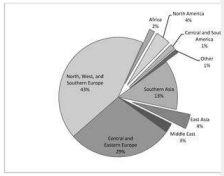

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Competing interests: The authors have declared that no competing interests exist.

Introduction

The phenomenon of people travelling abroad to access medical treatment – commonly termed 'Medical Tourism' – has received increasing attention in academic and popular media [1]. The confluence of available and affordable air travel, internet-based marketing by providers, and an increasing requirement for out-of-pocket expenditure, even in universal public health care systems such as the UK NHS, suggests that increasing numbers of patients may consider travelling for treatment. The PIP scandal highlighted challenges for UK patients in seeking redress from private providers, especially where these may be based in other jurisdictions [2], [3].

As the new NHS reforms introduce yet greater market elements, including the removal of the cap on income from private patients [4], and the EU Directive on crossborder healthcare is implemented which codifies rights around patient mobility [5], it is imperative to consider the challenges and opportunities that medical tourism – inward and outward – may present to the NHS [6].

Yet, reliable information on even the basic number, characteristics, motivations and experiences of such patients is scarce, as patients arrange and pay for such care privately [7]. Indeed, a recent review of medical tourism literature [8] found that academic literature relies heavily on opaque data from private consultancy firms or unverified media reports [9], [10]. In the absence of even the basic level of information in these areas, it is understandable that rhetoric has filled the vacuum. In this paper we present evidence from the largest study yet conducted concerning medical tourism, undertaken from an NHS perspective, to provide a firmer footing for debate and discussion by health professionals, NHS managers and those involved in the wider policy-making context.

Methods

Authors interviewed 77 UK medical tourists and 63 other UK stakeholders between March 2011 and August 2012. Interviewees gave written consent to participate in the study. Interviews were recorded, transcribed and thematically analysed. The study received ethical clearance from the National NHS Ethics review process submitted through the Sheffield Research Ethics Committee approval (11/H1308/3).

Analysis is three-fold: (i) the volume and characteristics of outbound and inbound UK medical tourists is based upon the International Passenger Survey (IPS); (ii) assessment of NHS income from foreign patients is based upon freedom-of-information requests submitted to 28 NHS Foundation Trust hospitals; and (iii) evaluation of the challenges encountered, costs incurred and potential savings for the NHS is based on a review of published and grey literature and interviews with UK nationals, NHS managers and policy makers. Each of these is described below.

Analysis of the International Passenger Survey (IPS)

The IPS, conducted by the UK Office of National Statistics (ONS), collects information from passengers as they enter or leave the UK. Passengers are randomly selected as they travel through passport control and a brief survey is administered. One of the survey questions asks passengers to define their primary purpose for travel; 'medical treatment' is one of the answers recorded, thus providing insight into the number of passengers who self-declare that they are travelling for medical treatment.

The IPS dataset from 2000–2010, from the Office of National Statistics (ONS), was analysed by two authors independently, triangulating results. Data from the IPS, interviews, literature and NHS tariffs were used to calculate cost impacts. Authors used the different data sources accessed to carefully triangulate and better understand the reliability of the data from the IPS, which is reflected on in the discussion.

FOI Requests

Submitted to 28 Foundation Trust hospitals on volume and income from international private patients. Trusts were purposely selected to be those most likely to be visited by inbound tourists i.e., large and well-known Trusts, such as Great Ormond Street Hospital for Sick Children, many of which are based in London. Data on foreign patients was analysed to understand the potential of earnings from foreign patients.

Qualitative Analysis

Authors interviewed 77 UK residents who travelled abroad for treatment and 63 other UK stakeholders between March 2011 and August 2012. Interviews were recorded, transcribed and thematically analysed. The study received ethical clearance from the National NHS Ethics review process.

Results

While the level of inward travel of foreign patients to the UK (although not necessarily the NHS) has been relatively stable over the last decade, there has been a substantial increase in the number of UK residents travelling abroad to access medical treatment, as indicated in Figure 1.

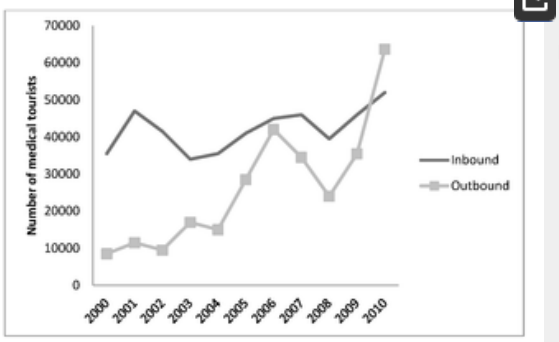

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Figure 1. The number of people who travelled into or out of the UK for medical treatment during the period 2000–2010.
doi:10.1371/journal.pone.0070406.g001

Destination of UK Outbound Medical Travellers

Figure 2 shows UK residents most commonly travel for medical treatment to North, West, and Southern Europe with France being the most visited country over the decade.

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Figure 2. Map depicting total numbers of medical travellers and their destinations from the UK over the period 2000–2010.
doi:10.1371/journal.pone.0070406.g002

Examining this in greater detail (Fig 3) suggests that Central and Eastern Europe are second most popular, and that Poland and Hungary are increasingly popular.

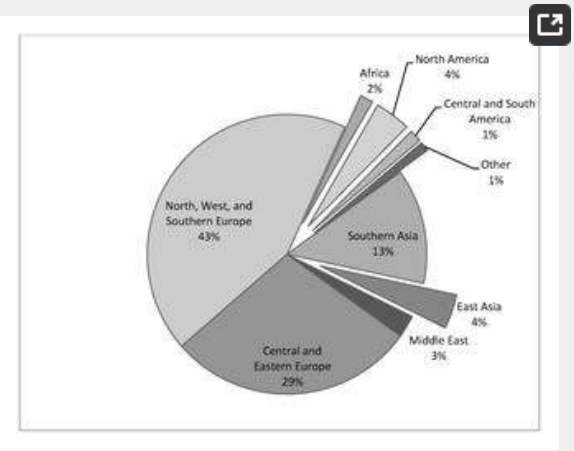

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Figure 3. Pie Chart showing total outward medical travel by UK residents by destination region over the time-period 2000–2010.
doi:10.1371/journal.pone.0070406.g003

South Asia, primarily India, also attracts large numbers of UK patients, making it the most frequently visited non-European country, with a relatively stable pattern of travel to India, Pakistan, and in much lower numbers Sri Lanka and Bangladesh, possibly reflecting a diaspora effect. In contrast, East Asia shows a different pattern, with virtually no medical travellers recorded by the IPS prior to 2003, yet by 2010 15% of all UK medical travellers went to East Asia. This increase of 430% is unlikely to be solely related to diaspora patients, but does correlate with many South East Asian countries marketing strategies at this time [11].

Based on the IPS data, and patient interviews, treatment specific destinations emerge. For example, UK dental patients increasingly travel to Hungary and Poland, which corresponds to the varied availability of NHS dental treatment over the last decade [12]. Fertility tourists often travel to countries in Eastern Europe, Cyprus and Spain possibly owing to more easily accessible gametes, and less stringent regulation which allows anonymous donation as well as a greater number of embryos transferred [13].

Inward Medical Travel

As evident in Figure 1, data from the IPS suggests that international patient inflows to the UK (independent sector and NHS private services) were in the region of 52,000 in 2010. Data over the decade also confirms that while growing, the overall numbers of patients travelling into the UK to access medical services is rising at a much slower rate than UK residents travelling out for care. So, contrary to some popular media reports, far from being a net importer of patients, the UK is now a clear net exporter of medical travellers.

Major source countries for patients coming into the UK include Spain, Greece, Cyprus and the Middle East. The number of Greeks and Cypriots travelling into the UK to access treatment rose rapidly in 2009 and 2010. These figures may reflect a change as a result of the economic crisis, which in turn has meant severe public sector cuts in these countries, including in health [14]. Similarly, while medical tourists from Ireland may choose to travel to access treatment not available there, including termination of pregnancies, the rapid increase in patients from Ireland in recent years may reflect the cuts in the health sector there and greater numbers of UK citizens resident in Ireland returning to the UK for treatments (see Figure 4). The 'dip' in both inbound and outbound medical travel evident in Figure 1 in 2008 may be attributable to the onset of the crisis. Examining the number of travellers by quarter found a much lower number of inward and outward medical travellers in Quarter 3 of 2008 during the onset of the crisis, than the rest of the year, or Quarter 3 in 2009. In the case of Irish, Spanish (and perhaps French) residents, it is highly likely that a substantial number will be UK expats and it is unclear whether these engage in out-of-pocket medical treatment (in the private sector or NHS) or whether they accept NHS services free at the point of use for which they may (or may not) be eligible.

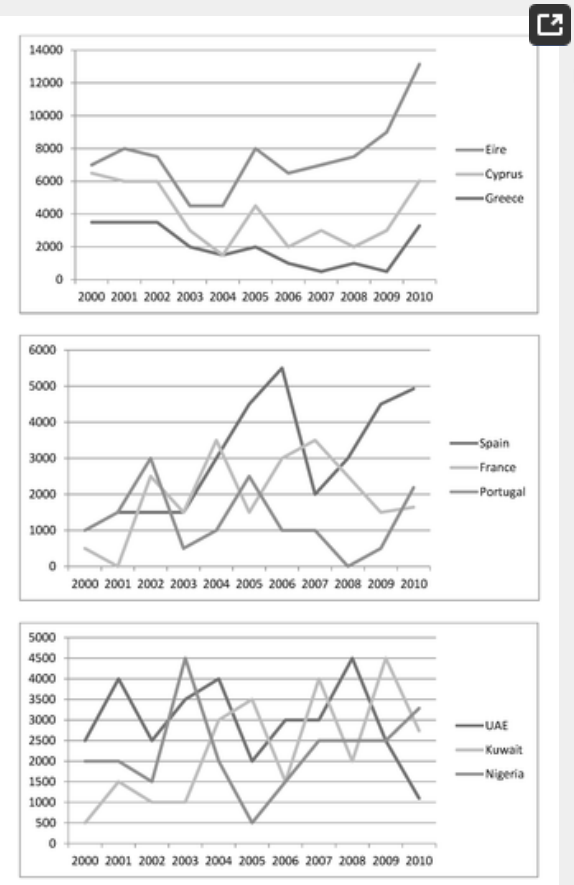

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Figure 4. Nine most common countries of origin for those who travelled to the UK for medical (2000–2010).
doi:10.1371/journal.pone.0070406.g004

A further significant number of patients travel from the Middle East (specifically from the United Arab Emirates and Kuwait) although visitor numbers from both countries dropped sharply in 2008 and 2009 respectively. Despite some variation between years, a stable inward flow of medical travellers from Nigeria is also evident over the past decade, perhaps reflecting the growing wealth of some sections of that population.

International activity within hospital trusts.

Our Freedom-of-Information requests suggest that Trusts could not always clearly identify international patients within their pool of private patients because nationality was not recorded when they underwent treatment and nationality/place of residence may differ. Looking at the 28 Trusts within our sample, their international activity ranged from relatively marginal to being one-third of their total private work.

Where Trust managers were interviewed (at seven sites) they spoke of international patient flows and activities within the context of pressure on NHS resources, and pre-existing international activities and linkages. Commercial imperatives were balanced with strong statements regarding the core NHS role, centred on NHS services and prioritising NHS patient care. International patient activity was typically specialist where it was not possible to treat locally because of relatively small volumes and the complex nature of treatment required. Relationships, primarily clinical ones, for example where a clinician from aboard had trained or worked in a UK hospital were paramount in maintaining flows of international patients. Established practices of education, training, consultancy and linkages were reported to help facilitate referrals. Rather than systematic links these personal networks appeared paramount in linking UK hospitals to international patients.

What is the Impact of Medical Tourism on the NHS 'Bottom-line'?

Using the IPS data, analysis from interviews with medical tourists, academic literature and published NHS data we calculated possible costs and savings for the NHS for three types of medical tourism identified (see annex S1 for calculations).

Fertility tourism.

Based on data from the Office of National Statistics on multiple births in the UK and evidence from a hospital in London which found over a quarter of multiple births were in women who had travelled abroad for fertility treatment [15], we estimated the cost incurred through multiple births as a result of individuals travelling abroad for fertility treatment. Multiple pregnancies pose risks to mothers and children. We concentrated on the actual costs of multiple births per se as the exact needs throughout pregnancy and possible complications are highly variable between women, and thus our estimates will be highly conservative. We calculated the additional cost of a twin or triplet over singleton birth resulting from fertility travel in 2010 to be £15.5 million.

The long-term costs resulting from assisted reproductive technologies, including multiple pregnancies will not differ between medical tourists and fertility patients who received care in the UK. However, our research indicates that patients will travel in search of reproductive care to countries with regulations that will allow fertility treatment likely to result in a higher number of multiple births. Any effort to address the rise in multiple births in the UK therefore needs to take account of medical travel and involve specific targeted information to be effective.

Cosmetic tourism.

We also calculated the likely cost of complications resulting from cosmetic tourism based on a recent study by Miyagi et al. [16], who described a cohort of patients in a tertiary facility which reported problems arising from cosmetic surgery undertaken abroad over a period of three years. The authors calculated the cost of treatment provided within the NHS for complications and highlighted the reimbursement received by the hospital from the PCT (which was less than the expenditure of the hospital). Based on our calculations complications of medical tourists are at a cost of £8.2 million per annum within the NHS.

Bariatric surgery.

Compared to other types of tourism discussed, bariatric tourism may represent savings rather than costs for the NHS, as well as wider social savings. With 25% of the UK population classified as clinically obese, the financial impact of obesity on the NHS is calculated as £4.3billion by the DoH [17]. Obesity also has wider costs for social services. For example, a study by the National Office of Accounting estimated that 18 million working days were lost due to obesity with surgery offering potential savings. Hawkins et al. [18] demonstrated that there was a 32% increase in bariatric patients in paid work after surgery.

Based on these estimates, the 13 bariatric tourists interviewed for this research would represent a saving of £112,506 (in cost of procedure and in future health care and social

services savings). Even as a high estimate, the key point remains that patients travelling abroad to receive bariatric surgery are likely to represent a saving to the NHS and social services. Further research on the longitudinal effects of bariatric surgery is needed and now underway in the University of Glasgow at the Surgical Obesity Treatment Study (ScOTS).

Income Generated by Inbound Medical Travellers

Income generated by inbound medical travellers can be divided into additional tourism revenue, capturing the general expenditure related to patients visit to the UK, and medical expenditure (revenue to hospital).

Tourism revenue from all inbound medical travelers.

Tourism revenue by medical travellers to the UK per annum is based on the most recent IPS data for inbound medical travellers (2010). As respondents in the IPS survey specifically state they are visiting for health care, it is assumed they would not have otherwise have visited the UK, and thus are an addition to visitor/tourist numbers to the UK. Hence, any spending would be seen to be a net benefit not otherwise coming to the UK.

Based on hospital data for patients treated within NHS hospitals, it can be assumed that 20% of inbound medical travellers receive treatment as inpatients, the remainder as day-case procedures. Expenditure was calculated for patients staying in the UK for a number of different scenarios, ranging from those who stay for four days to receive outpatient treatment to patients who receive in-patient treatment for 10 days and stay a further two weeks for follow-up (see Table 1). Assumptions were based on interview data collected and on an average hospital stay of inpatients (not just medical tourists) in 2010 to 2011 from the NHS Hospital Episode Statistics. These assumptions were that: patients likely arrive some days before treatment and remain additional days to fully recuperate or even take the opportunity for additional tourism activities; people travel with one companion, and travellers from the Middle East travel with two, and that these are not captured by the IPS (based on interview data and corroborated by a 2008 national survey conducted by *Which?*). This seems reasonable given the higher foreign patient number captured from the FOI letters and interview data from patients who often reported reluctance to be identified as medical tourists possibly due to the negative public image of medical tourism, making it unlikely that accompanying persons will identify as medical tourists. Cost of accommodation was calculated at £80 per night and £100 per day as spending for patients when they were not in hospital and for their travel companions.

Inbound medical travellers	No	Nights in hotel	Cost hotel	Expenditure	Total expenditure
	52000				
Inpatients*	10400				
Hospital for ten days 75% (75% from ME)	7800	14	8,736,000	10,920,000	19,656,000
Hospital for five days 25% (5% from ME)	2600	7	1,456,000	1,820,000	3,276,000
Subtotal inpatients			10,192,000	12,740,000	22,932,000
Accompanying persons inpatients					
Hospital for ten days 75% (75% from ME)	13650	24	26,208,000	32,760,000	58,968,000
Hospital for five days 25% (5% from ME)	2730	12	2,620,800	3,276,000	5,896,800
Subtotal accompanying persons			28,828,800	36,036,000	64,864,800
Total inpatient and accompanying			39,020,800	48,776,000	**87,796,800**
Outpatients	41600				
4 day stay (25%)	10400	4	3,328,000	4,160,000	7,488,000
7 day stay (40) (2.75% ME)	16640	7	9,318,400	11,648,000	20,966,400
14 day stay (35%) (2%ME)	14560	14	16,307,200	20,384,000	36,691,200
Subtotal outpatients			28,953,600	36,192,000	**65,145,600**
Accompanying persons outpatients	41600				
4 day stay (25%)	10400	4	3,328,000	4,160,000	7,488,000
7 day stay (40) (2.75% ME)	17098	7	9,574,880	11,968,600	21,543,480
14 day stay (35%) (2%ME)	14809	14	16,586,080	20,732,600	37,318,680
Subtotal accompanying persons OP	42307		29,488,960	36,861,200	**66,350,160**
Total outpatient and accompanying					**131,495,760**
Total					**219,292,560**

doi:10.1371/journal.pone.0070406.t001

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Table 1. Calculation of additional spend by incoming medical tourists and their travel companions.

doi:10.1371/journal.pone.0070406.t001

Calculations are summarized in Table 1 and further explained in Annex S1 suggest that, even without taking the cost of the actual medical treatment into account, medical tourists to the UK contribute around £219 million in additional 'tourism spending' to the UK economy per year.

Healthcare revenue from all inbound medical tourists.

To estimate the spend on medical procedure by inbound medical tourists in NHS facilities as accurately as possible, we submitted Freedom-of-Information requests for data on income from private patients in NHS hospitals, including UK and non-UK patients, to 28 NHS Foundation hospitals. Of 28 hospitals 19 were able to provide data on the percentage of income that

resulted from non-UK resident patients and number of non UK residents treated as private patients. Authors excluded Moorfields Eye Hospital, as a review of the data across different hospitals indicated this as an outlier. Given the focus on eye medicine, it has a very large number of patients visiting for outpatient procedures at a lower per cost treatments compared to other elective procedures. The remaining 18 reported a combined income from private patients of £195 million over a period of 12 months between 2010–2011.

Those who were able to provide differentiated data indicated that £42 million of their total income was from non-UK resident patients; looking across these 18 hospitals, this meant close to 25% of their private income was from incoming medical tourists. While our sample of hospitals was weighted towards large London-based facilities which do experience a higher number of international patients, income ranged vastly between hospitals surveyed: from over £20million to just £2,466 with a mean of £2.5million.

Those hospitals that were able to report numbers of patients reported a total of 6,722 patients from abroad out of a total of 88,775 private patients counted, i.e. seven percent of private patients were inbound medical tourists. It might therefore appear that medical tourists may be especially profitable, yielding close to a quarter of revenue from only 7% of volume. For a detailed listing of patients and income per hospital, see Annex S2.

Discussion

Results confirm that a small but increasing number of UK patients are travelling abroad to receive medical treatment. Medical travel is complex and not a uniform phenomenon. The majority of UK patients travel within Europe, but an increasing number are seeking treatment further afield. Patients are traveling specifically to Poland and Hungary, and increasingly to India and East Asia. Diaspora, country-specific marketing campaigns, and specific specialism's seem to determine patterns of flows of UK patients seeking care abroad. Patients returning from treatment abroad experience complications.

The analysis demonstrates both the possibility of costs and savings to the NHS as a result of patients travelling abroad, which need to be considered. Unsurprisingly, the largest numbers of inbound medical tourists were in the large hospitals which are internationally known for their specialism; foremost amongst these Great Ormond Street Hospital for Sick Children which reported income of over £20million from 656 patients. Data received and summarised in Appendix 2 also highlights the variation in the percentage of income that international revenue represents for hospitals; to some, especially the large hospitals in London, it marks a significant proportion of private patient income while for others it contributes a very small percentage of funding.

Our analysis of data suggests that the UK is now a net exporter of medical tourists. While incoming medical tourists may be less likely to declare treatment as primary purpose for their visit to the UK than outbound tourists, data over time clearly shows a greater acceleration in outbound over inbound medical tourists. Despite the variations in numbers of patients visiting different hospitals and in the income per patient, the number of medical tourists was comparatively smaller than the percentage of income generated by them (7% of patients generating close to 25% of private income). These figures suggest that non-UK residents travelling to the UK for medical treatment seek high-end specialist expensive procedures, and may generate substantial revenue. Additional numbers of patients for specialist procedures may also help NHS doctors with surgical learning curves.

The changing destinations of UK travellers and the differing origins of those travelling to the UK show that medical travel is a dynamic phenomenon, which can rapidly increase and change. This highlights the importance of continuous routine monitoring to understand medical tourism and to enable researchers, professionals and policymakers to better consider the costs and benefits of medical tourism to the UK.

UK residents who had travelled abroad reported experiencing complications following their return, which echoed case reports in the literature. While we calculated potential costs of these to the NHS, complications experienced also pose an ethical question. There is currently no guidance or regulation on risk or safety for UK residents who consider travelling abroad for treatment. Potential savings as a result of medical travel, especially evident from bariatric patients here, are noteworthy especially at a time of constrained public resources.

Our findings from NHS Trusts indicates that for those wishing to increase their private income as a result of the income cap being raised foreign private patients may be more attractive than

domestic private patients.

While this particular research focused on the impact of medical tourism on the UK NHS, the findings give an indication of possible impact of medical tourism in other countries. They are likely to have particular resonance for other universal public health systems.

Strengths and Weaknesses of the Study

While the study used the most robust data set available to measure volume of medical tourism to the UK, the International Passenger Survey, it has several weaknesses. The IPS only surveys 0.2% of travellers entering and leaving the UK. In addition, inbound figures on medical tourists do not provide information on whether these are accessing treatment in the public or the private sector. Interviews with medical tourists also suggested that not all may identify themselves as travelling for medical purposes. Moreover, costs calculated are based on published literature often drawing on small samples.

Thus, although data and analysis presented here represent the most comprehensive analysis of inbound and outbound medical tourism to date, they clearly identify the significant gap in understanding of this increasingly important phenomenon. The particular strength of the findings here lies in the mixed–methods approach. Authors undertook the first comprehensive analysis of the IPS from a medical tourism perspective. Findings were triangulated by drawing on published literature, and by analysis of interviews with 77 UK medical tourists. Similarly, the cost estimates were developed based on results from interviews, costs reported in the published literature, the IPS data set and freedom of information requests to 28 hospital foundation trusts. Hence, each finding has carefully been considered and based on more than one data source.

Directions for Future Research

The impact of medical tourism warrants better monitoring. Findings demonstrate impact in terms of possible costs and benefits and the highly dynamic nature of the phenomenon means that the absolute numbers presented here could grow rapidly. Only continuous monitoring will allow better understanding and informed policy-making to ensure patient safety.

Estimates of cost presented here mark a first step based on the limited data available. To better understand costs and potential savings of medical tourism requires not only better data on volume of travel but also on the differences in long-term health outcomes between patients who travelled and those having received treatment at home. Further research of comparative outcomes is needed.

This research does not explore the ethical dimensions that are involved in many of the considerations relating to medical tourism, including why patients opt to receive care outside of the UK. While data here represents the economic costs of complications experienced by patients these obviously will have to be considered alongside considerations of patient safety.

Conclusions

UK medical tourism is a growing phenomenon. To fully understand its implications and guide policy on issues such as NHS global activities and patient safety will require investment in further research and monitoring. Despite existing data limitations it is evident that UK medical tourism is dynamic and changing. Findings indicate costs arise where patients travel abroad and return with complications. Analysis also indicates possible savings in the case of specific procedures especially in future health care and social costs averted. Inbound medical tourists offer potentially high income to NHS hospitals. Results of this research may also be indicative of the impact of medical tourism in other public health systems.

Disclaimer

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.

Supporting Information

Annex_S1.docx

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'A year of pay restraint and public support'
Jenni Middleton, Editor

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Exclusive: Stress levels at work making nurses ill, finds survey

10 December, 2014 | By Steve Ford

More than 60% of nurses say they have suffered the side-effects of work-related stress, such as physical or mental health problems in the past year.

2011-12 figures released for physical assaults against NHS staff

NHS Protect Home
NHS Protect News
2011-12 figures released for physical assaults against NHS staff

News Article
30 November 2012

NHS Protect collects and collates figures for physical assaults against NHS staff from NHS bodies across England on an annual basis. NHS Protect today released the 2011-12 figures for physical assaults against NHS staff. 425 health bodies submitted figures this year, employing well over a million staff and contractors.

These figures show assaults on NHS staff that do and do not involve medical factors. This provides an indication of the number of assaults that could realistically result in a criminal sanction, since in cases involving medical factors the assailant may not be considered legally culpable for their actions and a successful criminal sanction against them may be unlikely.

Richard Hampton, Head of Local Support and Development Services at NHS Protect, said today:

"There is never any room for complacency when it comes to violence in the NHS. NHS Protect will continue to work closely with its partners to identify why assaults happen, provide practical tools to address threats and promote the prosecution of offenders wherever appropriate".

NHS Protect is working in partnership with an expert group to develop new guidance and research for health bodies on dealing with the issue of assaults against NHS staff involving medical factors, which the latest figures show have risen in the same period 16.3% (from 39,770 in 2010/11 to 46,265 in 2011/12). The new guidance on *The Prevention and Management of Challenging Behaviour* (which includes but is not limited to violence against staff) will be circulated shortly to all NHS employers. It suggests that health bodies review existing care models and delivery of care, and identifies a need to change and challenge existing cultures.

Mr Hampton comments: "We will be examining why we have seen this rise in assaults involving medical factors. It is important that good practice continues to be shared, to even out differences between trusts and focus on best practice in this area. Injured members of staff rightly expect to receive the best possible protection against such incidents."

Overall, there was a slight rise of 3.3% in total reported assaults on NHS staff from 57,830 in 2010/11 to 59,744 in 2011/12.

Mr Hampton stresses: "Staff committed to providing our NHS should never be expected to suffer an assault at work and it will not be tolerated. NHS Protect urges employers to take firm action in all cases of assault against NHS staff."

- take advantage of the joint working agreement with the Association of Chief Police Officers and the Crown Prosecution Service and use existing guidance to pursue local arrangements building on this national agreement - to ensure criminal assaults are identified and do not go unpunished.
- ensure staff are trained to use available powers to respond decisively to low-level nuisance behaviour before it escalates into violence against staff (powers under the Criminal Justice and Immigration Act (CJIA)).
- seek advice from the enhanced network of NHS Protect's Area Security Management Specialists (ASMSs). They give guidance to Local Security Management Specialists (LSMSs) and assist in assessing risks of violence, addressing these through prevention work and pursuing legal action when assaults do occur.

-ends-

For more information contact Nadine Agbedetse or James Robertson at the NHS Protect press office on 020 7895 4523/4524. Out of hours mobile 07717 851 926.

Further general information on NHS Protect is at www.nhsprotect.nhs.uk

The 2011-12 physical assault figures are available at: http://www.nhsbsa.nhs.uk/3645.aspx

Notes to Editors

1. NHS Protect incorporates some functions of the former NHS Security Management Service (NHS SMS).

2. NHS Protect provides policy and operational guidance relating to the management of security within the NHS in England. It strives to ensure permanent improvements are made to provide the best protection for NHS staff and property.

3. In 2010/11, there were 57,830 reported physical assaults against NHS staff in England.

4. NHS Protect has a national syllabus for conflict resolution training aimed at all frontline NHS staff. It gives staff the skills to recognise and defuse potentially violent situations.

5. Local Security Management Specialists (LSMSs) are in place in health bodies around England to investigate security breaches, along with the police, and implement new systems to better protect NHS staff and property. NHS Protect advises that all incidents of violence against staff are reported to the LSMS as well as the police. LSMSs receive professional training in areas such as witness interviewing and a background in law, and are supported nationally by NHS Protect.

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Office for National Statistics

Analysis of Employee Contracts that do not Guarantee a Minimum Number of Hours

Coverage: **GB**
Date: **30 April 2014**
Geographical Area: **GB**
Theme: **Labour Market**

1. Summary

There is no legal definition of “zero-hours contracts”. Consequently, different groups and bodies will not only measure the number of such contracts in different ways, they will also have different perceptions of what should be included as “zero-hours contracts”. Significantly, the perceptions of employers and employees on what constitutes a particular type of contract will differ. Also, estimates from both employers and employees may be influenced by their level of awareness of such contracts.

However, as Section 2 of the Government’s consultation on zero-hours contracts sets out: “In general terms, a zero-hours contract is an employment contract in which an employer does not guarantee the individual any work and the individual is not obliged to accept any work offered”. So although various bodies and surveys use slightly different definitions, there is the common factor of a lack of a guaranteed minimum number of hours of work.

In meeting its intention to produce an estimate of the number of “zero-hours contracts” from a business survey, ONS has concluded that the most useful definition to use is contracts that do not guarantee a minimum number of hours, rather than “zero-hours contracts” and that it should be designated in that way. This includes, but is not exclusively, “zero-hours contracts” and will include some other contract types that do not guarantee a minimum number of hours.

The provisional estimate from the ONS survey of 5,000 businesses indicates that in January to February 2014 there were around 1.4 million employee contracts that do not guarantee a minimum number of hours, which provided work in the survey reference period of the fortnight beginning 20 January 2014. This is the official ONS estimate based on a survey of businesses.

The most recent estimate, published on 19 February 2014, of the number of people who are employed on “zero-hours contracts” in their primary employment, from the Labour Force Survey (LFS) of individuals in households, is 583,000, for the period October to December 2013. This

relates specifically to the individual's perceptions of whether they are employed on the specific type of contract – a "zero-hours contract".

Estimates from employers are likely to be higher than those from individuals for a number of reasons. Employers may be more aware of formal contractual arrangements of their employees. In addition, one person can hold more than one contract and/or there may be people working on such a contract in addition to their primary employment and/or their working patterns may mean they do not consider themselves to be covered by such a contract. However, even if it were possible to take account of all these factors, it remains unlikely that the two estimates would be the same. This is because they are based on the perceptions of two different groups.

In comparing both figures, it must be noted that they are both 'point-in-time' estimates, and that whilst the LFS data exists for several years back, the business survey data is the first estimate of its type. It is not, therefore, possible to say from the business survey whether the number of employee contracts without a guaranteed minimum number of hours of work is increasing or decreasing.

From the ONS survey of businesses, and in addition to those that **provided work** in the reference period, there are also employee contracts that do not guarantee a minimum number of hours, **that did not provide work** in the survey reference period of the fortnight beginning 20 January 2014. These contracts are more difficult to analyse, as we do not currently have many more details about them. However, some evidence from qualitative analysis indicates that these include a mixture of: people with contracts with several employers (who will be included in the headline estimate if they worked for one of those employers); agency staff; those not wanting to work; those who have found another job elsewhere but remain on employer records; some people on leave or sick; and those not offered work in the reference period. Overall, this will probably include some people that need to be added to the official 1.4 million estimate but this needs to be investigated in more detail, and ONS will undertake further research in this area and report later in 2014. The initial estimate of the number of employee contracts that do not guarantee a minimum number of hours, that did not provide work in the survey reference period of the fortnight beginning 20 January 2014 is around 1.3 million.

Looking at the types of people employed on "zero-hours contracts", the Labour Force Survey shows that they are more likely to be women, in full-time education or in young (16-24) or older (65 and over) age groups, perhaps reflecting a tendency to combine flexible working with education or working beyond state retirement age. Nearly two thirds of people employed on "zero-hours contracts" work part-time compared with around a quarter of people not employed on "zero-hours contracts". On average, someone on a "zero-hours contract" usually works 25 hours a week compared with 37 hours a week for people not employed on "zero-hours contracts". Just over a third of those employed on a "zero-hours contract" want more hours, with most wanting them in their current job. This is somewhat greater than for people not employed on a "zero-hours contract".

2. Introduction

There has been significant interest over the last year around the issue of "zero-hours contracts". However, the debate around the figures has been clouded by the lack of a single definition of what such a contract is and the most appropriate source for the data. Most available definitions refer to

contracts where a person is not contracted to work a set minimum number of hours, is only paid for the work that they do, and is not obliged to accept hours if offered.

Labour Force Survey estimates

To date, the only ONS data on “zero-hour contracts” has come from the Labour Force Survey (LFS), which is a survey of individuals in households and classifies people according to their responses to the survey. On the LFS, “zero-hours contracts” is one of a number of options in response to a question relating to flexible working asked to people in employment. For the LFS, “zero-hours contracts” are defined as “where a person is not contracted to work a set number of hours and is only paid for the number of hours they do”. The latest LFS estimate for people on “zero-hours contracts” is 583,000 for the period October to December 2013.

The LFS estimate differs from some of the other figures in the public domain that come from surveys of businesses. A current example of such a survey is the Labour Market Outlook Survey carried out for the Chartered Institute of Personnel and Development (CIPD). Business surveys will give different results to the LFS as they will relate to employee contracts, rather than people (who can have more than one contract). Businesses may be more aware of their employees’ formal contractual arrangements and so report a “zero-hours contract”, when the employee, due to their working pattern, may not perceive that they are covered by such an arrangement.

Further analyses have also been undertaken on the LFS by the Department for Business, Innovation and Skills.

Other sources

The CIPD Labour Market Outlook survey defines “zero-hours contracts” as “an agreement between two parties that one may be asked to perform work for the other, but there is no set minimum number of hours. The contract will provide what pay the individual will get if they do work and will deal with the circumstances in which work may be offered (and, possibly, turned down)”. Information was collected from a sample of 1,000 businesses, who were each asked what proportion of their workforces were employed on “zero-hours contracts”. The returned data were used to estimate that in summer and autumn 2013:

- 23% of organisations have one or more people on a “zero-hours contract”;
- among those companies using “zero-hours contracts”, the average proportion of the workforce on “zero-hours contracts” is 19%.

Using this information, CIPD estimated that around 1 million people, or about 3% of the workforce, were on zero-hours contracts, nearly double the number reported on the LFS for 2013.

Other estimates from employers include estimates for the NHS and the domestic care sector, which put the number on “zero-hours contracts” at 75,000 and 300,000, respectively; based on returns by NHS trusts and estimates from a different data set covering social work in England and Wales.

Launching the ONS business survey

Given the differences in the definitions, perceptions and estimates between the outside surveys of businesses and of individuals in the LFS, ONS decided to undertake its own survey of businesses, announced on 22 August 2013. The aim was to produce an estimate of "zero-hour contracts" that would complement the existing LFS estimates and could also be compared to other employer estimates.

Section 3 looks at how the ONS business survey was set up, including how the questions were defined. Section 4 considers how the initial results from the ONS survey of contracts without a guaranteed minimum number of hours compare with the estimates of "zero-hours contracts" from the LFS and other employer surveys. Section 5 then looks at available information on the characteristics of people employed on such contracts, including the hours they work, the type of work they do and personal characteristics.

3. Defining "zero-hours contracts" and "no guaranteed hours contracts"

What are "zero-hours contracts"?

One of the problems with producing estimates of "zero-hours contracts" is the lack of a single agreed definition of what such a contract is. While some contracts are explicitly called zero-hours contracts, there are other definitions available and used in published statistics. These include:

- LFS: "where a person is not contracted to work a set number of hours and is only paid for the number of hours they do";
- CIPD: "an agreement between two parties that one may be asked to perform work for the other, but there is no set minimum number of hours. The contract will provide what pay the individual will get if they do work and will deal with the circumstances in which work may be offered (and, possibly, turned down)";
- Department for Business, Innovation & Skills (Section 2 of zero-hours consultation) "There is no legal definition of a zero-hours contract in domestic law. In general terms a zero-hours contract is an employment contract in which the employer does not guarantee the individual any work, and the individual is not obliged to accept any work offered. An example of a clause in a zero-hours contract which does not guarantee a fixed number of hours work per week is: 'The Company is under no obligation to provide work to you at any time and you are under no obligation to accept any work offered by the Company at any time.'";
- HM Revenue & Customs: "A zero-hours contract generally is a contract where the employer does not guarantee to provide the worker with work and will only pay the worker for those hours which are actually worked."

The common element to these definitions is the **lack of a guaranteed minimum number of hours.**

Therefore, the focus for question development for the business survey was around describing what needed to be measured rather than naming the contract. Looking from the employer's perspective, the term zero-hours contract was not familiar to some employers until recently. The term used by employers may vary depending on the type of employer and/or industry. The following have all

been used by employers when describing a zero-hours contract arrangement: casual worker, on-call relationship, hours to be notified and occasional professional assistance.

When developing the survey of businesses, ONS consulted on the definition to be used and decided on the 'lack of any guaranteed hours'. To provide clarity and prevent confusion with the other estimates of "zero-hours contracts" the remainder of this article will refer to estimates from the ONS business survey as no guaranteed hours contracts (NGHCs). This includes, but is not exclusively, "zero-hours contracts" and will include some other contract types that do not guarantee a minimum number of hours.

When comparing figures from the ONS business survey with the LFS estimates, a number of issues need to be considered:

- The LFS counts people who report that their primary employment is a "zero-hours contract";
- The estimate from businesses is counting employee contracts that are NGHCs. This will be greater than the number of people, as people can have more than one contract;
- Estimates from businesses will include contracts that cover a variety of working arrangements. These will include instances of people in their primary employment who are working a regular number of hours a week (although these hours are not guaranteed by their contract), as well as those who work on an irregular basis due to personal choice, availability for work or to fit in around their primary means of employment.

4. How many no guaranteed hours contracts (NGHCs) are there?

There are a number of existing estimates of the number of NGHCs in the public domain from different sources. This section looks at the most high profile estimates. Most of the sources are from sample surveys so will be subject to a degree of uncertainty. Where available, an indication of the level of uncertainty is shown at Annex 1.

Labour Force Survey

The LFS samples around 40,000 households a quarter and collects information about people's employment status. One of the questions on the LFS asked to people in employment relates to special working arrangements that vary daily or weekly. Respondents can choose up to three different arrangements from a list of eight options, one of which is "zero hours contracts" defined as "where a person is not contracted to work a set number of hours, and is only paid for the number of hours that they actually work".

As the LFS is based on respondents' views about their working arrangements, and counts people rather than contracts, it is likely that any estimate of "zero-hours contracts" from the LFS will be less than an estimate obtained from businesses. The number of people the LFS classed as being on a "zero-hours contract" will be those who:

(a) are employed (have done at least one hour of paid work in the week before they were interviewed or reported that they were temporarily away from their job);

(b) report that their working arrangements include some flexibility and that their hours can vary; and

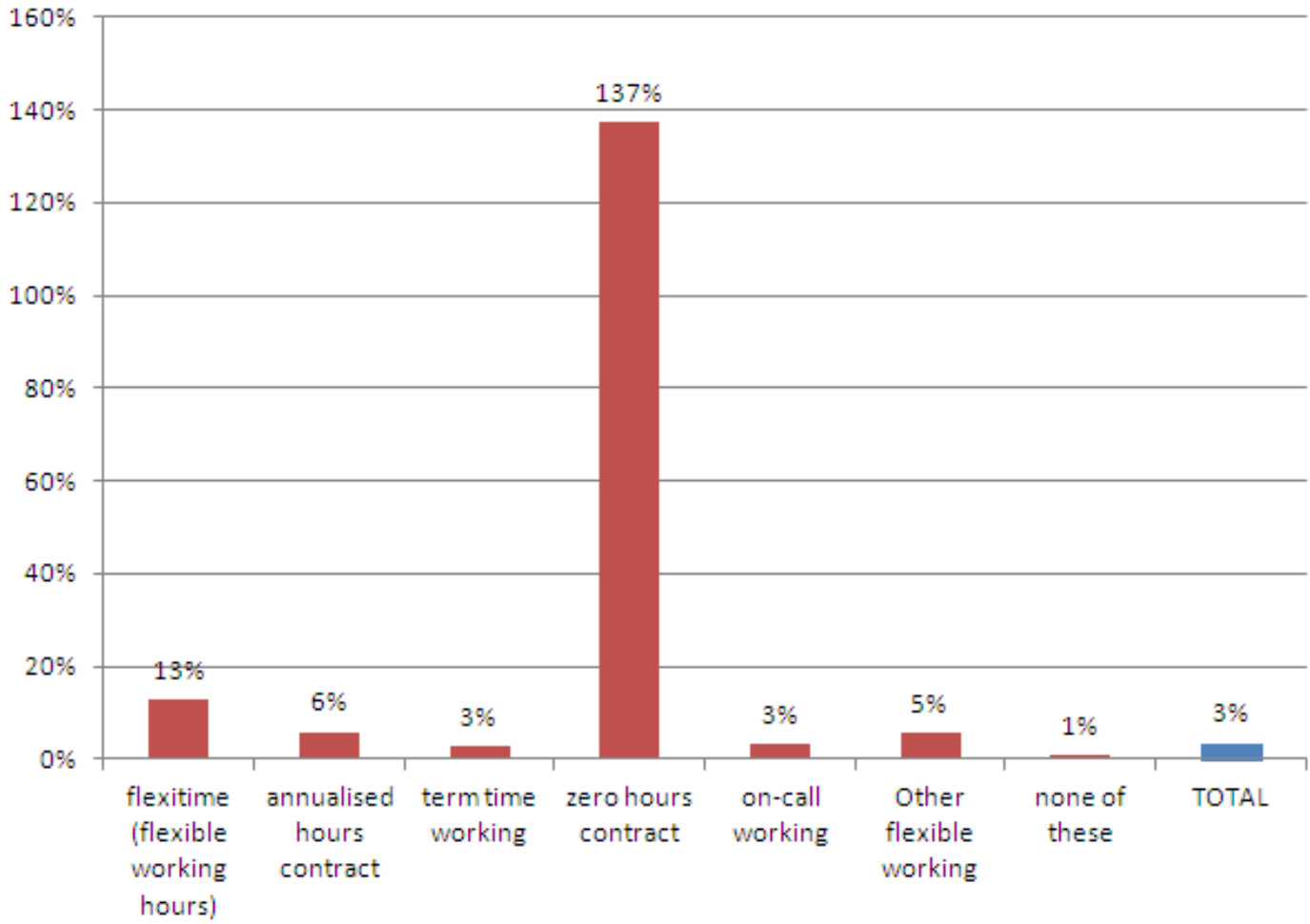
(c) recognise that the flexibility of their working arrangements is a result of being on a “zero-hours contract”.

Therefore, the people identified by the LFS as being on a “zero-hours contract” will be those in employment who are aware that their contract allows for them to be offered no hours.

The latest estimate from the LFS shows that 583,000 people reported that they were on a “zero-hours contract” in the period October to December 2013. This is more than twice the reported figure from the same period in 2012 (250,000). Looking at the difference between 2012 and 2013, a large part of the increase would appear to be from people who previously reported no flexible working arrangements (see Chart 1). Some of this increase is likely to be due to the increased awareness of “zero-hours contracts” following the coverage in the media.

This conclusion is backed up when the length of time in current job is considered. Around half of the increase in the level of “zero-hours contracts” is for people who have been in their job for more than a year, so would not be “new” contracts. However, the number of people working less than a year also increased indicating that at least some of the rise between 2012 and 2013 may have been a genuine rise in the number of “zero-hours contracts”, although increased awareness is likely to be the main driver of change for this group as well (Chart 2). Therefore, zero hours contracts are unlikely to be a key driver of the increase in total employment, as these people were probably already in the employment estimates, but in another (non “zero-hours contracts”) category.

Figure 1: Percentage change in LFS flexible working responses, by category, between October to December 2012 and October to December 2013



Source: Labour Force Survey - Office for National Statistics

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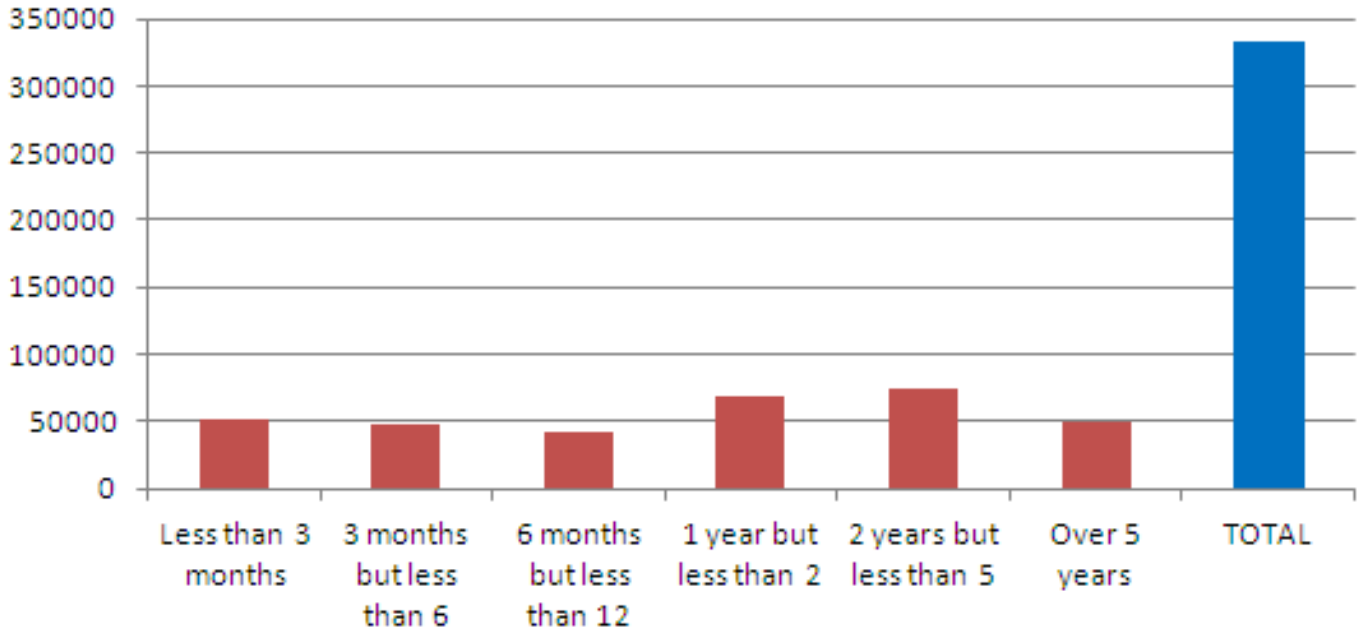
XLS XLS format
(20.5 Kb)

Figure 2: Change in the number of "zero-hours contracts" by length of employment, October to December 2012 to October to December 2013



Source: Labour Force Survey - Office for National Statistics

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ONS business survey

The ONS business survey asked a sample of 5,000 businesses how many people were employed on contracts that do not guarantee a minimum number of hours (NGHCs). It is the first time this has been asked, and therefore the results are an initial 'point-in-time' estimate; this must be recognised when comparing the estimates with other figures. The initial estimates from the employer survey indicate that there were 1.4 million employee contracts that do not guarantee a minimum number of hours, which also provided work in the survey reference period of the fortnight beginning 20 January 2014. Providing work in the reference period is the key aspect here, as it confirms that these were active contracts and related to current jobs.

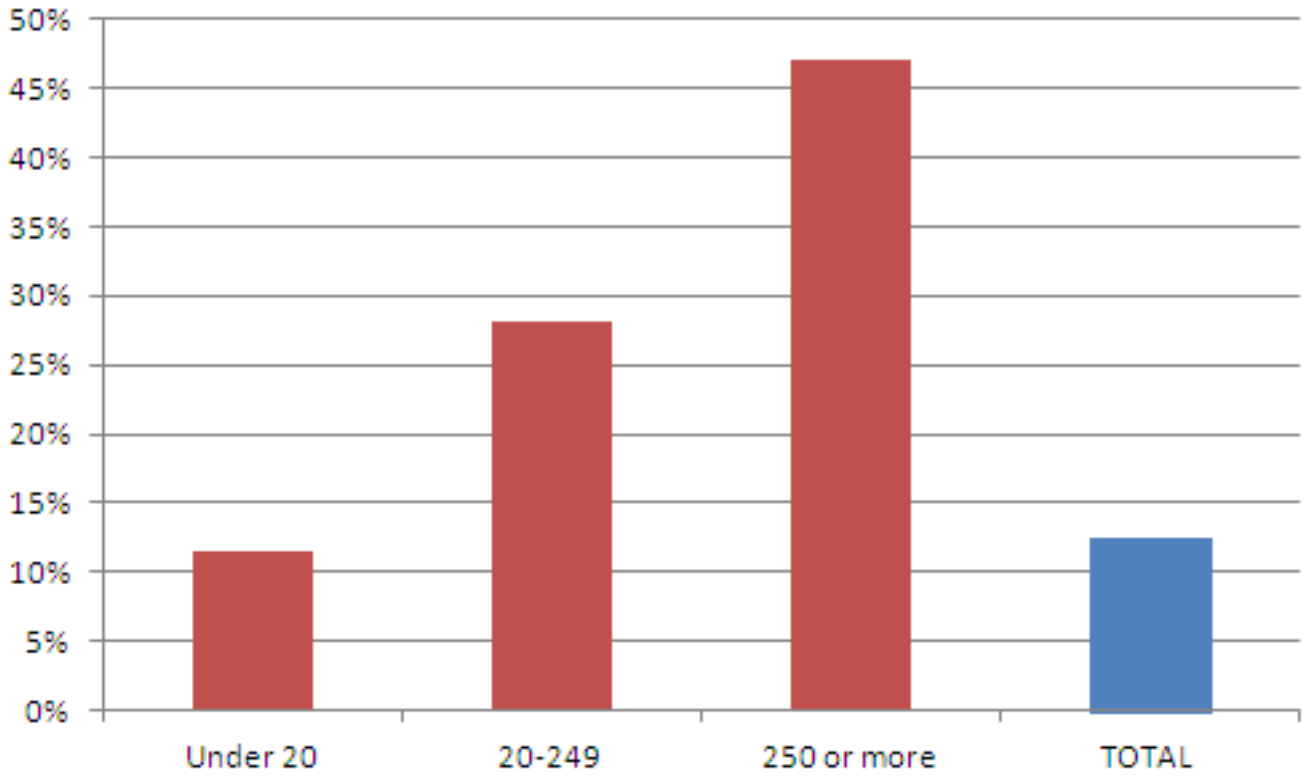
The ONS business survey data, as is the case with the LFS, has been collected from a sample, rather than the whole population. Whilst the sample was designed to allow for this, and be as accurate as possible, results from sample surveys are always estimates, not precise figures. This means that they are subject to some uncertainty, and these are provided in Annex 1. However, 1.4 million is the best estimate of the number of employee contracts that do not guarantee a minimum

number of hours that provided work in the reference period of the fortnight beginning 20 January 2014.

In addition to those that worked in the reference period, there are also employee contracts that do not guarantee a minimum number of hours, where work was not undertaken in the survey reference period of the fortnight beginning 20 January 2014. These are more difficult to analyse, as we do not currently have many more details about them. However, some evidence from the qualitative analysis indicates that these include a mixture of: people with contracts with several employers (who will be included in the headline estimate if they worked for that employer); agency staff; those not wanting to work; those who have found another job elsewhere but remain on employer records; some people on leave or sick; and those not offered work in the reference period. Overall, this will probably include some people that need to be added to the official 1.4 million estimate but this needs to be investigated in more detail, and ONS will undertake further research in this area and report later in 2014. The initial estimate of the number of employee contracts that do not guarantee a minimum number of hours, where work was not undertaken in the survey reference period of the fortnight beginning 20 January 2014 is around 1.3 million, but this requires considerable further investigation.

Looking further at the 1.4 million employee contracts, which did provide work in the reference period, the ONS business survey estimated that 13% of businesses make some use of NGHCs. The proportion of businesses using NGHCs differs across businesses of different size and between industries. Chart 3 shows the proportion of businesses using NGHCs by size of business. It shows that nearly half of businesses with 250 or more employees make some use of NGHCs compared with 12% of businesses with fewer than 20 employees.

Figure 3: Proportion of businesses using NGHCs by size of business



Source: Office for National Statistics

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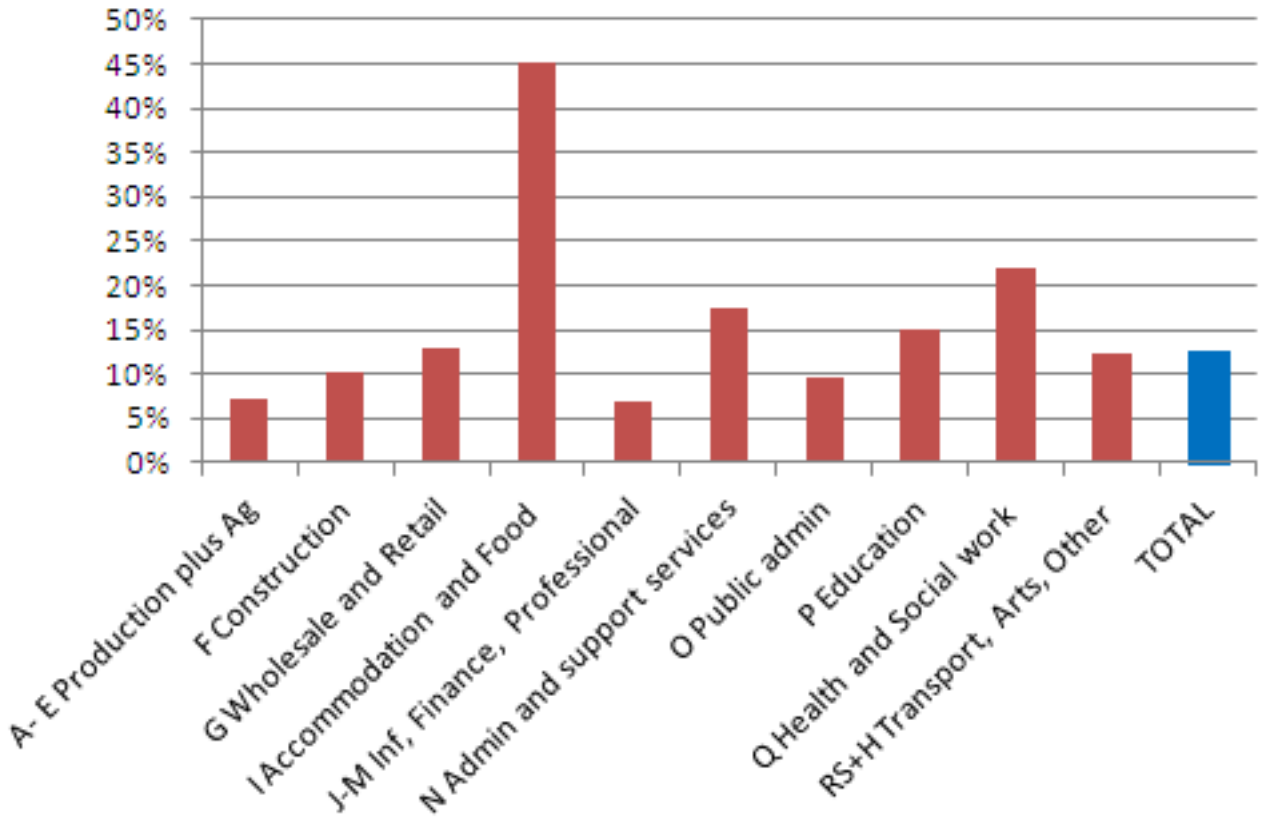
Looking at industrial sector, the proportion of businesses using NGHCs varies considerably (Chart 4). The industrial classification of the businesses is based on the Standard Industrial Classification (SIC) 2007 - this defines most of ONS' business surveys and is based on the European Communities classification of Economic Activities. Some of the classification sections (letters A-S) have been grouped, to address quality issues from small sample sizes.

In Accommodation and Food Services, 45% of businesses make some use of NGHCs, with Health and Social Work having more than one in five businesses using them. However, relatively few businesses in Financial, Insurance and Professional, Scientific and Technical Activities and Production plus Agriculture use NGHCs.

Figure 4: Proportion of businesses using NGHCs by industry



Source: Office for National Statistics

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Comparison of LFS and ONS business survey

The number of NGHCs from the business survey is higher than the figure reported in the LFS. The results of the business survey will differ from the LFS for a number of reasons:

i. employers and employees will have differing perceptions and awareness about the types of employment contracts used;

ii. the employer survey will count employee contracts, not people, and will provide higher estimates (as one person can have more than one contract);

iii. employers in the business survey may report multiple contracts for each job;

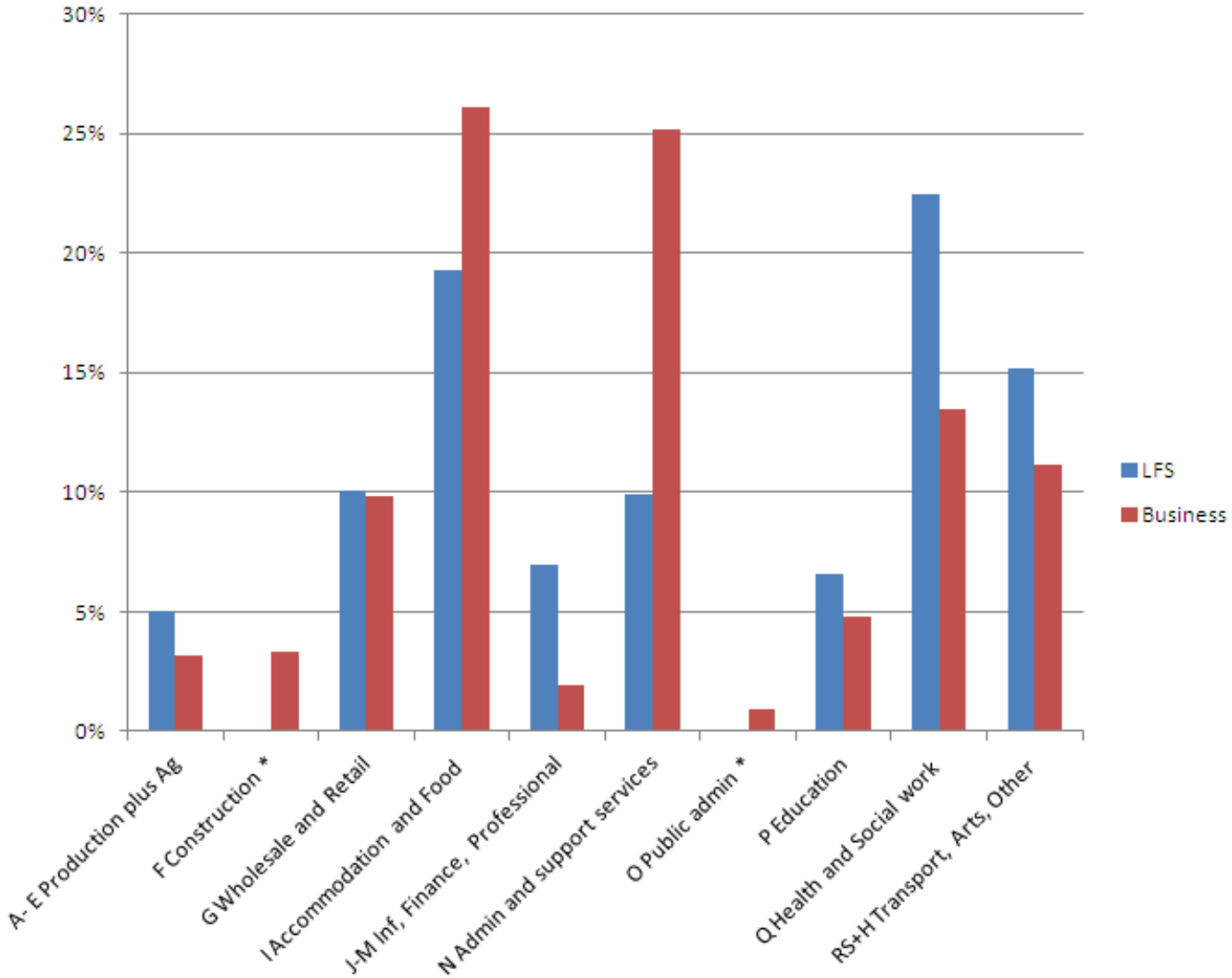
iv. the questions asked of respondents differed slightly, with the business survey asking about contracts not guaranteeing any hours, while the LFS question uses the term “zero-hours contracts”;

v. the LFS includes all people in employment (including the self-employed) while the business survey only includes employees.

Figure 5 shows the distribution by industry of NGHCs from the ONS business survey and “zero-hours contracts” from the LFS. Where there are differences in the distributions, this will be partly due to how people are classified in the two surveys. In the LFS people are self-classified to an industry. Businesses are allocated to the industry where most of their employees work.

This means that many local authorities are classified to Education (section P of the SIC), while their employees will cover other areas such as social work (section Q), public administration (section O) and recreation (section R). Similarly, employment agencies are classified to Administration & Support Services (Section N), while people employed by them, but placed at another employer, may give a different answer in the LFS. The distribution may also be affected by the business survey including second jobs.

Figure 5: Proportion of workers on “zero-hour contracts” by industry



Source: Office for National Statistics

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* LFS data not available, for quality reasons, due to small sample sizes

Other measures

The recent report from the CIPD, based on their 2013 Labour Market Outlook Survey (which sampled 1,000 employers), suggested that 23% of organisations have at least one person on a "zero-hours contract" (defined as a contract with no minimum contracted hours). The CIPD surveys also estimated that where businesses use "zero-hour contracts", around 19% of the workforce were employed on them. On that basis, CIPD estimated that around 1 million people, or about 3% of the UK workforce, were on "zero-hours contracts".

The difference between the ONS business survey and CIPD estimates may partly be explained by differences in the sample selected. Nearly two thirds of the organisations in the CIPD sample had employment of 250 or more compared with a third of the ONS sample. Information from the ONS survey indicates that larger companies (250 or more employees) are more likely to use NGHCs, with nearly half using them compared with one in eight of smaller businesses. However, when they do use them, smaller businesses have a larger proportion of their workforce on NGHCs compared to larger businesses.

5. What is the experience of people employed on "zero-hours contracts"?

Whilst the ONS business survey provides a measure of the number of employee contracts that do not guarantee hours, the LFS can provide information about the type of people who report that their primary employment is on a "zero-hours contracts".

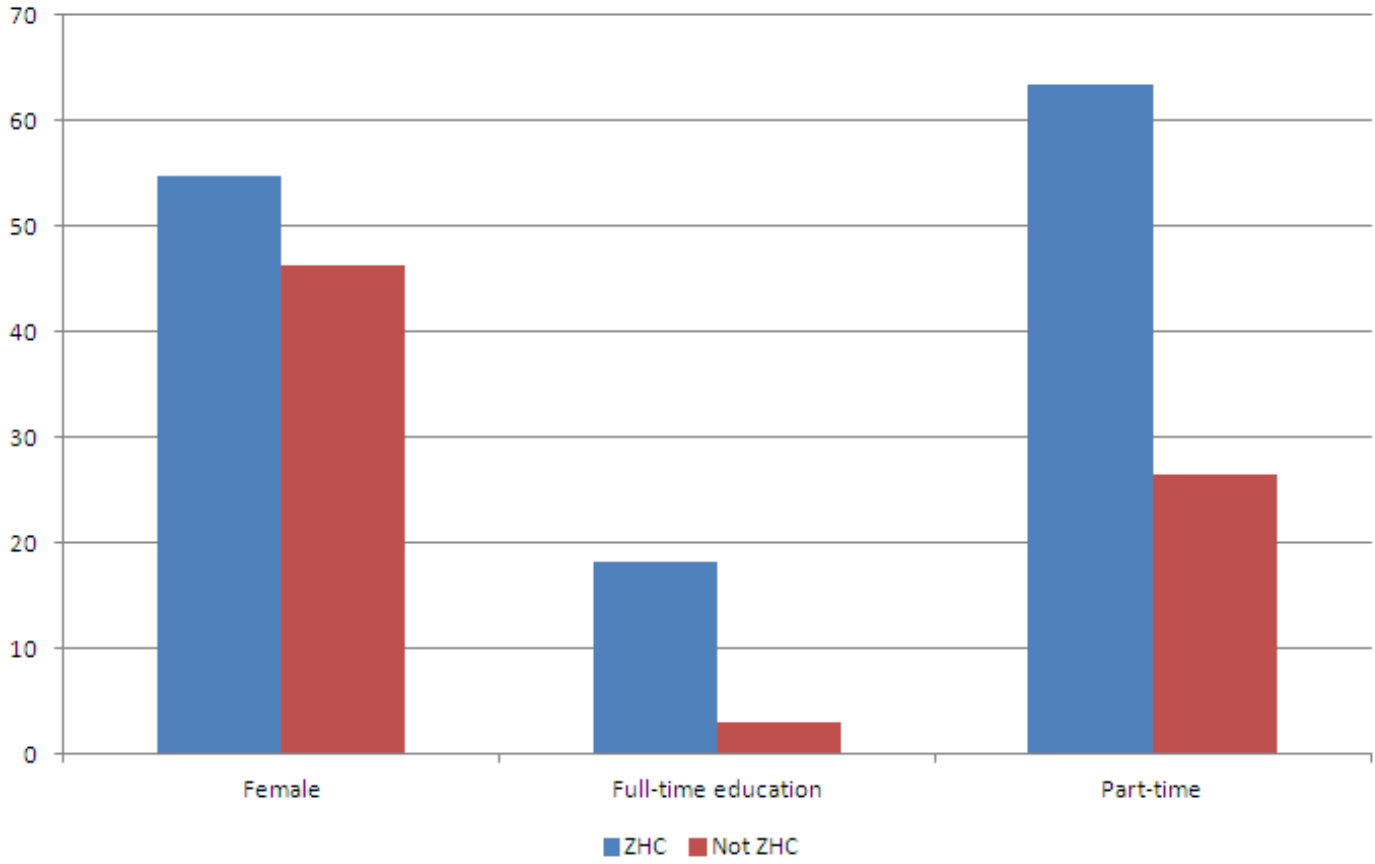
Who are they?

Looking at the type of people who report that they are employed on a "zero-hours contract", compared to other people in employment who are not on a "zero-hours contract", shows that there are differences in their characteristics (Figures 6 and 7). For October to December 2013:

- women make up a bigger proportion of those reporting working on "zero-hours contracts" (55%) compared with those employed who are not on "zero-hours contracts" (46%)
- 18% of people on "zero-hours contracts" are in full-time education compared to 3% of those employed who are not on "zero-hours contracts"
- 64% of people on "zero-hours contracts" reported that they worked part time, compared with a quarter (27%) of those employed who are not on "zero-hours contracts"
- people who report being on a "zero-hours contract" are more likely to be younger or older. 36% of people on "zero-hours contracts" are aged 16 to 24 and 7% are aged 65 and over (compared with 12% and 4% respectively for those employed who are not on "zero-hours contracts").

These patterns may partly reflect the groups most likely to find the flexibility of “zero-hours contracts” an advantage. For example, young people who combine flexible working with their studies or people working beyond state pension age.

Figure 6: Proportion of people in employment by gender, full-time education and part-time employment



Source: Office for National Statistics

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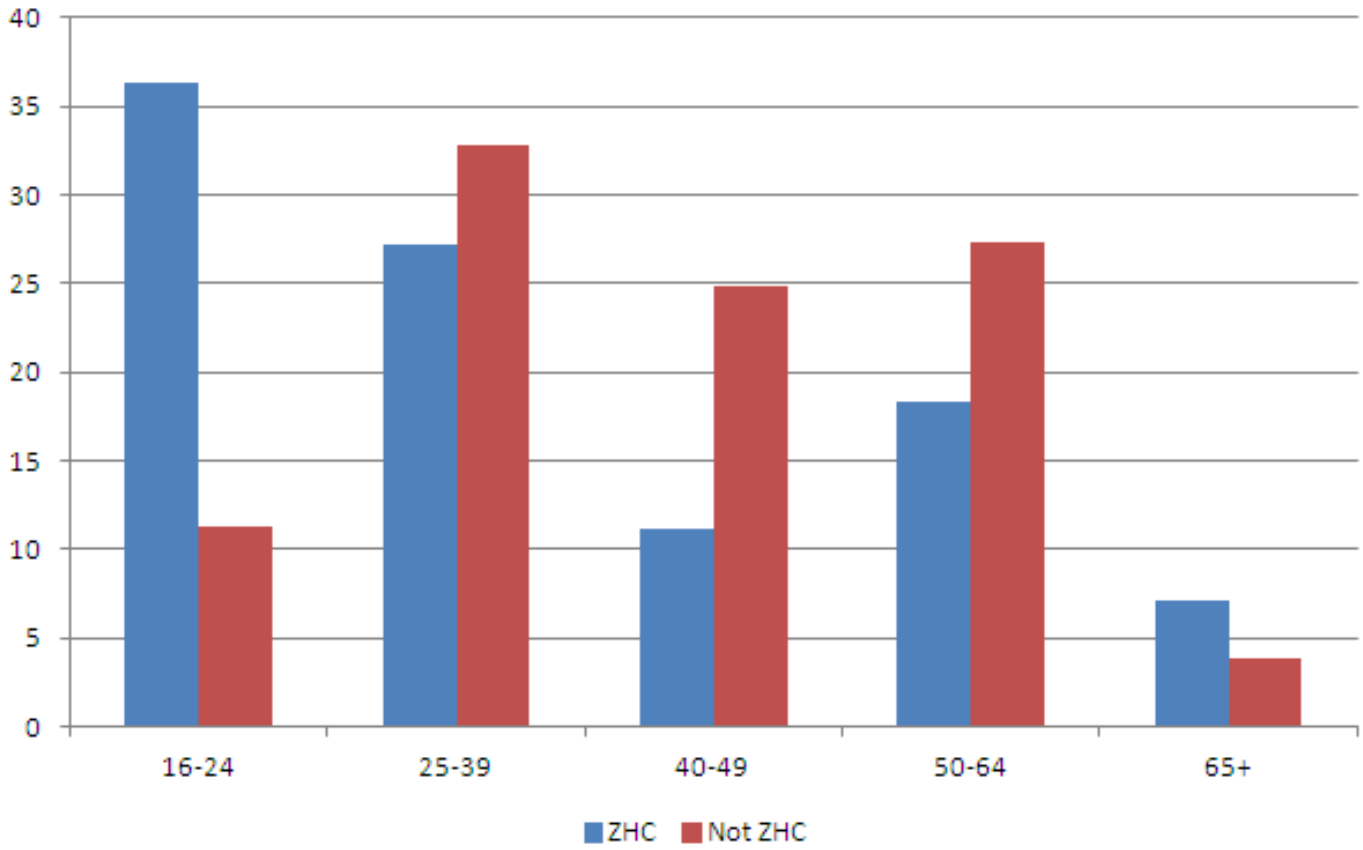
Figure 7: Proportion of people in employment by age



Source: Office for National Statistics

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Hours worked and flexibility

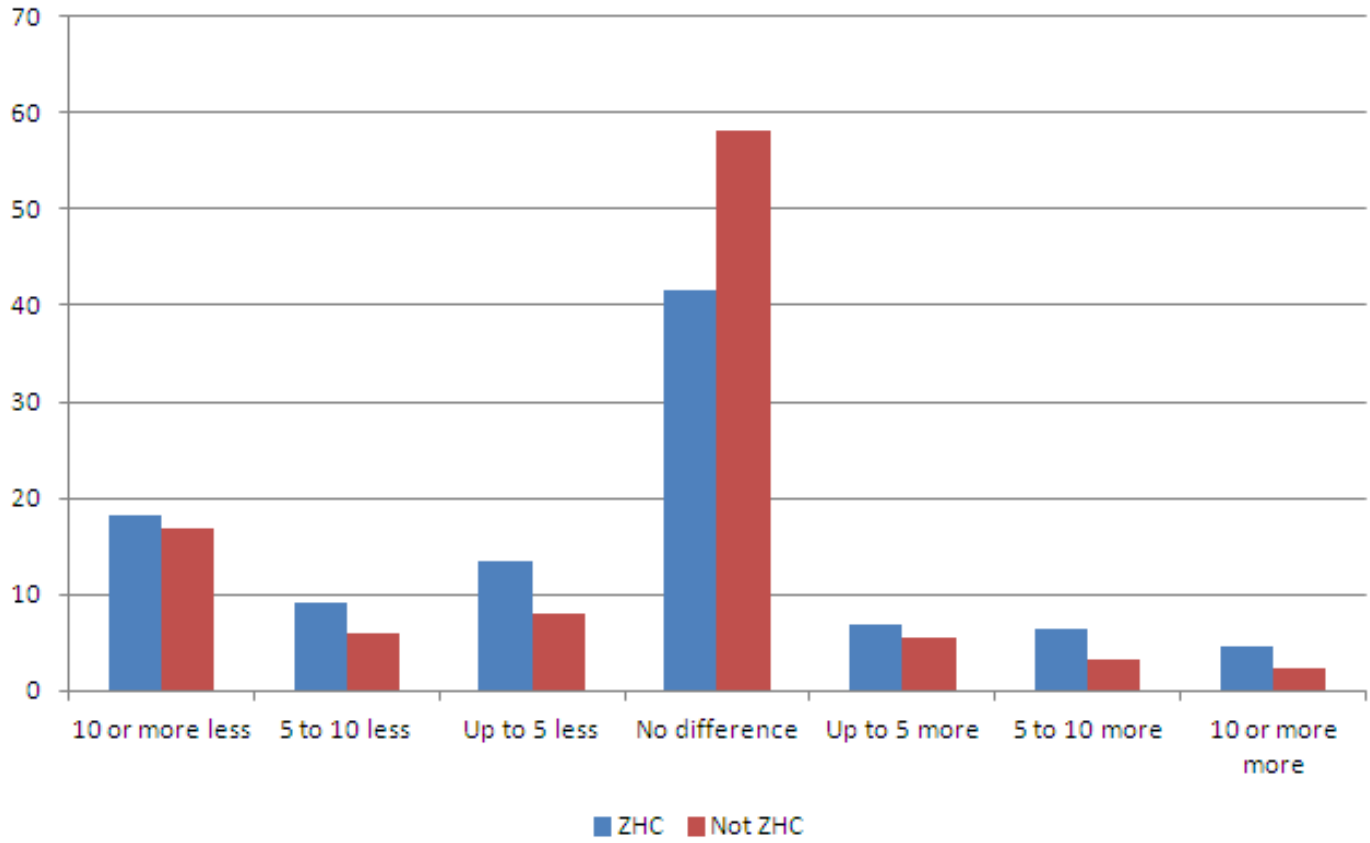
The majority of people on “zero-hours contracts” (64%) reported that they worked part time, compared with a quarter (27%) of others in employment. This means that the average usual weekly hours worked in their main job by someone on a “zero-hours contract” is lower, at 25 hours per week, compared to 37 hours for those employed but not on a “zero-hours contract”.

In October to December 2013, 16% of people on “zero-hours contracts” worked no hours in the week before their LFS interview compared with 11% of people not employed on “zero-hours contracts”.

Comparing usual hours worked with actual hours worked in the reference week, Chart 8 shows the differences between actual and usual hours worked for people on “zero-hours contracts” and those not employed on “zero-hours contracts”. For October to December 2013:

- 42% of people on “zero-hours contracts” worked their usual hours in the week before the LFS interview compared with 58% of employed people not on “zero-hours contracts”;
- 41% of people on “zero-hours contracts” worked less than their usual hours in the week before the LFS interview compared with 31% of employed people not on “zero-hours contracts”;
- 18% of people on “zero-hours contracts” worked more than their usual hours in the week before the LFS interview compared with 11% of employed people not on “zero-hours contracts”.

Figure 8: Actual hours minus usual hours, October to December 2013



Source: Office for National Statistics

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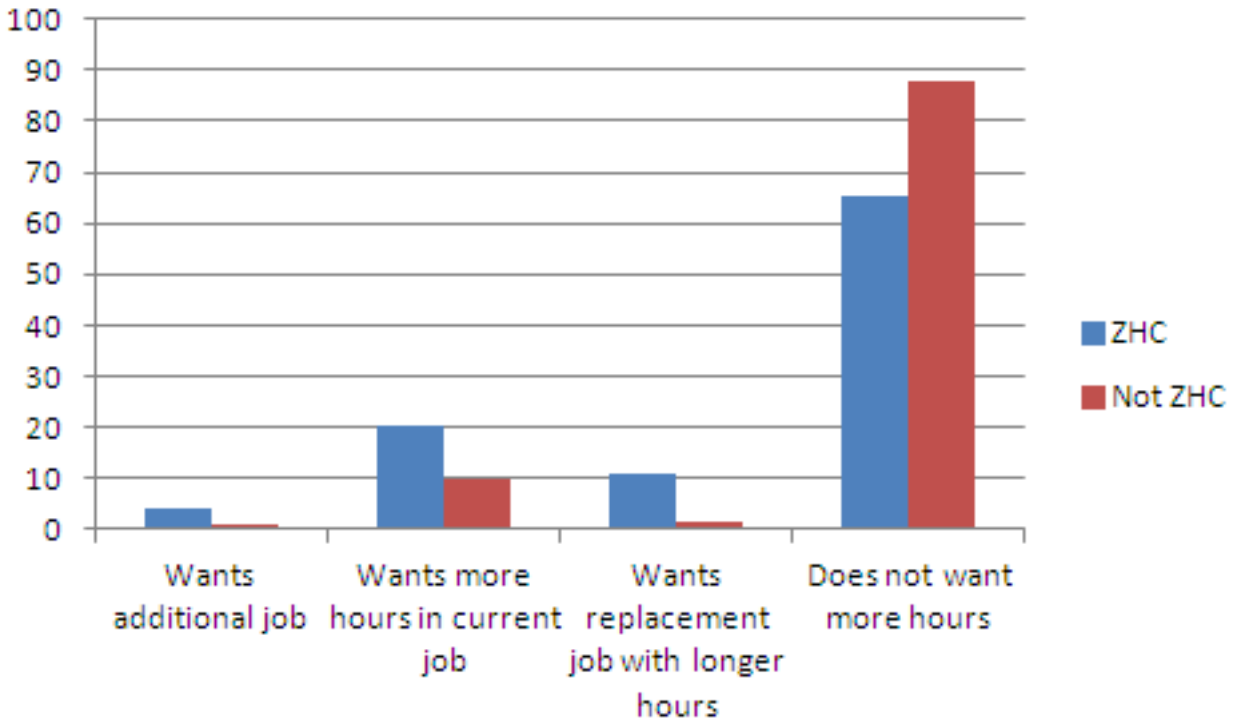
About a third (35%) of people on “zero-hours contracts” want more hours compared to 12% of those not on “zero-hours contracts”. Looking in more detail, 11% of people on “zero-hours contracts” would like a different job with more hours and 14% are actively looking for another job. For people not on “zero-hours contracts”, these rates are 2% and 3% respectively (the remainder would like more hours in their current job or an additional job). More people on “zero-hours contracts” want more hours than those not on “zero-hours contracts”, though this could be linked to a higher proportion of “zero-hours contract” jobs being part-time.

Figure 9: Looking for more hours, October to December 2013



Source: Office for National Statistics

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Other sources

As well as surveying employers, CIPD also carry out a survey of employees, identifying those on “zero-hours contracts” by asking if they have no minimum contracted hours in their primary employment. Where there are comparable figures, results from the CIPD survey are similar to those from the LFS and show that:

- Those employed on “zero-hours contracts” typically work on average 24 hours a week (compared with 25 from the LFS);
- 38% of those employed on “zero-hours contracts” would like to work more hours (compared with 35% from LFS);
- 24% of those employed on “zero-hours contracts” are looking for another job (compared with 14% from the LFS).

The CIPD survey also asks employees directly about their experience of working on a “zero-hours contract”, including their levels of satisfaction which show that 47% of those employed on “zero-hours contracts” are satisfied with having no minimum contracted hours compared with 27% being dissatisfied.

6. Conclusions

There is no legal definition of “zero-hours contracts” and there are a number of different definitions and perceptions relating to this concept. The common element to most of the definitions relates to the lack of a guaranteed minimum number of hours of work. This is the definition used by the ONS in its survey of businesses. This includes, but is not exclusively, “zero-hours contracts” and will include some other contract types that do not guarantee a minimum number of hours. However, this will give different results to the LFS measure of people in employment, as the perceptions of employees and employers will differ.

The provisional ONS estimate from businesses indicates that for January to February 2014, there were 1.4 million employee contracts that do not guarantee a minimum number of hours, that provided work in the reference period of the fortnight beginning 20 January 2014. This is higher than the LFS estimate of 583,000 for the number of people in whose primary employment is on a “zero-hours contracts” for October to December 2013. The difference between the two estimates will partly be due to employees being able to have more than one contract (including people who supplement their primary employment with a NGHC), employers being more aware of the contractual arrangements of their employees as well as the differing perceptions of the two groups.

From the ONS survey of businesses, and in addition to those that **provided work** in the reference period, there are also 1.3 million employee contracts that do not guarantee a minimum number of hours, **that did not provide work** in the survey reference period of the fortnight beginning 20 January 2014. These contracts are more difficult to analyse, as we do not currently have many more details about them. Overall, this will probably include some people that need to be added to the official 1.4 million estimate but this needs to be investigated in more detail, and ONS will undertake further research in this area and report later in 2014.

Looking at the LFS data shows that the characteristics of people on “zero-hours contracts” are different from people not employed on “zero-hours contracts”. People on “zero-hours contracts” are more likely to be women, in full-time education, young (aged 16-24) or older (aged 65 and over). These patterns may partly reflect the groups most likely to find the flexibility of “zero-hours contracts” an advantage. For example, young people who combine flexible working with their studies or people working beyond state pension age.

Nearly two thirds of people on “zero-hours contracts” are part-time compared with around a quarter of people not on “zero-hours contracts”. While more people on “zero-hours contracts” want more hours (around a third) when compared to people not on “zero-hours contracts” this may be linked to the higher incidence of part-time working.

Around 14% of people on “zero-hours contracts” are looking for another job, more than for people not on “zero-hours contracts”, but indicates that most people on “zero-hours contracts” are currently content to stay with their job which is the same conclusion drawn from the CIPD data.

As for next steps, the combination of the employer, and employee, based estimates has proved highly valuable in providing a more complete picture of people on NGHCs or “zero-hours contracts”. The ONS will carry out further analysis of the data collected as part of the business survey,

specifically in getting more details about those who did not work in the fortnight reference period. It will report on this later in 2014. ONS also plans to conduct a further survey to businesses, similar to the one carried out in February, during summer 2014 and will report by end 2014.

Annex 1 – Measures of uncertainty

We can calculate the level of uncertainty (also called “sampling variability”) around a survey estimate by exploring how that estimate would change if we were to draw many survey samples for the same time period instead of just one. This allows us to define a range around the estimate (known as a “confidence interval”) and to state how likely it is in practice that the real value that the survey is trying to measure lies within that range. Confidence intervals are typically set up so that we can be 95% sure that the true value lies within the range – in which case we refer to a “95% confidence interval”.

Labour Force Survey

The estimate of 583,000 people employed on “zero-hour contracts” has a 95% confidence interval of ±61,000, which means the true figure is likely to lie between 522,000 and 645,000.

ONS business survey

The estimate of 1.4 million employee contracts that do not guarantee hours where work was provided in the reference period of the fortnight starting 20 January 2014 has a 95% confidence interval of ±240,000, which means the true figure is likely to lie between 1.2 million and 1.7 million.

The standard errors by broad industry groups are shown in Table 1:3

Table 1: Employee contracts that do not guarantee minimum hours which provided work in the reference period of the fortnight beginning 20 January 2014

Millions

		95 % confidence intervals	
	Central estimate	**Lower**	**Upper**
TOTAL	1.42	1.18	1.66
A- E Production plus Ag. Fish and Mining	0.04	0.01	0.08
F Construction	0.05	0.02	0.07
G Wholesale and Retail	0.14	0.01	0.27
I Accommodation and Food	0.37	0.28	0.46
J-M Information, Finance, Professional	0.03	0.00	0.05
N Admin and support services	0.36	0.22	0.50
O Public admin	0.01	0.00	0.02
P Education	0.07	0.02	0.12
Q Health and Social work	0.19	0.13	0.26
RS+H Transport, Arts, Other	0.16	0.09	0.22

Table source: Office for National Statistics

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(26.5 Kb)

Background notes

1. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

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Office for National Statistics

People in employment reporting a zero-hours contract, August 2014

Author Name(s): **Mark Chandler, Office for National Statistics**

Abstract

This report contains estimates of the number of people in employment on zero-hours contracts from the Labour Force Survey (LFS) for April to June 2014.

Introduction

On 30 April 2014 the ONS published "Analysis of Employee Contracts that do not Guarantee a Minimum Number of Hours" which aimed to bring together results relating to zero-hours contracts from the Labour Force Survey (LFS) and no guaranteed hours contracts (NGHCs) from the newly launched business survey. The report compared estimates from both sources and provided information and context on the experience of people employed on zero-hours contracts and NGHCs.

The following report, which focuses on the LFS measure, presents the latest estimate for the period April to June 2014 and includes a number of methodological changes to the survey as explained in the article "Estimating Zero-Hours Contracts from the Labour Force Survey" (90.6 Kb Pdf) published in July 2013. These changes have improved the data collection and estimation process and allowed for estimates of zero-hours contracts from the LFS to be published twice a year on a consistent basis. Further details are available in a further methodological note published on the Labour Market Statistics articles and reports page on 13 August 2014.

Labour Force Survey estimates for April to June 2014

The latest Labour Force Survey (LFS) estimate of the number of people in employment on zero-hours contracts is 622,000 for the period April to June 2014.

The LFS is a quarterly survey of around 100,000 individuals resident in households in the UK and classifies people according to their responses to the survey. The number of people who are shown as on a zero-hours contract will therefore be affected by whether people perceive they are on a zero-hours contract and by how aware they are of the concept. The increased media coverage of zero-hours in the latter half of 2013 and early 2014 is likely to have affected the response, although it is also likely that a degree of under reporting remains. This is explored in more detail within the accompanying methodological note published on the Labour Market Statistics articles and

reports page. The details in this methodological note indicate that data from October to December 2013 should not be used to calculate a measure of change across the time series.

As with any sample survey, estimates from the LFS are subject to a margin of uncertainty. For the April to June 2014 figure, it is estimated that the true figure is likely to lie between 558,000 and 686,000. This is in addition to the likely reporting error as mentioned above.

The estimates presented here are not seasonally adjusted. This means that possible short-term effects associated with the time of year may influence the figures. For this reason, ONS does not recommend comparing the difference between the latest estimates for April to June 2014 with October to December 2013 as a measure of change. Any seasonal factors associated with zero-hours contracts will not be measurable until a sufficient time-series has been established.

Analysis of zero-hours contracts

Looking at the type of people who report that they are employed on a zero-hours contract, compared with other people in employment who are not on a zero-hours contract, shows that there are differences in their characteristics. For April to June 2014:

- Women make up a greater proportion of those reporting working on zero-hours contracts (54%); compared with those employed who are not on zero-hours contracts (46%).
- People who report being on a zero-hours contract are more likely to be younger. 37% of people on zero-hours contracts are aged 16 to 24, compared with 12% for those employed who are not on zero-hours contracts.
- 64% of people on zero-hours contracts reported that they worked part time, compared with just over a quarter (27%) of those employed who are not on zero-hours contracts.
- People who report being on a zero-hours contract are more likely to be working in Accommodation & Food Services or Health & Social Work. Relatively few work in Financial, Insurance and Professional, Scientific & Technical Activities and Production (including Agriculture).
- The average actual weekly hours worked by people in employment who report being on a zero-hours contract is 22 hours compared with 32 hours for all workers. The average usual weekly hours is higher at 24 hours (37 hours for all workers).

A spreadsheet containing the above zero-hours contract estimates is available at data table X04 (100 Kb Excel sheet).

Zero-hours contracts and no guaranteed hours contracts (NGHCs)

Estimates of the numbers and characteristics of people in employment on zero-hours contracts are available from the Labour Force Survey (LFS), a survey of people resident in households. The LFS asks people in employment if their job has any flexible working arrangements and, if so, to identify them from a list of employment patterns. “Zero-hours contract” is listed and is described as a contract ‘where a person is not contracted to work a set number of hours, and is only paid for the number of hours that they actually work’.

Further to this, in January 2014 ONS undertook a survey of businesses to obtain an employer-based estimate to complement the existing LFS employee-based figure. Results from this survey were published on 30 April 2014 in the report "Analysis of Employee Contracts that do not Guarantee a Minimum Number of Hours".

This adopted a slightly different definition to the LFS, and reported on the number of employee contracts that do not guarantee a minimum number of hours, which provided work in the survey reference period. This estimate includes, but is not exclusively, "zero-hours contracts" and covers some other contract types that do not guarantee a minimum number of hours (NGHCs).

For the ONS business survey, there were 1.4 million employee contracts that did not guarantee a minimum number of hours, which provided work in the survey reference period of the fortnight beginning 20 January 2014. This is different from the LFS figure for a number of reasons:

- employers and employees will have differing perceptions and awareness about the types of employment contracts used,
- the employer survey will count employee contracts, not people, and will provide higher estimates (as one person can have more than one contract),
- employers in the business survey may report multiple contracts for each job,
- the questions asked of respondents differed slightly, with the business survey asking about contracts not guaranteeing any hours, while the LFS question uses the term "zero-hours contracts",
- the LFS includes all people in employment (including the self-employed) while the business survey only includes employees, and
- the LFS measure is for people who are on a zero-hours contract in their main job only.

Future plans

Improvements to the coverage and estimation of people in employment reporting a zero-hours contract have led to more reliable and comparable recent estimates from the LFS. These resultant changes have introduced a discontinuity in the time series in 2013 and ONS is advising users to make only very broad judgements when making comparisons over time.

The LFS employee based estimates of people in employment reporting a zero-hours contract will continue to be published twice a year; in February and August. ONS is carrying out further analysis of the data collected as part of the business survey on 'no guaranteed hours contracts (NGHCs)' and will report on this later in 2014. ONS also plans to conduct a further survey to businesses, similar to the one carried out in February 2014, during summer 2014 and will report by December 2014.

Background notes

1. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

13 March 2014 Last updated at 14:43

Fresh squeeze on NHS pay sparks union strike warning

"It is right to take difficult decisions.... it means we can keep more people employed"

Unions have reacted with anger to news of a fresh round of below-inflation pay rises for NHS staff in England.

Ministers have announced a basic 1% pay rise, but the 600,000 nurses and other staff receiving automatic "progression-in-job" increases, "typically worth over 3%", will not get the 1% as well.

The main health service unions in England said they would consult members on taking industrial action.

Members of the armed forces, prison officers and judges are due 1% rises.

The Consumer Prices Index (CPI) measure of inflation is currently at 2%, and the NHS pay review body had recommended that all NHS staff should get a 1% pay rise - whether they were also entitled to progression pay increases or not.

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% annual growth

* Consumer Prices Index

Notes: Figures show the % change in median gross weekly earnings since previous year (April).

Source: ONS

The Scottish government has said it will adopt the NHS pay review body's

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recommendations in full, meaning that all NHS staff in Scotland will receive the 1% pay rise. In addition, NHS staff in Scotland earning under £21,000 a year will get a £300 rise.

The devolved governments in Northern Ireland and Wales have not yet announced whether they will follow suit.

But **Health Secretary Jeremy Hunt said** implementing the pay body's recommendations in England would be "unaffordable and would risk the quality of patient care".

He told BBC Radio 4's The World at One around 6,000 nursing job would have had to be cut if everyone in the NHS had got the 1% rise.

He said: "The whole progression pay system is mad. I mean someone on a £50,000 salary will get a 4.7% progression pay rise, whereas someone on £14,000 would only get a 2.5% progression pay rise. It shouldn't just be about time served it should be about how well you look after patients."

Unison's Christina McAnea accused the government of mixing up annual pay rises with the increments "designed to reflect the growing skills and experience of nurses and other healthcare workers".

It was the classic Catch-22. Ministers felt on the one hand they couldn't afford to give staff a pay rise, while on the other realising they couldn't afford not to. The result? A pay rise for some, and (arguably) none for others. But the risk is that this turns out to be a fudge that makes no-one happy."

Nick Triggle
Health correspondent

Read more from Nick

'Very modest'

Jeremy Hunt: "I would dearly like to be more generous, but not if it means laying off 6,000 nurses"

"They are not a substitute for the annual pay rise that is needed to meet the increasing cost of living," she said.

"If the government is set on imposing this change, it clearly doesn't understand how increments work. As it stands, they save the NHS money but if this divisive plan goes ahead Unison will be arguing strongly that staff should be paid the full rate for the job from day one.

"I am appalled that this coalition government can openly boast about the economic recovery and claim that we are all feeling the benefits and then treat health workers so shoddily."

But Chief Secretary to the Treasury Danny Alexander claimed that the progression pay increases were often worth 3%-4% and were awarded simply "because of time served in the job" to more than half of NHS

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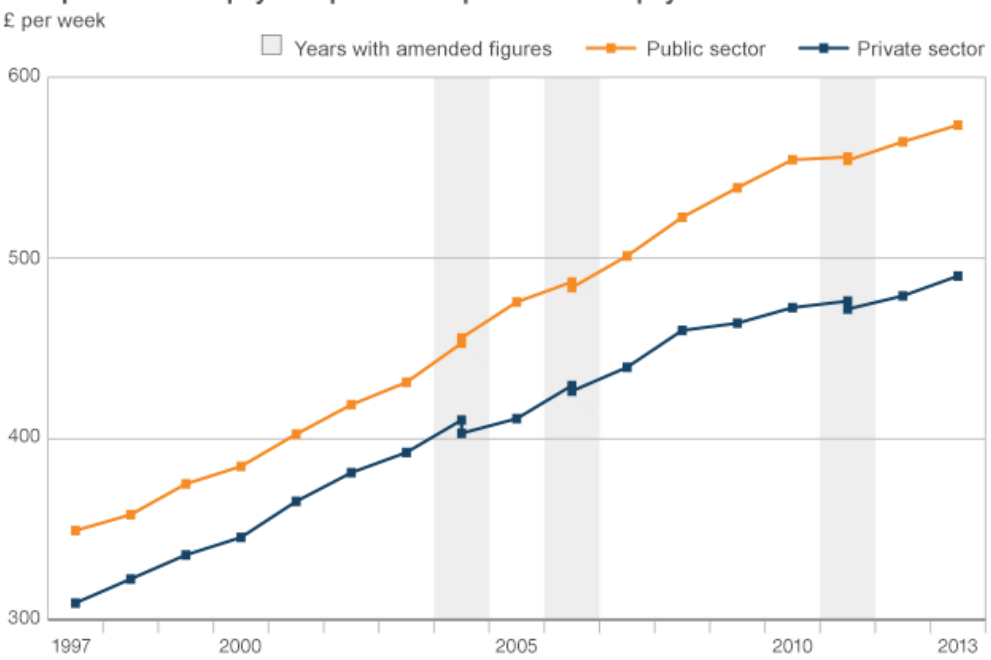
workers.

He told the BBC: "The extra 1% should be confined to those who otherwise wouldn't see any pay rise at all.

"That's what the country can afford."

How public sector pay compares with private sector pay



Notes: Figures cover full-time employees on adult rates. There were amended ONS estimates in 2004, 2006 and 2011. Data from 2013 are provisional.
Source: Annual Survey of Hours and Earnings, Office for National Statistics

He conceded this was a "very modest increase", but said: "We had two years of a pay freeze, where people who worked for the government didn't get any pay rise at all - except those who receive these increments, who continued to get those even during the years of the pay freeze."

Pay restraint had to be a "big part" of resolving the "huge financial problems we have as a country", he added.

Rachel Maskell, of Unite the union which represents 100,000 NHS workers, told the BBC that the pay offer was "the straw that breaks the camel's back - a step too far".

"People have got a right to stand up for their terms and conditions, and the government over the years have taken advantage of the fact that people are professional at their work, they are predominantly women workers, and have made a calculation that they can abuse their staff over their pay," she said.

"Enough is enough, and our members are saying they want consultation over industrial action."

NHS pay facts

- Senior managers' average pay is £78,513
- Doctors' average earnings: £74,167
- Managers' average earnings £49,475
- Nurses' and midwives' average earnings is £30,854
- 55% of staff get incremental pay increases
- 45% don't get incremental pay increases because they are at top of their pay band

The government said the 1% pay offer for 2014-15, which is to non-pensionable earnings, would be followed up with a 2% pay offer for 2015-16, also to non-pensionable earnings and also excluding those getting incremental increases.

It urged unions to forgo progression pay increases for a year in 2015-16, in exchange for applying the 1% rise across the board to the pensionable salary of NHS staff.

Workers in Northern Ireland said a 1% pay rise would make little difference

Separately, Mr Alexander has also announced that government departments were not contributing enough to their employees' pension funds.

A detailed review of NHS, teachers' and civil service pension schemes was not due to be published until later in the spring, he said.

"But it is already clear that these will show the level of contributions paid by employers have not been sufficient to meet the full long-term costs of these schemes.

"If current rates were allowed to continue, the shortfall would be nearly £1bn a year across the teachers', civil service and NHS schemes.

"The government is therefore taking corrective action, and will introduce new higher employer contribution rates for these schemes from 2015. This will ensure that the contributions paid by public service employers reflect the full costs of the schemes, including the costs of the deficits that have arisen since previous valuations.

Unite's Rachel Maskell says the pay offer is "a step too far"

"This will not have any impact on existing pensioners, on member benefits, or on the contributions paid by employees in those schemes. Instead it will ensure that pension costs are properly met by employers and do not fall as an additional cost to the taxpayer."

GPs' expenses

But Brian Strutton, of the GMB union, said the pensions announcement was a "con trick" to justify the "harsh NHS pay announcement" by suggesting that the cost of pensions had increased.

"But that is not the case. There are no extra costs. Let's not be fooled, there is no justification for the NHS pay review body being overruled."

The government also said that GPs in England would see an increase of 1% to their income, adding that there would also be "movement in their expenses".

The British Medical Association's Mark Porter predicted that GPs would be "unfairly hit" by the changes.

"Despite delivering substantial efficiency savings while at the same time facing ever increasing workload pressures and patient demand, today's announcement will continue to see practice income eroded as practice expenses increase disproportionately to income," he said.

Mr Alexander said it would be left to individual departments in Whitehall to decide whether to offer senior civil servants the 1% pay rise.

Police and crime commissioners, who oversee the 41 police forces in England and Wales, are not due to receive the 1% pay increase.

The pay offer for prison officers is also relevant to England and Wales only.

Salaries for police officers, council workers and teachers are determined in a separate process.

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5 December 2012 Last updated at 17:20

NHS regional pay plan halt welcomed in South West

An MP in the South West has welcomed an announcement by Chancellor George Osborne that proposals for regional NHS pay will not go ahead.

A consortium of 19 hospitals and health trusts had published proposals about changing pay, terms and conditions to reflect regional levels of pay.

In his Autumn Statement, Mr Osborne said national pay arrangements for the NHS would continue.

Cornish MP Stephen Gilbert said the move was a "victory for people power".

Fair wages 'deserved'

Members of the NHS consortium wanted to bypass the long-established national Agenda for Change agreement and replace it with local pay deals

The consortium's proposals for "an affordable pay, terms and conditions system" is opposed by unions who say it is an excuse to make wage cuts.

Mr Gilbert, the Liberal Democrat MP St Austell and Newquay, said he was against the proposals because he believed "hard-working public sector employees deserve a fair wage for the work they do - no matter where they live".

He said: "The announcement in the Autumn Statement that the government won't be pursuing these devastating plans is a victory for people power and the work that has been done by unions and public sector employees to lobby the government."

Workers will still face below-inflation wage rises, Mr Osborne told MPs.

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15 January 2014 Last updated at 08:54

Private f rms 'win 70% of NHS contracts'

By Dominic Hughes
Health correspondent, BBC News

More than 70% of NHS contracts awarded since April 2013 have gone to private sector bidders

Almost 70% of contracts for NHS services in England between April-December 2013 were won by private firms, a campaign group claims.

NHS reforms mean "qualified providers" can bid to provide clinical services, such as scans and out-of-hours care.

The NHS Support Federation, which opposes a competitive market in the NHS, said that, of 57 contracts awarded, 39 went to private firms.

The government said the figures were "selective and misleading".

The NHS Support Federation said 15 of the 57 contracts went to the NHS, two went to charities and one was shared between the NHS and a non-NHS supplier.

They cover everything from mental health services, GP and out-of-hours services and diagnostics such as blood tests, X-rays and scans.

The campaign group says that contracts worth a total of £5bn were advertised between April-December 2013. Of those, contracts worth £510m were actually awarded in that time with £450m worth awarded to non-NHS suppliers.

'Genuinely surprised'

The figures come from an analysis of competitive tender notices on the **European public procurement** website, compiled by the federation.

Director Paul Evans says the big question is whether private companies will provide a better service for patients.

"I think people are going to be genuinely surprised by what's happening,"

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he said.

"The scope of this change means that it is affecting all kinds of care that you might experience as a patient, everything from your first visit to the GP, diagnostic tests, treatment in hospital and care further on from that.

"We're talking about the whole gamut of care and a massive change in the way we use services in the future."

But the Department of Health (DoH) said the NHS Support Federation's figures "only relate to a small sample of NHS contracts and are therefore selective and misleading".

"The reality is that private sector providers only carry out around 6% of all NHS work," a spokesperson said.

The NHS Support Federation's figures related only to contracts for clinical services awarded between April and December 2013 while the DoH figures covered the period from 2010 to now and were for both clinical services and other supplier contracts, such as management and catering services.

The contracts involved relatively small sums of money in the grand scheme of the overall NHS budget of £100bn each year but there are some very big contracts coming down the pipeline.

More collaboration

Much of what is called primary care - GPs, dentists and pharmacists for example - is already run by private businesses on behalf of the health service.

A minority of hospital services - about 5% - were already delivered by the private sector before the coalition government's reforms but the NHS Support Federation says it is now taking a bigger stake.

In 2012 a private company, Circle, took over the running of the failing Hinchingbrooke Hospital in Cambridgeshire, the first time an NHS Trust was handed over to the private sector.

The hospital's chief executive, Hisham Abdel-Rahman, says more private sector involvement is vital for the future of the NHS.

"I would hope to see more collaboration between industry, including the private sector and universities, to bring innovations in medicine into everyday practice in hospitals.

"This is the only way we can overcome the financial and workload challenges in the NHS.

"However, it will depend on the the bravery - as well as the appetite - of the politicians to go that far."

But campaigners like Dr Jacky Davis, of Keep our NHS Public, say competitive tendering is undermining the National Health Service.

"The problem is the government are wasting tens of millions of pounds on these contracts, money that should be spent on front-line patient care.

"These companies have a record of just walking away when things go wrong and dumping the problems back on the NHS as we saw with the PIP breast implants scandal.

"This isn't privatisation by the back door, it's privatisation by the front door, and it is really putting patients' lives at risk."

Clinical need

“The reality is that private sector providers only carry out around 6% of all NHS work”

Department of Health

“This isn't privatisation by the back door, it's privatisation by the front door, and it is really putting patients' lives at risk”

Dr Jacky Davis

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NHS care is already moving from the hospital to the High Street.

The Scrivens chain of opticians is among those offering a service for testing and fitting hearing aids.

Director Mark Georgevic says private sector involvement will be good for patients.

"I'm sure if there are other services that could be easily provided on the High Street they will benefit.

"Patients like it. They don't want necessarily to have to go to a hospital environment.

"Being in the community is very important. We're still an NHS provider, based on clinical need and not necessarily the ability to pay."

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14 October 2014 Last updated at 18:21

More than half of local health contracts 'go outside NHS'

The value of clinical contracts awarded by local health commissioning groups has risen to just over £2bn between April and September this year, data shows.

Of the total contracts awarded since April 2013, more than half have gone to non-NHS providers, says the NHS Support Federation.

Opponents say it is tantamount to privatisation.

But supporters say it could improve patient care.

The England figures come at a time of increasing debate about the role of health organisations in England which are not part of the NHS.

A £1.2bn contract for cancer and end-of-life care in Staffordshire, currently out to tender, has caused controversy because it is the biggest such outsourcing deal in NHS history.

Back door

Some contracts have been awarded to private companies, some to voluntary organisations and some to existing NHS providers including a recent £800m deal for elderly care in Cambridgeshire.

Clinical commissioning groups, known as CCGs and run largely by local doctors, control budgets for patient care in their local areas in England.

The campaigning group NHS Support Federation has examined tendering notices published by CCGs under European Union rules.

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It says the groups have advertised 573 contracts since April 2013, worth a total of £7bn. Of those, 88 have been awarded so far - 56% of them to non-NHS providers, although less than half by value.

The research shows there has been a sharp increase in the value of contracts awarded by CCGs. Deals worth £266m were agreed between April and September 2013. Over the same period this year, the total was just over £2bn. To put that in perspective, the total annual budget for CCGs is £65bn.

One of the first contracts of its kind has been awarded to a private company to organise musculoskeletal services (care of muscles and joints) in Bedfordshire. Circle started the five-year £120m contract in April this year. Its role is to co-ordinate care, using hospitals and physiotherapists as necessary.

Nick Boyle, head of business development at Circle, believes the service can be made more efficient and better for patients.

He says: "We believe that because we can get clinicians working better together to cut out unnecessary tests and unnecessary investigations and make sure people have the right care at the right time, we can provide a better quality of care while at the same time reducing the total cost."

Private providers

But there's a concern in some quarters that local hospitals will lose revenue as patients are sent to private providers for care and treatment.

According to Prof Tim Briggs, a leading orthopaedic surgeon, hospitals will be left only with emergency work and that may prove impossible to sustain.

"I think for trauma services, patients want to know that if they fall down, they've got a local hospital that they can give them the trauma help they need. And I'm concerned that that might be at risk because of the financial destabilisation of the Trusts," he says.

The NHS Support Federation argues that the rising trend of contracts being advertised means that more of the NHS budget could be drained into the hands of alternative providers.

But a government spokesman said: "It's now local doctors and nurses - not politicians - who have control of NHS budgets, because they know the needs of their patients best. Use of the private sector grew far faster under the previous government, and it now represents only 1% more of the NHS budget than in 2010."

The issue of non-NHS providers in the health service is generating more debate. What will become clear in the months ahead is whether it has a higher profile in the political debate over health before the general election.

You can hear Hugh Pym's full report on **BBC Radio 4 - File on 4**, *20:00 Tuesday 14 October, repeated at 17:00 Sunday 19 October.*

best"

A government spokesman

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10 December 2014 Last updated at 00:04

A third of NHS contracts awarded to private f rms - report

COMMENTS(746)

By Michelle Roberts
Health editor, BBC News online

A third of NHS contracts in England have been awarded to private sector providers since the service was reorganised in 2013, figures suggest.

The information comes from a Freedom of Information request made by the British Medical Journal.

Of 3,494 contracts awarded by 182 Clinical Commissioning Groups in England between April 2013 and August 2014, 33% went to the private sector.

The government says the data is misleading.

It's unclear how much the contracts were worth because the CCGS would not disclose this information citing commercial sensitivities.

A Department of Health spokesperson said: "Official NHS accounts show that use of the private sector amounts to only six pence in every pound the NHS spends, slowing the rate of increase to just one penny since May 2010.

"Charities, social enterprises and other providers of healthcare play an important role in the NHS, as they have done for many years."

Slow creep

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The investigation looked at different types of contract to provide NHS clinical services, including those awarded to a single provider without an open tender, those awarded via a competitive tendering process, and those awarded to multiple providers under Any Qualified Provider - a government policy that opened up a wide range of community-based NHS services to different providers from outside the NHS.

Private sector providers were most successful at winning contracts awarded via competitive tender - 80 compared with 59 won by NHS providers.

The total value of all the contracts investigated was £10bn. Around £8.5bn worth of contracts went to NHS providers, £690m to voluntary and social enterprise providers and £490m to the private sector - 5% of the total.

NHS budget spent on commissioning private providers

YEAR	AMOUNT (% OF NHS BUDGET)
2006/07	2.8 %
2007/08	3.4 %
2008/09	3.9 %
2009/10	4.4 %
2010/11	4.9 %
2011/12	5.3 %
2012/13	5.5 %
2013/14	6.1 %

Private firms were also more likely to win smaller contracts on an Any Qualified Provider basis, for services such as diagnostics, audiology, and podiatry in the community.

Critics say the results are evidence of privatisation of the NHS.

The government denies this.

The vast majority of care continues to be provided by NHS providers, it says.

And although controversial, private sector involvement within the NHS is not new.

Dr Jacky Davis of Keep our NHS Public said doctors were being forced to tender out all work, and big corporations were best placed to win these contracts.

Dr Mark Porter of the British Medical Association said: "These figures show the extent of creeping privatisation in the NHS since the Health and Social Care Act was introduced. The government flatly denied the Act would lead to more privatisation, but it has done exactly that.

"Enforcing competition in the NHS has not only led to services being fragmented, making the delivery of high-quality, joined-up care more difficult, but it has also diverted vital funding away from frontline services to costly, complicated tendering processes."

Shadow health secretary Andy Burnham said: "These figures blow apart Jeremy Hunt's claim that 'NHS privatisation isn't happening'. It is happening and it is happening on his watch.

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"The NHS of the future demands more integration. The problem with this Government's policy is that it's taking it in the opposite direction, towards more fragmentation.

"These figures show what is at stake at the coming election. David Cameron's Government is stealthily hiving off NHS services without the permission of the public."

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10TH DECEMBER 2014 - 9:53
+57
Private companies are not being altruistic in taking on public sector contracts, they are doing it for profit; they are doing it to make money not simply break even. Every penny that ends up in the bank accounts of shareholders is a penny lost to the Health Service

129. **David**
10TH DECEMBER 2014 - 9:50
-2
Time for people to face reality, there are simply some services which the NHS is not good at delivering at a reasonable cost and value. As with most organisations the NHS needs to focus on it's core activities and doing these well. If this means private sector companies doing more of the non core work at better value for the public then this has to be right.

35. **Old Father Thames**
10TH DECEMBER 2014 - 9:28
+107
How can private companies provide better value for money when private companies exist for the sole purpose of making profit?

State run services, when run efficiently and effectively, should provide a better service at a better cost - because there are no shareholders or directors taking a cut along the way.

27. **Delvin**
10TH DECEMBER 2014 - 9:26
+113
Having worked for both private health providers and the NHS, I can categorically say, that I would far rather be treated by the NHS. Why? Because they use far higher standards of clinical governance and patient

June GP Omnibus
ONLINE Fieldwork Dates: 21st-26th June 2012

Absolutes/col percents

Table 1
Q1 Thinking about patients who require referral to secondary care…

Compared to six months ago, to what extent are you now more or less likely to ask patients whether they have private medical insurance?
Base: All respondents

	Total		North West SHA		North East SHA		Yorkshire & Humber SHA		East Midlands SHA		West Midlands SHA		East of England SHA		London SHA		South East Coast SHA		South Central SHA		South West SHA		Scotland		Wales		Northern Ireland	
			A		B		C		D		E		F		G		H		I		J		K		L		M	
Much more likely	120	12%	11	K10%	2	5%	8	K10%	10	K15%	11	K13%	11	K12%	22	ABCKm20%	10	K15%	14	BK20%	12	K12%	2	2%	5	10%	2	7%
Somewhat more likely	471	46%	50	46%	17	39%	40	48%	34	52%	38	43%	50	JK56%	55	50%	31	46%	30	43%	37	38%	46	41%	27	54%	16	55%
Somewhat less likely	128	13%	16	C15%	10	CL23%	5	6%	8	12%	9	10%	10	11%	11	10%	14	CL21%	8	12%	12	12%	15	13%	4	8%	6	21%
Much less likely	25	2%	3	3%	0	0%	2	2%	1	2%	3	3%	1	1%	3	3%	0	0%	2	3%	1	1%	8	BFHJm7%	1	2%	0	0%
Don't know	271	27%	28	26%	15	G34%	28	DFGH34%	13	20%	27	G31%	17	19%	19	17%	13	19%	15	22%	36	DFGHIm37%	42	DFGHIm37%	13	26%	5	17%
Total	**1015**	**100%**	**108**	**100%**	**44**	**100%**	**83**	**100%**	**66**	**100%**	**88**	**100%**	**89**	**100%**	**110**	**100%**	**68**	**100%**	**69**	**100%**	**98**	**100%**	**113**	**100%**	**50**	**100%**	**29**	**100%**
AVG	2.9		K2.9		2.7		K3.0		K3.0		K2.9		bK3.0		bK3.1		K2.9		K3.0		K3.0		2.6		K3.0		2.8	

Prepared by ComRes

June GP Omnibus
ONLINE Fieldwork Dates: 21st-26th June 2012

Absolutes/col percents

Table 2

Q2 Within clinical commissioning groups (CCGs), GPs decide which services will be provided by the NHS and which will be provided by private providers. As you know, GPs also offer advice to patients on options for treatment and services offered both on the NHS and privately.

Thinking about this relationship, how comfortable or uncomfortable do you feel when directing a patient to private treatment (irrespective of whether or not they have private medical insurance)?
Base: All respondents

	Total		North West SHA		North East SHA		Yorkshire & Humber SHA		East Midlands SHA		West Midlands SHA		East of England SHA		London SHA		South East Coast SHA		South Central SHA		South West SHA		Scotland		Wales		Northern Ireland	
			A		B		C		D		E		F		G		H		I		J		K		L		M	
Very comfortable	104	10%	13	K12%	3	7%	9	11%	10	KLm15%	7	8%	12	KLm13%	12	K11%	9	K13%	10	KLm14%	12	K12%	4	4%	2	4%	1	3%
Fairly comfortable	443	44%	49	K45%	19	43%	38	K46%	29	K44%	45	K51%	45	K51%	56	K51%	26	38%	31	K45%	41	K42%	30	27%	18	36%	16	k55%
Fairly uncomfortable	282	28%	28	26%	11	25%	20	24%	18	27%	17	19%	23	26%	29	26%	25	EI37%	14	20%	34	EI35%	40	EI35%	15	30%	8	28%
Very uncomfortable	84	8%	10	9%	6	14%	11	FH13%	3	5%	11	H13%	4	4%	7	6%	2	3%	4	6%	6	6%	11	H10%	8	DFHm16%	1	3%
Don't know	102	10%	8	7%	5	11%	5	6%	6	9%	8	9%	5	6%	6	5%	6	9%	10	J14%	5	5%	28	ABCDEFGHJm25%	7	14%	3	10%
Total	**1015**	**100%**	**108**	**100%**	**44**	**100%**	**83**	**100%**	**66**	**100%**	**88**	**100%**	**89**	**100%**	**110**	**100%**	**68**	**100%**	**69**	**100%**	**98**	**100%**	**113**	**100%**	**50**	**100%**	**29**	**100%**
AVG	2.6		KL2.7		2.5		K2.6		KL2.8		K2.6		KL2.8		KL2.7		KL2.7		KL2.8		KL2.6		2.3		2.3		k2.7	

Prepared by ComRes

June GP Omnibus
ONLINE Fieldwork Dates: 21st-26th June 2012

Absolutes/col percents

Table 3
Q1 Thinking about patients who require referral to secondary care…

Compared to six months ago, to what extent are you now more or less likely to ask patients whether they have private medical insurance?
Base: All respondents

	Total		S2 GP type								D3 - Gender				D4 - Year of qualification										D6 - Age									
			GP Principal		Salaried GP		GP Registrar		Locum GP		Male		Female		1960-1969		1970-1979		1980-1989		1990-1999		2000-2010		Under 30		30 – 39		40 – 49		50 – 59		60 or over	
			A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P	
Much more likely	120	12%	79	c12%	28	c12%	0	0%	13	c12%	75	13%	45	10%	2	25%	13	13%	26	11%	40	12%	39	12%	3	19%	51	11%	32	11%	22	10%	12	O23%
Somewhat more likely	471	46%	297	c44%	117	c50%	0	0%	57	c53%	259	45%	212	49%	2	25%	42	41%	104	44%	163	48%	160	49%	7	44%	220	50%	129	46%	93	42%	22	42%
Somewhat less likely	128	13%	95	c14%	24	c10%	0	0%	9	c8%	82	14%	46	11%	1	13%	16	16%	37	K16%	46	K13%	28	9%	0	0%	45	l10%	40	l14%	36	lM16%	7	l13%
Much less likely	25	2%	18	c3%	6	c3%	0	0%	1	1%	14	2%	11	3%	1	13%	4	4%	10	J4%	4	1%	6	2%	1	6%	9	2%	5	2%	9	4%	1	2%
Don't know	271	27%	183	27%	59	25%	1	abd100%	28	26%	148	26%	123	28%	2	25%	28	27%	61	26%	88	26%	92	28%	5	31%	119	27%	76	27%	60	27%	11	21%
Total	**1015**	**100%**	**672**	**100%**	**234**	**100%**	**1**	**100%**	**108**	**100%**	**578**	**100%**	**437**	**100%**	**8**	**100%**	**103**	**100%**	**238**	**100%**	**341**	**100%**	**325**	**100%**	**16**	**100%**	**444**	**100%**	**282**	**100%**	**220**	**100%**	**53**	**100%**
AVG	2.9		2.9		3.0				3.0		2.9		2.9		2.8		2.9		2.8		2.9		I3.0		3.1		O3.0		2.9		2.8		O3.1	

Prepared by ComRes

June GP Omnibus
ONLINE Fieldwork Dates: 21st-26th June 2012

Absolutes/col percents

Table 4

Q2 Within clinical commissioning groups (CCGs), GPs decide which services will be provided by the NHS and which will be provided by private providers. As you know, GPs also offer advice to patients on options for treatment and services offered both on the NHS and privately.

Thinking about this relationship, how comfortable or uncomfortable do you feel when directing a patient to private treatment (irrespective of whether or not they have private medical insurance)?
Base: All respondents

	Total		S2 GP type								D3 - Gender				D4 - Year of qualification										D6 - Age									
			GP Principal		Salaried GP		GP Registrar		Locum GP		Male		Female		1960-1969		1970-1979		1980-1989		1990-1999		2000-2010		Under 30		30 – 39		40 – 49		50 – 59		60 or over	
			A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P	
Very comfortable	104	10%	77	Bc11%	14	c6%	0	0%	13	c12%	77	F13%	27	6%	3	38%	14	14%	30	13%	32	9%	25	8%	1	6%	38	9%	28	10%	27	12%	10	19%
Fairly comfortable	443	44%	284	c42%	112	c48%	0	0%	47	c44%	251	43%	192	44%	1	13%	46	g45%	90	g38%	155	g45%	151	gI46%	6	38%	211	48%	117	41%	90	41%	19	36%
Fairly uncomfortable	282	28%	176	26%	71	30%	1	abd100%	34	31%	142	25%	140	E32%	2	25%	23	22%	70	29%	96	28%	91	28%	4	25%	118	27%	89	32%	58	26%	13	25%
Very uncomfortable	84	8%	68	BcD10%	11	c5%	0	0%	5	c5%	50	9%	34	8%	2	25%	12	12%	25	11%	22	6%	23	7%	0	0%	33	I7%	17	I6%	26	IN12%	8	I15%
Don't know	102	10%	67	c10%	26	c11%	0	0%	9	c8%	58	10%	44	10%	0	0%	8	g8%	23	g10%	36	g11%	35	g11%	5	p31%	44	10%	31	11%	19	9%	3	6%
Total	**1015**	**100%**	**672**	**100%**	**234**	**100%**	**1**	**100%**	**108**	**100%**	**578**	**100%**	**437**	**100%**	**8**	**100%**	**103**	**100%**	**238**	**100%**	**341**	**100%**	**325**	**100%**	**16**	**100%**	**444**	**100%**	**282**	**100%**	**220**	**100%**	**53**	**100%**
AVG	2.6		2.6		2.6		2.0		2.7		F2.7		2.5		2.6		2.7		2.6		2.6		2.6		2.7		2.6		2.6		2.6		2.6	

Prepared by ComRes

June GP Omnibus
ONLINE Fieldwork Dates: 21st-26th June 2012

Absolutes/col percents

Table 5
Q1 Thinking about patients who require referral to secondary care…

Compared to six months ago, to what extent are you now more or less likely to ask patients whether they have private medical insurance?
Base: All respondents

	Total		D2 - Practice Location										D1 - Overall practice size						D5 - Dispensing Practice				D7 - Number of patients on practice list					
			Rural area		Urban area		Semi-rural area		Suburban area		Other (please specify)		Single handed		2-3		4-5		6>		Yes		No		1-2000		2001-4000		4001-6000		6001-8000		8000 plus	
			A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P	
Much more likely	120	12%	11	e12%	44	e11%	27	e12%	38	e13%	0	0%	0	0%	27	f15%	47	fI15%	46	f9%	23	14%	97	11%	6	10%	17	14%	27	14%	23	12%	47	11%
Somewhat more likely	471	46%	39	42%	176	44%	115	50%	140	48%	1	33%	8	57%	82	45%	134	42%	247	H49%	67	42%	404	47%	35	M56%	50	40%	86	44%	82	43%	218	50%
Somewhat less likely	128	13%	13	e14%	58	e15%	27	e12%	30	e10%	0	0%	2	14%	26	14%	41	13%	59	12%	24	15%	104	12%	4	6%	22	L18%	25	13%	29	L15%	48	11%
Much less likely	25	2%	3	3%	11	3%	4	2%	6	2%	1	33%	0	0%	9	f5%	5	f2%	11	f2%	4	2%	21	2%	3	5%	4	3%	6	3%	3	2%	9	2%
Don't know	271	27%	26	28%	107	27%	57	25%	80	27%	1	33%	4	29%	40	22%	90	28%	137	27%	43	27%	228	27%	15	24%	31	25%	52	27%	55	29%	118	27%
Total	**1015**	**100%**	**92**	**100%**	**396**	**100%**	**230**	**100%**	**294**	**100%**	**3**	**100%**	**14**	**100%**	**184**	**100%**	**317**	**100%**	**500**	**100%**	**161**	**100%**	**854**	**100%**	**63**	**100%**	**124**	**100%**	**196**	**100%**	**192**	**100%**	**440**	**100%**
AVG	2.9		2.9		2.9		e3.0		e3.0		2.0		2.8		2.9		3.0		2.9		2.9		2.9		2.9		2.9		2.9		2.9		2.9	

Prepared by ComRes

June GP Omnibus
ONLINE Fieldwork Dates: 21st-26th June 2012

Absolutes/col percents

Table 6

Q2 Within clinical commissioning groups (CCGs), GPs decide which services will be provided by the NHS and which will be provided by private providers. As you know, GPs also offer advice to patients on options for treatment and services offered both on the NHS and privately.

Thinking about this relationship, how comfortable or uncomfortable do you feel when directing a patient to private treatment (irrespective of whether or not they have private medical insurance)?
Base: All respondents

	Total		D2 - Practice Location										D1 - Overall practice size								D5 - Dispensing Practice				D7 - Number of patients on practice list									
			Rural area		Urban area		Semi-rural area		Suburban area		Other (please specify)		Single handed		2-3		4-5		6>		Yes		No		1-2000		2001-4000		4001-6000		6001-8000		8000 plus	
			A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P	
Very comfortable	104	10%	10	e11%	31	e8%	27	e12%	36	e12%	0	0%	1	7%	17	9%	30	9%	56	11%	12	7%	92	11%	3	5%	13	10%	20	10%	14	7%	54	LO12%
Fairly comfortable	443	44%	41	45%	167	42%	102	44%	132	45%	1	33%	5	36%	85	46%	135	43%	218	44%	79	49%	364	43%	31	49%	49	40%	85	43%	81	42%	197	45%
Fairly uncomfortable	282	28%	29	32%	120	30%	60	26%	72	24%	1	33%	6	43%	49	27%	93	29%	134	27%	44	27%	238	28%	18	29%	43	P35%	50	26%	63	P33%	108	25%
Very uncomfortable	84	8%	6	7%	36	9%	17	7%	24	8%	1	33%	0	0%	21	f11%	28	f9%	35	f7%	12	7%	72	8%	6	10%	11	9%	21	O11%	10	5%	36	8%
Don't know	102	10%	6	e7%	42	e11%	24	e10%	30	e10%	0	0%	2	14%	12	7%	31	10%	57	G11%	14	9%	88	10%	5	8%	8	6%	20	10%	24	13%	45	10%
Total	**1015**	**100%**	**92**	**100%**	**396**	**100%**	**230**	**100%**	**294**	**100%**	**3**	**100%**	**14**	**100%**	**184**	**100%**	**317**	**100%**	**500**	**100%**	**161**	**100%**	**854**	**100%**	**63**	**100%**	**124**	**100%**	**196**	**100%**	**192**	**100%**	**440**	**100%**
AVG	2.6		2.6		2.5		2.7		B2.7		2.0		2.6		2.6		2.6		2.7		2.6		2.6		2.5		2.6		2.6		2.6		2.7	

Prepared by ComRes

April GP Omnibus
ONLINE Fieldwork Dates: 18th-24th April 2012

Absolutes/col percents

Table 1
Q1 Which of the following, if any, would make you more likely to discuss with patients the option of paying for private treatment out of their own money
Base: All respondents

	Total		S3 Region																							
			North West SHA		North East SHA		Yorkshire & Humber SHA		East Midlands SHA		West Midlands SHA		East of England SHA		London SHA		South East Coast SHA		South Central SHA		South West SHA		Scotland		Wales		Northern Ireland	
			A		B		C		D		E		F		G		H		I		J		K		L		M	
An indicative price list for procedures that was made available to GP surgeries to share with patients	666	66%	69	63%	31	L74%	54	61%	46	69%	54	65%	67	Lm74%	75	67%	44	67%	45	66%	69	CLm74%	73	67%	26	52%	13	52%
Information on what procedures are available on the NHS and which are not	548	55%	62	56%	18	43%	50	56%	34	51%	51	B61%	46	51%	66	59%	37	56%	42	B62%	45	48%	54	50%	29	58%	14	56%
Greater knowledge of waiting times for procedures	501	50%	49	45%	20	48%	46	52%	32	48%	42	51%	52	57%	54	48%	33	50%	33	49%	44	47%	51	47%	28	56%	17	ak68%
A simpler process for how to refer people	237	24%	22	20%	13	31%	14	16%	10	15%	22	27%	29	CDH32%	36	ACDHL32%	10	15%	21	CDH31%	19	20%	25	23%	9	18%	7	28%
Information about how to refer patients for private treatment being made available to GP surgeries	225	22%	31	HJ28%	8	19%	21	J24%	13	19%	20	J24%	25	HJ27%	27	J24%	9	14%	18	J26%	11	12%	24	J22%	10	20%	8	j32%
Guidelines suggesting how to discuss the subject with patients	138	14%	16	D15%	5	12%	12	D13%	3	4%	10	12%	16	D18%	23	D21%	11	D17%	7	10%	13	D14%	13	12%	7	14%	2	8%
None of these	115	11%	14	13%	4	10%	13	15%	4	6%	10	12%	8	9%	8	7%	5	8%	8	12%	11	12%	19	DGH17%	9	18%	2	8%
Don't know	31	3%	3	3%	2	5%	3	3%	4	m6%	1	1%	2	2%	3	3%	2	3%	3	4%	2	2%	5	m6%	1	2%	0	0%
Total	**1005**	**100%**	**110**	**100%**	**42**	**100%**	**89**	**100%**	**67**	**100%**	**83**	**100%**	**91**	**100%**	**112**	**100%**	**66**	**100%**	**68**	**100%**	**93**	**100%**	**109**	**100%**	**50**	**100%**	**25**	**100%**

Prepared by Comres

April GP Omnibus
ONLINE Fieldwork Dates: 18th-24th April 2012

Absolutes/col percents

Table 2
Q2 For each of the following, would you say that the proportion has increased, decreased or stayed about the same compared to 12 months ago?
Base: All respondents

	Total		S3 Region																									
			North West SHA		North East SHA		Yorkshire & Humber SHA		East Midlands SHA		West Midlands SHA		East of England SHA		London SHA		South East Coast SHA		South Central SHA		South West SHA		Scotland		Wales		Northern Ireland	
			A		B		C		D		E		F		G		H		I		J		K		L		M	
The proportion of your patients who initiated a discussion with you about paying for private treatment out of their own money																												
Decreased	59	6%	8	m7%	3	7%	7	m8%	8	HKm12%	5	m6%	7	m8%	6	m6%	2	3%	3	4%	5	m6%	3	3%	2	4%	0	0%
Stayed the same	578	58%	64	m58%	31	EFGHILm74%	53	Lm60%	39	m58%	40	48%	48	53%	61	m64%	36	m65%	37	m64%	64	EFGLm69%	76	EFGHILm70%	21	42%	8	32%
Increased	354	35%	37	34%	8	19%	26	29%	19	28%	36	BJK43%	35	BJ38%	43	BJ38%	26	B39%	27	BJ40%	23	25%	30	28%	27	ABCDJK54%	17	abcdefghijk68%
Don't know	14	1%	1	1%	0	0%	3	3%	1	1%	2	2%	1	1%	2	2%	2	3%	1	1%	1	1%	0	0%	0	0%	0	0%
Total	**1005**	**100%**	**110**	**100%**	**42**	**100%**	**89**	**100%**	**67**	**100%**	**83**	**100%**	**91**	**100%**	**112**	**100%**	**66**	**100%**	**68**	**100%**	**93**	**100%**	**109**	**100%**	**50**	**100%**	**25**	**100%**
AVG	2.3		2.3		2.1		2.2		2.2		BDJ2.4		2.3		B2.3		BDJ2.4		B2.4		2.2		2.2		ABCDJK2.5		abcdefghijk2.7	
The proportion of your patients with whom you initiated a discussion about paying for private treatment out of their own money																												
Decreased	31	3%	4	m4%	1	2%	2	2%	4	m6%	3	4%	2	2%	1	1%	3	5%	3	4%	5	m6%	2	2%	1	2%	0	0%
Stayed the same	713	71%	78	m71%	35	DGHIm83%	70	DGIm79%	42	63%	61	m73%	65	m71%	72	64%	43	65%	42	62%	73	DGIm78%	88	DGHIm81%	33	66%	11	44%
Increased	238	24%	27	25%	6	14%	13	15%	19	C28%	18	22%	22	24%	35	BCJK31%	17	26%	22	BCJK32%	15	16%	17	16%	13	26%	14	abcdefghijkl56%
Don't know	23	2%	1	1%	0	0%	4	BJm4%	2	3%	1	1%	2	2%	4	BJm4%	3	5%	1	1%	0	0%	2	2%	3	6%	0	0%
Total	**1005**	**100%**	**110**	**100%**	**42**	**100%**	**89**	**100%**	**67**	**100%**	**83**	**100%**	**91**	**100%**	**112**	**100%**	**66**	**100%**	**68**	**100%**	**93**	**100%**	**109**	**100%**	**50**	**100%**	**25**	**100%**
AVG	2.2		2.2		2.1		2.1		2.2		2.2		2.2		BCJK2.3		2.2		CJK2.3		2.1		2.1		2.3		abcdefghijkl2.6	

Prepared by Comres

April GP Omnibus
ONLINE Fieldwork Dates: 18th-24th April 2012

Absolutes/col percents

Table 3
Q3 Which of the following reasons, if any, do you think has caused this increase in patients initiating a discussion with you about paying for private treatment out of their own money?
Base: 354

	Total		S3 Region																									
			North West SHA		North East SHA		Yorkshire & Humber SHA		East Midlands SHA		West Midlands SHA		East of England SHA		London SHA		South East Coast SHA		South Central SHA		South West SHA		Scotland		Wales		Northern Ireland	
			A		B		C		D		E		F		G		H		I		J		K		L		M	
There are more procedures that are no longer available on the NHS	234	66%	21	m57%	4	50%	15	m58%	17	abcklm89%	25	m69%	26	m74%	32	m74%	22	acklm85%	20	m74%	17	m74%	16	m63%	16	m69%	3	18%
Patients are generally less willing to wait	230	65%	17	46%	5	63%	21	ae81%	13	68%	20	56%	28	AE80%	32	A74%	16	62%	16	59%	14	61%	23	A77%	16	59%	9	53%
They are no longer eligible for the procedure under NHS criteria	209	59%	23	Km62%	3	38%	13	m60%	17	abcefiklm89%	23	Km64%	22	Km63%	32	bcKlm74%	18	km69%	17	km63%	15	km65%	11	37%	12	44%	3	18%
NHS waiting lists have got longer	199	56%	20	F54%	5	63%	15	f58%	13	f68%	22	F61%	11	31%	20	47%	12	46%	18	f67%	10	43%	18	F60%	21	afghj78%	14	afghj82%
Increased desire for 'private' treatment	100	28%	10	l27%	1	13%	5	19%	9	bcl47%	8	22%	13	l37%	14	l33%	8	l31%	9	l33%	6	26%	10	l33%	2	7%	5	29%
Fewer people have private medical insurance, and therefore have to pay for private treatment out of their own money	75	21%	9	24%	2	25%	2	8%	2	11%	9	25%	13	cdKl37%	8	19%	5	19%	5	19%	11	cdghiklm48%	4	13%	2	7%	3	18%
None of the above	2	1%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	1	3%	0	0%	0	0%
Total	**354**	**100%**	**37**	**100%**	**8**	**100%**	**26**	**100%**	**19**	**100%**	**36**	**100%**	**35**	**100%**	**43**	**100%**	**26**	**100%**	**27**	**100%**	**23**	**100%**	**30**	**100%**	**27**	**100%**	**17**	**100%**

Prepared by Comres

April GP Omnibus
ONLINE Fieldwork Dates: 18th-24th April 2012

Absolutes/col percents

Table 4
Q4 On average, and to your best estimates, how often, if at all, are you not able to refer a patient because they do not fit current PCT criteria for the procedure required?
Base: All respondents

	Total		S3 Region																									
			North West SHA		North East SHA		Yorkshire & Humber SHA		East Midlands SHA		West Midlands SHA		East of England SHA		London SHA		South East Coast SHA		South Central SHA		South West SHA		Scotland		Wales		Northern Ireland	
			A		B		C		D		E		F		G		H		I		J		K		L		M	
Every day	28	3%	5	BKLm5%	0	0%	1	1%	2	3%	2	2%	4	BKLm4%	5	BKLm4%	4	BKLm6%	3	4%	2	2%	0	0%	0	0%	0	0%
Every week	185	18%	15	m14%	6	m14%	20	KLm22%	19	AKLm28%	15	m18%	14	m15%	29	AKLm26%	14	m21%	21	ABFJKLm31%	16	m17%	11	m10%	5	m10%	0	0%
Every 2 weeks	172	17%	22	K20%	7	17%	13	15%	13	K19%	17	K20%	24	CGIKL26%	16	14%	17	IK26%	7	10%	17	K18%	8	7%	6	12%	5	20%
Every month	318	32%	37	F34%	10	24%	32	F36%	21	31%	26	31%	17	19%	32	29%	22	F33%	26	F38%	39	BFGK42%	27	25%	21	FK42%	8	32%
Every 3 months	152	15%	18	16%	8	19%	12	13%	5	7%	13	16%	20	DHIm22%	17	15%	7	11%	6	9%	13	14%	20	D18%	11	D22%	2	8%
Every six months	61	6%	6	H5%	7	GHIJ17%	7	H8%	6	H9%	6	H7%	5	H5%	4	H4%	0	0%	2	3%	4	H4%	8	H7%	3	6%	3	12%
Less often	66	7%	5	5%	4	10%	4	4%	1	1%	4	5%	6	7%	7	6%	2	3%	2	3%	2	2%	23	ACDEFGHIJL21%	2	4%	4	16%
Never	23	2%	2	2%	0	0%	0	0%	0	0%	0	0%	1	1%	2	2%	0	0%	1	1%	0	0%	12	ABCDEFGHIJ11%	2	4%	3	12%
Total	**1005**	**100%**	**110**	**100%**	**42**	**100%**	**89**	**100%**	**67**	**100%**	**83**	**100%**	**91**	**100%**	**112**	**100%**	**66**	**100%**	**68**	**100%**	**93**	**100%**	**109**	**100%**	**50**	**100%**	**25**	**100%**

Prepared by Comres

LaingBuisson Press Releases

PRESS INFORMATION

FOR IMMEDIATE PUBLICATION: 29 JANUARY 2014

UK independent healthcare markets remain stable at £40bn in 2012/13 with the future bright as public sector outsourcing continues apace

Published today, the 2013-2014 edition of LaingBuisson's annual Healthcare Market Review calculates that revenues generated by independent sector providers in the 12 health and care market segments it monitors stood at £40.5bn in 2012/13 (2011/12: £39.9bn).While there have been some gainers and some losers, the grand total of £40bn is not significantly different from the previous year, reflecting subdued private spending out of disposable income and budget constraints amongst NHS and council purchasers of health and care services.

Table 1 UK Independent Healthcare Market Value by sub-sector

Health/Care market	Value of services provided by the independent sector, UK 2012/13
Private acute medical care	£6.7bn
Care Homes: older/physically disabled	£13.4bn
Care Homes: learning disabilities/mental illness	£3.1bn
Homecare (all client types)	£5.9bn
Mental health hospitals	£1.1bn
Children's homes (England only)	£0.7bn
Foster care (England only)	£0.7bn
Special educational needs (England only)	£1.2bn
Primary care dentistry (Dentists with NHS practices counted as 'independent')	£5.7bn
Primary medical care (England only)*	£0.7bn
Commercial occupational health services	£0.25m
Community health services	£1.0bn
Total	**£40.5bn**

* of which: private GPs earn £0.5bn

Source: LaingBuisson Healthcare Market *Review* 2013-2014

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Speaking at a launch event hosted by report sponsor GVA, LaingBuisson CEO William Laing said:

'Independent healthcare is still feeling the repercussions from the 2008 global credit and ensuing recession. Private demand for hospital treatment has been flat for five years, and private demand for care homes for older people has only kept growing because of the expanding older population and because private payers fund long term care out of assets rather than disposable income.'

'Looking forward, LaingBuisson believes that the better economic news of the last few months will – if continued - boost private spending on healthcare again, though past experience shows that there is often a lag, so it may not be until the end of 2014 that we see evidence of increased private spending on healthcare'.

Tight public sector budgets mean more outsourcing

2013 witnessed a continuation of the established outsourcing trend across nearly all publicly funded segments of health and care services – as illustrated for selected markets in Table 2 (below).

William Laing explained: 'There are two drivers of this broad-based outsourcing trend, which has been in progress for more than three decades in some segments: Cost (e.g. for care homes and homecare, where public sector costs are up to double independent costs on a like for like basis); and Choice (e.g. in elective surgery and special education, where both Labour and Coalition

administrations have sought to give individual consumers options other than public sector provision).'

Table 2 Public sector outsourcing in selected health and care markets

Health/care market	Share of public sector services which are outsourced to independent sector providers, by VALUE	
	2013	2012
Private acute medical care	4.7%	4.3%
Care Homes: Older/physically disabled residents	90%	89%
Care Homes: Care Homes: Learning disabled / mental health	90%	88%
Homecare (all client types)	86%	86%
Mental health hospitals	28%	27%
Children's homes	69%	62%
Foster care	47%	44%
Special educational needs	34%	34%

Source: LaingBuisson Healthcare Market *Review* 2013-2014

LaingBuisson Healthcare Market Review - 26th edition

The 26th edition of LaingBuisson's Healthcare Market Review includes twelve chapters giving unique market insight into the full range of health, care and special education services in which independent sector providers have a significant presence, plus chapters on:

- Private medical insurance, which is the principal funding source for private hospitals;

- The growing role of Private Equity in UK healthcare, identifying the health and care companies that each of them backs.

- The political and regulatory environment in which independent providers operate

The work also includes Laing's Directory – a fully comprehensive listing of provider organisations, insurers, hospitals and clinics, plus a financial directory of up to 5 years' statutory accounts for over 300 of the largest providers currently operating.

- END OF RELEASE -

LaingBuisson's Healthcare Market *Review* 2013 – 2014 is sponsored by GVA Property Advisors and is available now priced at £425 for hard copy and £785 in a digital package (hard copy, PDF and Excel files). To purchase contact LaingBuisson, 29 Angel Gate, City Road, London, EC1V 2PT. Tel: 020 7923 5396. Fax: 020 7833 9129. www.laingbuisson.co.uk

PRESS COPIES AVAILABLE ON REQUEST

FOR FURTHER INFORMATION:

William Laing
LaingBuisson
CEO
Tel: 020 7923 5399
william@laingbuisson.co.uk

Justin Merritt
LaingBuisson
COO
Tel: 020 7841 0049
justin@laingbuisson.co.uk

Hospital Episode Statistics

Hospital Episode Statistics (HES) processes over 125 million admitted patient, outpatient and accident and emergency records each year.

What is HES?

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver. HES data is designed to enable secondary use, that is use for non-clinical purposes, of this administrative data.

It is a records-based system that covers all NHS trusts in England, including acute hospitals, primary care trusts and mental health trusts. HES information is stored as a large collection of separate records - one for each period of care - in a secure data warehouse.

We apply a strict statistical disclosure control in accordance with the HES protocol, to all published HES data. This suppresses small numbers to stop people identifying themselves and others, to ensure that patient confidentiality is maintained.

Who is HES for?

HES provides data for a wide range of healthcare analysis for the NHS, government and others including:

- national bodies and regulators
- local commissioning organisations
- provider organisations
- researchers and commercial healthcare bodies
- patients, service users and carers.

What are the benefits of HES?

- monitor trends and patterns in NHS hospital activity
- assess effective delivery of care
- support local service planning
- provide the basis for national indicators of clinical quality
- reveal health trends over time
- inform patient choice
- determine fair access to health care
- develop, monitor and evaluate government policy
- support NHS and parliamentary accountability

Why was HES developed?

HES was originally conceived in 1987 following a report on collection and use of hospital activity information published by a steering group chaired by Dame Edith Körner (1921-2000).

Before 1987, only a 10 per cent sample of admitted patient records were collected

User documents

- Read the results of our November 2011-12 HES customer survey [122kb]
- Users and uses of HES [124kb]

Related information

- Go to monthly HES publications
- Go to monthly A&E Quality Indicators
- Go to annual HES publications for:
  - Admitted Patient Care
  - Outpatients
  - Maternity
  - Accident and Emergency
  - Adult Critical Care

nationally. By comparison HES aims to collect a detailed record for each 'episode' of admitted patient care delivered in England, either by NHS hospitals or delivered in the independent sector but commissioned by the NHS.

Admitted patient care data is available for every financial year from 1989-90 onwards. During this period, the mechanisms for collecting the data have changed considerably, often in response to changes in the organisation of the NHS. For example, HES was once initially collated sub-nationally by regional health authorities. In 1996 these bodies were abolished and the NHS-Wide Clearing Service (NWCS) was set up to provide a means of transmitting the records. In 2006 this work was taken over by the Secondary Uses Service, which is run by the Health and Social Care Information Centre and the National Programme for IT.

Initially, data for HES publications was collected annually from provider submissions. After a number of years the frequency of collections increased to quarterly to allow analysis and investigation (these were not published) and a final annual publication was released at the end of the year. HES data is now collected monthly.

PRESS INFORMATION

EMBARGO: FOR IMMEDIATE RELEASE FRIDAY 1 APRIL 2011

NHS'S PRIVATE PATIENT REVENUES STALL

Recessionary pressures and the private patient cap pushed back the NHS's revenues from treating private patients in 2009/2010, according to Laing and Buisson's new NHS Trusts & Primary Care Trusts Financial Information 2011 data product.*

Total private patient income of NHS Trusts in the UK was £430 million in 2009/2010, shrinking by just over 2% from £439 million in 2008/2009. Overall since 2006/2007, there has been no growth in revenues. As a proportion of Trusts' total core income from patient activities, private patient income in the UK fell to just 0.6%.

Private patient activity in England accounts for 96% of the UK total. NHS Trusts in England generate 0.7% of core revenues from private patients, whereas the proportion remains much lower in the rest of the UK (0.2% in Wales, and 0.1% in Scotland and Northern Ireland).

London NHS hospitals lead the way in private patient activity, accounting for the first 8 NHS Trust largest private earners (see Table 1). The Royal Marsden Hospital NHS Trust earned the highest private revenues of all UK Trusts in 2009/2010, at £41.5 million, though this fell from £43 million a year earlier. This equated to 26% of its total core income from all patient activities.

Stalling growth reflects a clear dip in demand for private healthcare funded by medical insurance and from patients' own pockets, which has yet to recover from recessionary cutbacks. In addition growth for Foundation Trusts is limited because their private patient income as a ratio of their total income is capped at 2003/2004 levels. UK private patient revenues have only risen by 9% in the five years since the cap was introduced. Looking forward, however, the proposal to remove this restriction in the Health and Social Care Bill, suggests more positive growth prospects from this source for the NHS.

Agency Costs Up Before Sharp Cuts

The cost of employing agency and other temporary staffing in the NHS in England continued to grow in 2009/2010, as non-NHS staff spending reported by Trusts grew by 17.5% overall from 2008/2009.*

Total agency & other non-NHS staff costs of Trusts in England were recorded at £2.22 billion in 2009/2010, up from £1.89 billion a year earlier, and more than double spending from a low of £0.96 billion in 2006/2007. As a proportion of UK Trusts' total staff costs, agency costs increased to 5.1% in 2009/2010 compared with only 2.7% three years earlier.

However, facing heavy pressure to realise massive cost savings by 2014 under Coalition government NHS reforms, NHS spending on agency & other non-NHS staff is expected to fall back significantly from 2010/11 onwards, as Trusts clamp down on rising permanent and temporary staffing bills.

The highest spenders on agency staff in 2009/2010 were South London & Maudsley NHS Foundation Trust (£52.1 million), Imperial College Healthcare NHS Trust (£48 million), Newcastle Upon Tyne Hospitals NHS Foundation Trust (£44.4 million), Guy's and St Thomas' NHS Foundation Trust (£34.4 million), Royal Free Hampstead NHS Trust (£33.6 million), and St George's Healthcare NHS Trust (£32.1 million).

TABLE 1: INCOME FROM TREATING PRIVATE PATIENTS

Top 10 NHS Trusts	Private Patient Revenue £ million 2009-2010	Private Patient Revenue £ million 2008-2009	Annual Growth %
ROYAL MARSDEN	41.5	43.2	-3.8
IMPERIAL COLLEGE H'CARE	31.0	32.3	-4.0
GREAT ORMOND STREET	21.0	19.7	6.2
ROYAL BROMPTON & HAREFIELD	18.5	21.1	-12.1
ROYAL FREE HAMPSTEAD	17.7	14.4	23.4
GUY'S & ST THOMAS	17.0	14.3	18.8
KING'S COLLEGE HOSPITAL	14.5	14.1	2.9
MOORFIELDS EYE HOSPITAL	13.4	11.3	17.9
OXFORD RADCLIFFE	11.4	9.5	19.7
THE CHRISTIE	10.2	9.6	5.9
TOP 10 TOTAL	196.2	189.6	3.5
UK TOTAL	429.7	439.0	-2.1

- END OF RELEASE -

* NHS TRUSTS & PRIMARY CARE TRUSTS FINANCIAL INFORMATION 2011 (ELECTRONIC VERSION) Price £630.00 inc. vat. Available now from Laing & Buisson, 29 Angel Gate, City Road, London EC1V 2PT. Tel: 0207 833 9123 Web: www.laingbuisson.co.uk

FOR FURTHER INFORMATION:

Philip Blackburn
Laing & Buisson
Analyst
Tel: 0207 833 9123
philipb@laingbuisson.co.uk

Justin Merritt
Laing & Buisson
Creative Director
Tel: 0207 841 0049
justin@laingbuisson.co.uk

NOTES TO EDITORS:

Founded by William Laing in 1986, Laing & Buisson is the UK's leading provider of information and market intelligence on the independent health, community care and childcare sectors.

Laing & Buisson offers a uniquely focused range of expert services to providers, purchasers and investors in the health and community care markets. Information about the range of products and services provided is summarised below.

Annual Directories & Market Reports

Laing & Buisson publishes a series of special market reports and directories on the health and community care sectors. Annual publications include Laing's Healthcare Market Review, Long Term Care: Directory of Major Providers, and the Care of Elderly People Market Survey. The research and conclusions within the reports are frequently cited in parliamentary questions and answers, official documents and company prospectuses, and are regularly drawn upon by the national media.

Consultancy & Market Intelligence

Market intelligence and consultancy work, focusing on non-clinical aspects of health and social care

markets, is tailor-made for companies with an active interest in the sector. Examples of recent work include a report on the future of the independent healthcare sector for the Healthcare Commission, the seminal work conducted by Laing & Buisson on 'A Fair Price for Care' for the Joseph Rowntree Foundation and 'Improving Lives – Improving Life', a report on the key strategic issues facing the long term care sector. Laing & Buisson also frequently assists investors in market due diligence work in the health and care sectors. Laing & Buisson can also offer consultancy on the broader European market through its Healthcare Europa joint venture.

Healthcare Data in an Electronic Format

CareSearch is Laing & Buisson's flagship data product, a 'one stop shop' with extremely flexible search facilities for those needing detailed, reliable and up-to-date information on care homes, independent hospitals, health and care commissioners and regulators in each neighbourhood in the UK, together with details of group operators, their holdings and financial information from statutory accounts. Alternatively, data can be selected specifically and supplied on disks or labels for mailing purposes.

Newsletters

Laing & Buisson publishes three authoritative monthly newsletters - Community Care Market News, which covers the long-term care sector, Healthcare Market News, which covers the acute healthcare sector, and Healthcare Europa, which looks at the private care, healthcare and outsourcing sectors across Europe.

Conferences & Awards

In addition to one-off conferences on subjects selected for their special interest or topicality, Laing & Buisson's annual programme features a series of conferences - definitive events covering key developments and leading edge practice in specific areas including homecare, supported living, extra care housing, long term care for the older people, learning disabilities and mental health sectors, acute healthcare, private healthcare insurance, investing in healthcare and children's nurseries.

The Independent Healthcare Forum consists of two major conferences: the acute healthcare conference and the mental health conference and a workshop for private patient units and smaller providers, with an exhibition area representing a selection of providers to the sector.

The Independent Specialist Care Awards and the Independent Healthcare Awards take place in March and September, highlighting the range of achievements and recognising best practice within the sectors, and paying tribute to those who have demonstrated excellence in their particular fields.

Income from private patients soars at NHS hospital trusts

NHS trusts accused of exploiting raised limit on numbers of paying patients amid health service's 'creeping privatisation'

Nicholas Watt, chief political correspondent

The Guardian, Tuesday 19 August 2014 21.28 BST

Jump to comments (495)

University College Hospital, London, had a 39% increase in private patient revenue from 2010 to 2014. Photograph: Akira Suemori/AP

Some of Britain's leading hospitals stand accused of exploiting the coalition's controversial lifting of the cap on the number of private patients they can treat to increase their income as part of a "creeping privatisation" of the NHS.

As new figures show that some hospitals have seen a big increase of up to 40% in their private income since the cap was lifted, Labour accused ministers of presiding over a scandal of declining standards for NHS patients while allowing paying patients to enjoy high standards of care.

The determination of NHS trusts to make the most of the cap being lifted

Article history

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Guardian Professional

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has been highlighted by the decision of the Royal Brompton Trust, a centre of expertise in treating heart and lung disease, to open a "private outpatient facility" in Harley Street, the world centre of private medical treatment. But less than a mile away from the Brompton Hospital, at the Chelsea and Westminster Hospital on the Fulham Road, west London, there is concern about the implementation of the lifting of the private patient cap. Its annual report lists it as one of the "principal risks and uncertainties facing the trust".

Hospitals were given the right to generate up to 49% of their income from private patients under the terms of the Health and Social Care Act, which was the former health secretary Andrew Lansley's brainchild. Under the rules introduced by the last Labour government for foundation hospitals, the amount of private income was capped at the level reached in 2006. This averaged about 2% around the country but there were regional variations, with higher rates in London.

New figures released under the Freedom of Information Act show that six trusts in London and the south-east have hugely increased their private patient income since the passage of the Health and Social Care Act in 2012. The figures, released to the shadow minister for London, Gareth Thomas, showed an increase in private patient income at:

• University College Hospital Trust in London by 39.63% – from £7.3m in 2010 11 to £10.3m in 2013 14.

• Royal Brompton Hospital Trust in London by 37.7% – from £24.3m to £33.6m.

• Moorfields Eye Hospital in London by 31.84% – from £16.1m to £21.3m.

• Papworth Hospital Trust in the South Cambridgeshire constituency of the former health secretary Andrew Lansley by 29.9% – from £4.9m to £6.4m.

• Royal Surrey County Hospital Trust, which serves the South West Surrey constituency of the health secretary, Jeremy Hunt, by 25.6% – from £3.6m to £4.6m.

• Chelsea and Westminster Hospital Trust in London by 20.99% – from £10.7m to £13m.

Thomas told the Guardian: "When more people are waiting on trolleys or waiting longer to see their GP, it is a scandal that top hospitals are allowed to prioritise increasing income from private patients. Lifting the cap on the level of private patient income is just one further example of the creeping privatisation of NHS services."

"Ministers said that lifting the cap wouldn't make a dramatic difference. What is quite clearly the case is that a number of NHS hospitals have rapidly expanded their private patient services at the same time as services to NHS patients have deteriorated."

He was highly critical of the Royal Brompton Hospital Trust, which boasts in its annual report of how it has "built a significant private patient business" that has exceeded £30m for the first time. The report said the trust had created a special logo for private patients and said it would open a clinic in Harley Street to improve "brand awareness".

The annual report said: "The trust considers that a presence in the Harley Street area of London would increase both brand awareness and market share within central and north London as well as from international patients. With this in mind, the trust intends to open a private outpatient facility in that area in the coming year."

Weekend staff shortages are the fatal flaw at the heart of the NHS

NHS patient groups warn more doctor assistants may be 'healthcare on cheap'

A sick joke: the NHS in 2024, as seen by GP and graphic novelist Ian Williams

Guardian Professional Could community services be the Lidl of the NHS?

Guardian Professional 'The biggest challenge facing the NHS is the demand of an ageing population'

Andrew Collins' week in TV
Telly addict **Andrew Collins** gives his verdict on this week's TV, including Mapp & Lucia, Downton Abbey, Miranda and The Wrong Mans
25 comments

Palestinian football team joins the party ahead of 2015 Asian Cup
Palestine's hurdle-jumping national football team parties into the evening at Sydney's Palestinian Club

How did darts get its own Sky Sports channel?
We ask how darts generated such a big following

Puskás Award 2014: the top three goals – brick-by-brick
A reimagining of the contenders for the Puskás Award

35 comments

Thomas said: "Hospitals have gone out of their way to exploit the lifting of the private patient cap at the same time as waiting lists have got longer and services in A&E have got worse. This sounds like Brompton hospital has lost sight of the fact that they are an NHS hospital first and foremost, and they should prioritise the needs of NHS patients, not building up more private patient income."

But the Chelsea and Westminster Hospital Trust raised concerns about the implementation of the private patient cap. It said in its annual report: "There remain uncertainties around the impact of the practical implementation of the Health and Social Care Act, in particular the transfer of responsibility for commissioning services to GPs, the relaxation of the private patient income cap, more choice for patients and increased competition. The overall trust strategy has taken these issues into account and plans are in place to mitigate and/or benefit from these changes." The report added: "Private income currently accounts for 5% of the trust's overall income.Tony Bell OBE [chief executive] on 25 February 2014 said he would like the trust to increase this figure. We trust that any concentration on promoting the most profitable services do not have any negative impact on the NHS clinical services the hospital provides."

Government sources said the increase in private patient income, which has to be invested in NHS services, was unsurprising in leading London hospitals, which have a lengthy history of treating private patients from around the world.

The income from private patients in English NHS trusts as a whole has barely changed since the lifting of the cap. Income from private patients accounted for 0.69% of overall provider income in England 2012-13, rising slightly to 0.7% in 2013-14. It stood at 0.71% in 2010-11 and 0.68% in 2011-12.

A government spokesman said: "Hospitals are treating record numbers of NHS patients, with 850,000 more operations being carried out each year than under the last government. NHS hospitals have always been able to generate small amounts of additional income – which has remained well below 1% of hospitals' total income in the last four years – by treating private patients, every penny of which is used to improve the services that NHS patients receive."

A spokesman for the Papworth Hospital Trust said: "Papworth Hospital is internationally renowned for cardiothoracic care and subsequently attracts patients both within the NHS and those looking for private healthcare. Although private practice does complement the lifesaving services provided at Papworth Hospital, it makes up just 5% of the overall activity, which is below the current and previous allocated private patient allowances set by government. Revenue generated from private practice at Papworth Hospital supplements patient care and research to further develop lifesaving treatments that benefit thousands of patients every year."

A spokeswoman for Moorfields said: "Moorfields' main focus is the treatment of NHS patients and our private patient activities exist to entirely to augment and support the care we provide to NHS patients. Changes to the cap enabled the trust to pursue our strategy for growth in our commercial activities, which includes, but is not limited to, treating private patients in the UK so as to generate more income for reinvestment in services for NHS patients, without impacting on our NHS activity. Although our private patient income has increased it represents 12% of our total income in 2013-14 as compared to 13% in 2010-11."

The Guardian approached the Royal Brompton Hospital Trust, Chelsea and Westminster, University College Hospital, and Royal Surrey for comment but none had responded at time of publication.

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NHS income from private patients rose 12% in 2012-13

Income from private patient procedures has risen by 12% in English NHS hospitals and is forecast to rise a further 10% over the next 12 months.

A Freedom of Information request by Labour MP Gareth Thomas has revealed that English NHS hospitals saw a £47 million growth in private patient income in 2012-13, with £434 million earned from private patient fees.

Hospitals have predicted that private patient income will grow to £480 million in 2013-14.

Under the Health & Social Care Act 2012 NHS hospitals can now raise up to 49% of their funds through non-NHS work.

Ealing Hospital NHS Trust experienced a 250% increase in income generated from private payers over the last two years. Great Ormond Street hospital saw a 58% rise during the same period. Meanwhile, Nottingham University Hospitals NHS Trust has budgeted for a 30% rise over the next year.

Commenting on these figures, Thomas said: “With yet more increases to come this year, it’s clear that under David Cameron a two-tier health service is emerging; pay privately and you’ll be seen quickly – don’t pay privately and join an increasingly long waiting list.”

A spokeswoman for the Department of Health said that the “figures need to be put into context” as the figures represent less than 0.5% of the NHS budget for 2013-14.

“This income must be reinvested back into NHS services and patients will benefit from increased investment in facilities and new technology,” she said.

The spokeswoman added that average waiting times in NHS hospitals are “low and stable” and “the number of patients waiting longer than 18 weeks is nearly 55,000 lower than in May 2010”.

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Chee Yam Cheng, the current chief executive of the Singapore-based National Healthcare Group (NHG), will step down on Saturday.

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Santander has appointed Graham McKean has head of SME healthcare and Mark Pavis as head of corporate healthcare at the bank.

Bupa to up stake in Max Bupa to 49%
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Bupa has announced that it is to increase its stake in Indian private health insurer Max Bupa Health Insurance (Max Bupa) from 26% to 49%.

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Although Britain has seen two successful healthcare IPOs this year, much of the action has been in Australia and the Middle East. Adrian Murdoch reports

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PRESS INFORMATION

FOR IMMEDIATE PUBLICATION: 29 JANUARY 2014

UK independent healthcare markets remain stable at £40bn in 2012/13 with the future bright as public sector outsourcing continues apace

Published today, the 2013-2014 edition of LaingBuisson's annual Healthcare Market Review calculates that revenues generated by independent sector providers in the 12 health and care market segments it monitors stood at £40.5bn in 2012/13 (2011/12: £39.9bn).While there have been some gainers and some losers, the grand total of £40bn is not significantly different from the previous year, reflecting subdued private spending out of disposable income and budget constraints amongst NHS and council purchasers of health and care services.

Table 1 UK Independent Healthcare Market Value by sub-sector

Health/Care market	Value of services provided by the independent sector, UK 2012/13
Private acute medical care	£6.7bn
Care Homes: older/physically disabled	£13.4bn
Care Homes: learning disabilities/mental illness	£3.1bn
Homecare (all client types)	£5.9bn
Mental health hospitals	£1.1bn
Children's homes (England only)	£0.7bn
Foster care (England only)	£0.7bn
Special educational needs (England only)	£1.2bn
Primary care dentistry (Dentists with NHS practices counted as 'independent')	£5.7bn
Primary medical care (England only)*	£0.7bn
Commercial occupational health services	£0.25m
Community health services	£1.0bn
Total	**£40.5bn**

* of which: private GPs earn £0.5bn

Source: LaingBuisson Healthcare Market *Review* 2013-2014

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Speaking at a launch event hosted by report sponsor GVA, LaingBuisson CEO William Laing said:

'Independent healthcare is still feeling the repercussions from the 2008 global credit and ensuing recession. Private demand for hospital treatment has been flat for five years, and private demand for care homes for older people has only kept growing because of the expanding older population and because private payers fund long term care out of assets rather than disposable income.'

'Looking forward, LaingBuisson believes that the better economic news of the last few months will – if continued - boost private spending on healthcare again, though past experience shows that there is often a lag, so it may not be until the end of 2014 that we see evidence of increased private spending on healthcare'.

Tight public sector budgets mean more outsourcing

2013 witnessed a continuation of the established outsourcing trend across nearly all publicly funded segments of health and care services – as illustrated for selected markets in Table 2 (below).

William Laing explained: 'There are two drivers of this broad-based outsourcing trend, which has been in progress for more than three decades in some segments: Cost (e.g. for care homes and homecare, where public sector costs are up to double independent costs on a like for like basis); and Choice (e.g. in elective surgery and special education, where both Labour and Coalition

administrations have sought to give individual consumers options other than public sector provision).'

Table 2 Public sector outsourcing in selected health and care markets

Health/care market	Share of public sector services which are outsourced to independent sector providers, by VALUE	
	2013	2012
Private acute medical care	4.7%	4.3%
Care Homes: Older/physically disabled residents	90%	89%
Care Homes: Care Homes: Learning disabled / mental health	90%	88%
Homecare (all client types)	86%	86%
Mental health hospitals	28%	27%
Children's homes	69%	62%
Foster care	47%	44%
Special educational needs	34%	34%

Source: LaingBuisson Healthcare Market *Review* 2013-2014

LaingBuisson Healthcare Market Review - 26th edition

The 26th edition of LaingBuisson's Healthcare Market Review includes twelve chapters giving unique market insight into the full range of health, care and special education services in which independent sector providers have a significant presence, plus chapters on:

- Private medical insurance, which is the principal funding source for private hospitals;

- The growing role of Private Equity in UK healthcare, identifying the health and care companies that each of them backs.

- The political and regulatory environment in which independent providers operate

The work also includes Laing's Directory – a fully comprehensive listing of provider organisations, insurers, hospitals and clinics, plus a financial directory of up to 5 years' statutory accounts for over 300 of the largest providers currently operating.

- END OF RELEASE -

LaingBuisson's Healthcare Market *Review* 2013 – 2014 is sponsored by GVA Property Advisors and is available now priced at £425 for hard copy and £785 in a digital package (hard copy, PDF and Excel files). To purchase contact LaingBuisson, 29 Angel Gate, City Road, London, EC1V 2PT. Tel: 020 7923 5396. Fax: 020 7833 9129. www.laingbuisson.co.uk

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FOR FURTHER INFORMATION:

William Laing
LaingBuisson
CEO
Tel: 020 7923 5399
william@laingbuisson.co.uk

Justin Merritt
LaingBuisson
COO
Tel: 020 7841 0049
justin@laingbuisson.co.uk

29 August 2010 Last updated at 01:17

Government confr ms plan to scrap NHS Direct helpline

The government has confirmed it is planning to scrap the NHS Direct telephone service in England and replace it with an alternative service.

Nick Chapman, chief executive of NHS Direct: "The new helpline will be better and more cost effective than NHS Direct"

A new 1-1-1 helpline is already being piloted in north-east England.

It was previously reported that the new service may replace NHS Direct, but now the Department of Health has confirmed it will definitely do so.

The move comes as the government curtails public spending, even though it has promised to protect the NHS.

The change will not affect existing NHS helpline services in Scotland and Wales.

Health Secretary Andrew Lansley announced the plan to scrap NHS Direct in England during a hospital visit this week.

NHS Direct currently employs more than 3,000 staff, 40% of whom are trained nurses. It is understood the ratio on the 1-1-1 helpline is "slightly less" in the pilot, but no figures are yet available for what will happen when the scheme is rolled out nationally.

Critics claim the change would undermine the quality of the service by reducing the number of qualified nurses answering calls, but chief executive of NHS Direct Nick Chapman told the BBC the new helpline would be better and more cost effective than NHS Direct.

He said: "More value for money doesn't necessarily mean that something will be worse. It will be a more seamless service."

He said the 1-1-1 helpline's telephone number would also be easier for callers to remember than the current NHS Direct one.

In June GPs urged the government to get rid of NHS Direct, claiming it was not cost effective.

The plan has provoked an angry reaction from Labour, with shadow health secretary Andy Burnham using it as evidence of what he claims is the government's intention to "dismantle" the NHS.

He said: "The health secretary's statement will stun people across the NHS.

"It is yet more evidence that Andrew Lansley is on a vindictive mission to break up the NHS, ruthlessly dismantling services before alternatives are in place."

Mr Burnham told the BBC that the government had shown "arrogance" and acted in a "cavalier" way by choosing to scrap NHS Direct without

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consulting the public.

He said the service saved the NHS £200m a year and played a key role in taking pressure off the health service.

He said: "It's been a proven success for a decade and simply to scrap it is no way to run the NHS."

Roughly 14,000 people a day call NHS Direct for medical advice, with the service costing £123m a year to run.

Lord Prescott: "You know you are talking to a nurse or a doctor; to have a call service will not be the same."

Former Labour health secretary Frank Dobson, who helped establish NHS Direct in 1998, told the BBC the decision to replace the service was "crackers," and said the professionally staffed advice line would be replaced with a "call centre".

His views were echoed by former deputy prime minister, Lord Prescott, who urged the public to sign an online petition he initiated to save the helpline.

He said people would lose trust in using the new service if it was staffed by fewer qualified nurses.

He told the BBC: "It will be a lesser service determined by saving money.

"(The government) told us they would cut the deficit, not the NHS. This is another promise broken."

Staff will be 'devastated'

Dr Peter Carter, chief executive and general secretary of The Royal College of Nursing , said reducing the number of specialist nurses who worked on the new helpline was "short-sighted."

He said: "We urge the government to consult fully and look at all the evidence before enacting changes which could leave people without expert advice from trained nurses."

Gail Adams, head of nursing for the public service union Unison, told the BBC that NHS Direct staff would be "devastated" by news that the service was to be scrapped.

She said the service's success was based on "compassionate nurses providing sensitive care," and that less qualified staff could not offer the same level of expertise and reassurance to the public.

BBC political correspondent Arif Ansari said NHS Direct had a "mixed record," with critics complaining that its staff were too cautious in their advice to callers.

"There are people who have used NHS Direct and say they did not get a lot from it," he said.

Mr Ansari said GPs were unhappy that many callers were unnecessarily referred to their local hospital when they did not require treatment there.

Mr Chapman said staff involved with the 1-1-1 helpline "pathfinder" in north-east England were currently working with the local ambulance service to handle calls relating to health information or inquiries about medicines.

He said the service would also be tested in the East Midlands and in the East of England, where helpline staff would also assist with nurse assessment, health information and referrals.

"When detailed plans are made to roll out the service nationally, we hope NHS Direct staff will be able to contribute their experience to the new

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service," he said.

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ANNEX A – DETAILED TABLES

NHS 111 minimum data set - data to May 2013

Table 1: Key indicators across sites

Key indicators - access & quality	North	M&E	South	London	All sites	England[1]
% abandoned calls (after 30 seconds waiting time)	1%	4%	5%	2%	3%	
% calls answered in 60 seconds	96%	86%	85%	93%	90%	
% answered calls triaged	81%	79%	80%	80%	80%	
% answered calls transferred to clinical advisor	20%	24%	20%	19%	22%	
% transferred calls live transferred	81%	71%	51%	62%	86%	
Average NHS 111 live transfer time (mins)[2]	00:02:17	00:01:52	00:00:16	00:00:57	00:01:26	
Average warm transfer time (secs)	NCA	NCA	NCA	NCA	NCA	
% answered call passed for call back	4%	7%	10%	7%	6%	
% call backs within 10 minutes	45%	54%	25%	59%	47%	
Average episode length	00:08:50	00:13:03	00:25:30	00:11:08	00:12:49	

Key indicators - costs						
% handling time by clinical staff	25%	30%	17%	NCA	27%	

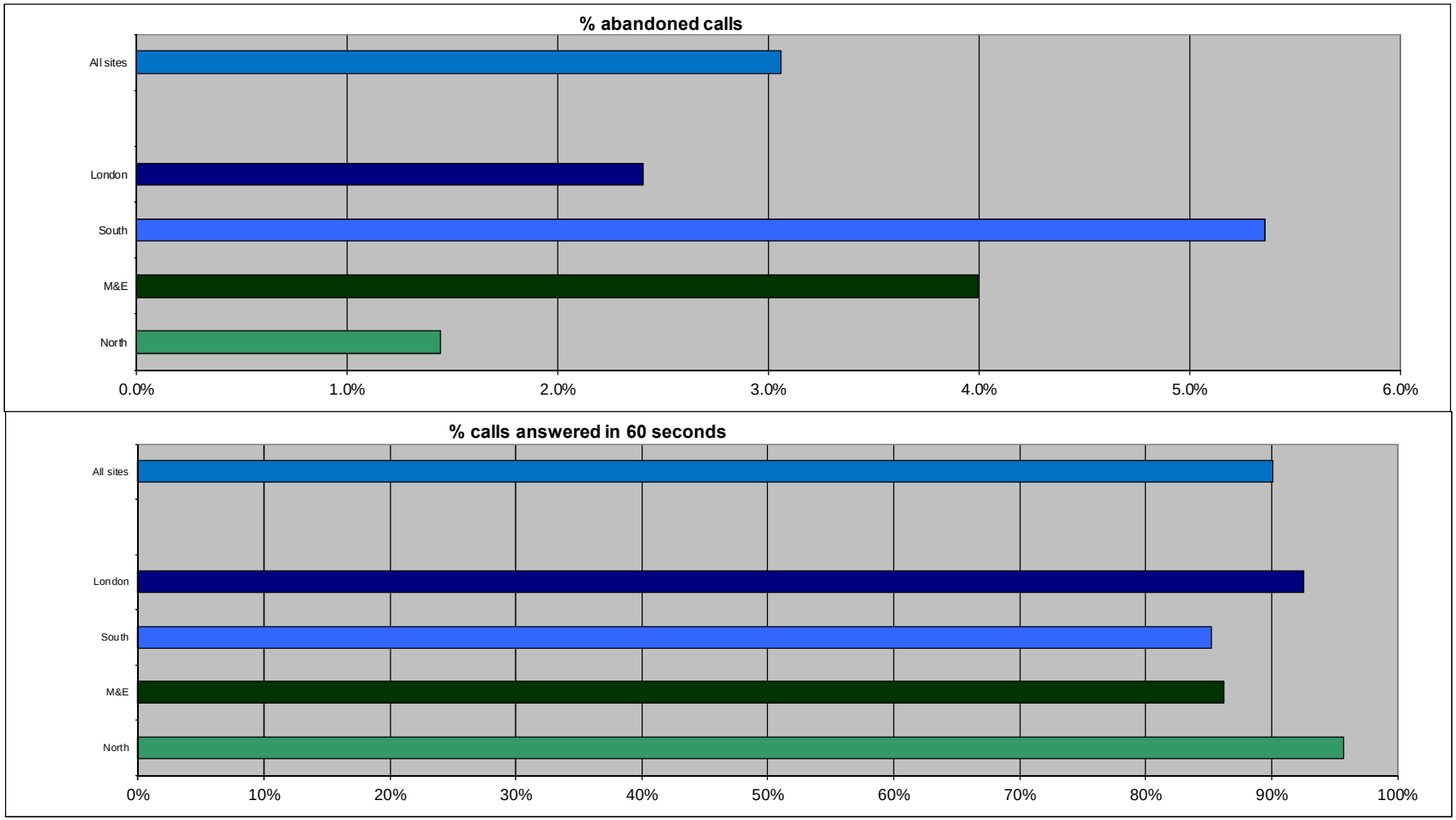
Key indicators - patient experience						
% dissatisfied with 111 experience	4%	5%	2%	5%	5%	
% very or fairly satisfied with 111 experience	93%	92%	96%	89%	92%	
% callers who fully complied with advice	89%	88%	93%	93%	89%	
% callers where problem resolved or improved	83%	82%	82%	84%	83%	

Key indicators - system impact [3]						
% 111 triggered ambulances transporting patient	73%	68%	52%	81%	70%	
111 dispositions: % Ambulance dispatches	11%	9%	7%	10%	9%	
111 dispositions: % Recommended to attend A&E	6%	5%	5%	5%	6%	
111 dispositions: % Recommended to attend primary and community care	51%	49%	51%	50%	50%	
Of which - % Recommended to contact primary and community care	36%	34%	35%	37%	35%	
- % Recommended to speak to primary and community care	10%	12%	12%	10%	11%	
- % Recommended to dental / pharmacy	5%	3%	4%	3%	4%	
111 dispositions: % Recommended to attend other service	3%	5%	7%	4%	4%	
111 dispositions: % Not recommended to attend other service	29%	32%	30%	31%	31%	
Of which - % Given health information	1%	2%	2%	1%	2%	
- % Recommended home care	6%	7%	5%	6%	6%	
- % Recommended non clinical	4%	6%	4%	4%	5%	
- % of calls not triaged	18%	18%	19%	19%	18%	

Key indicators - system impact: data to January 2012						
% annual change: A&E attendances[5]	-3%	1%	-4%	1%	-1%	2%
% annual change: GP out of hours consultations[7]	14%	-3%	18%	-8%	9%	NA
% annual change: Urgent care centre attendances[5, 6]		NCA	-7%	5%		2%
% annual change: Walk in centre attendances[5, 6]		10%	2%	4%		
% annual change: Calls to NHS Direct 0845	-46%	-43%	-29%	-15%	NCA	-7%
% annual change: Ambulances arriving at scene	8%	9%	7%	14%	-21%	3%

NHS 111 minimum data set - data to May 2013

Chart 1: Volume and access issues - individual sites



NHS 111 minimum data set - data to May 2013

Chart 2: During the call issues - individual sites

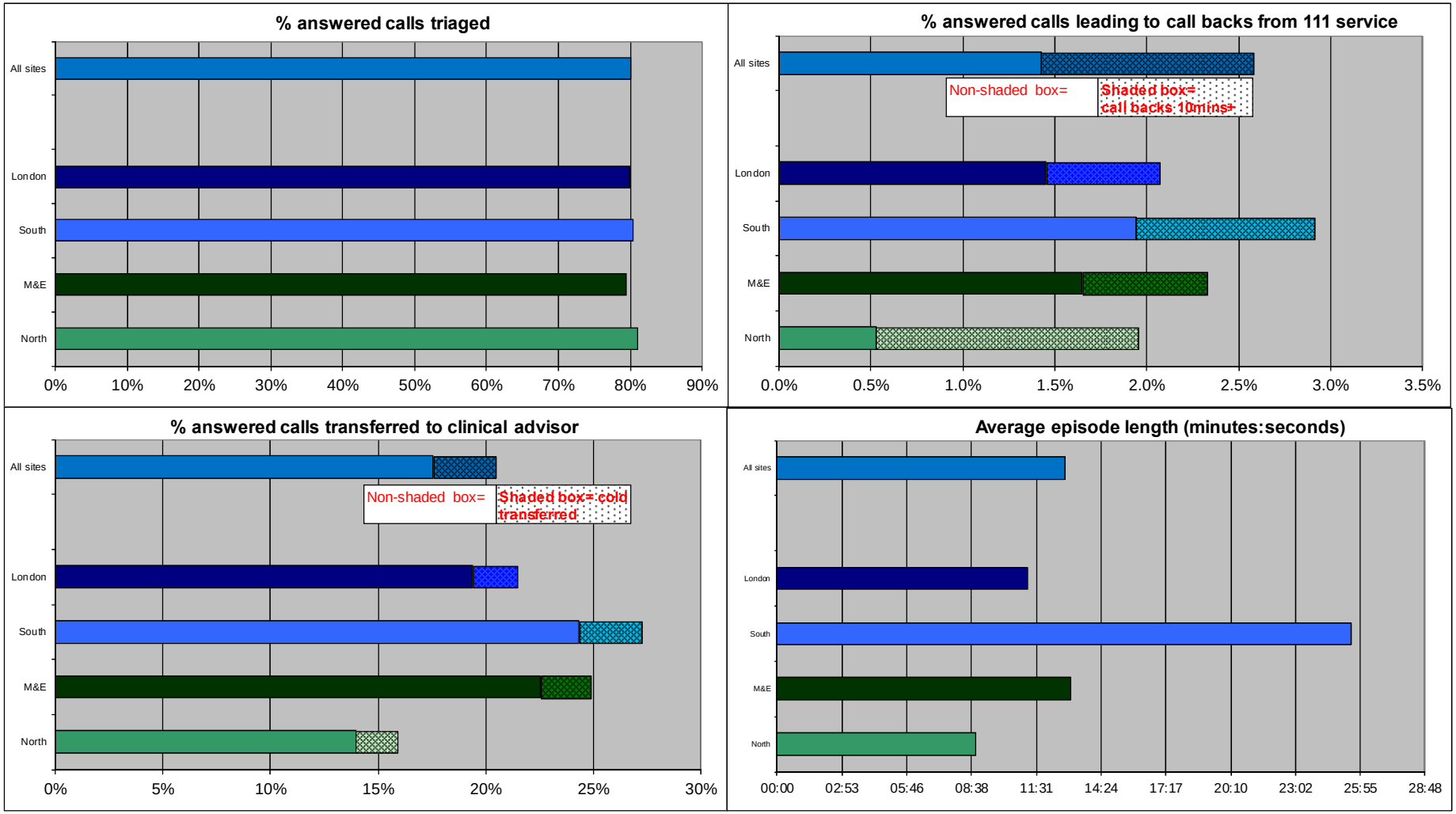
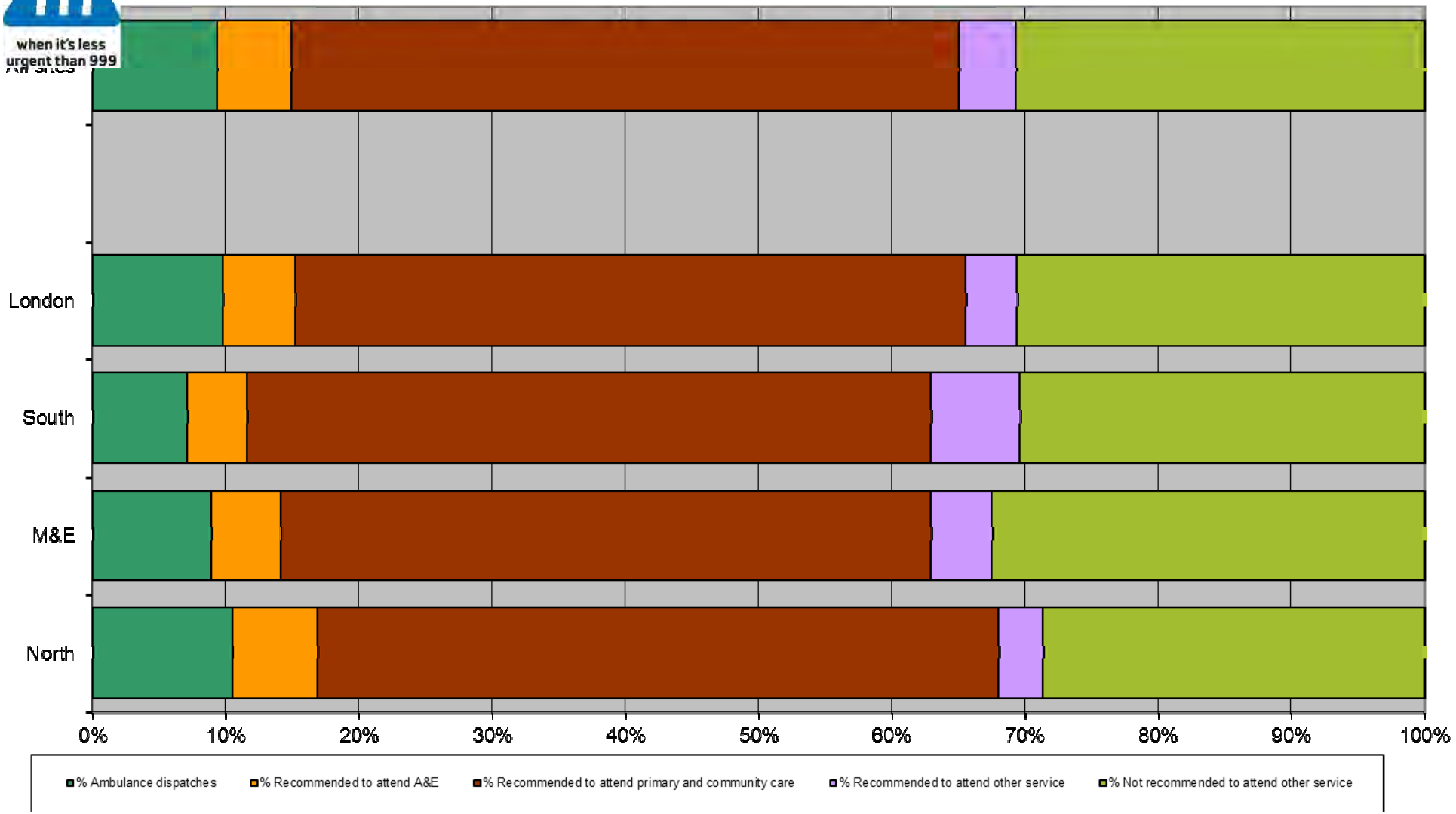
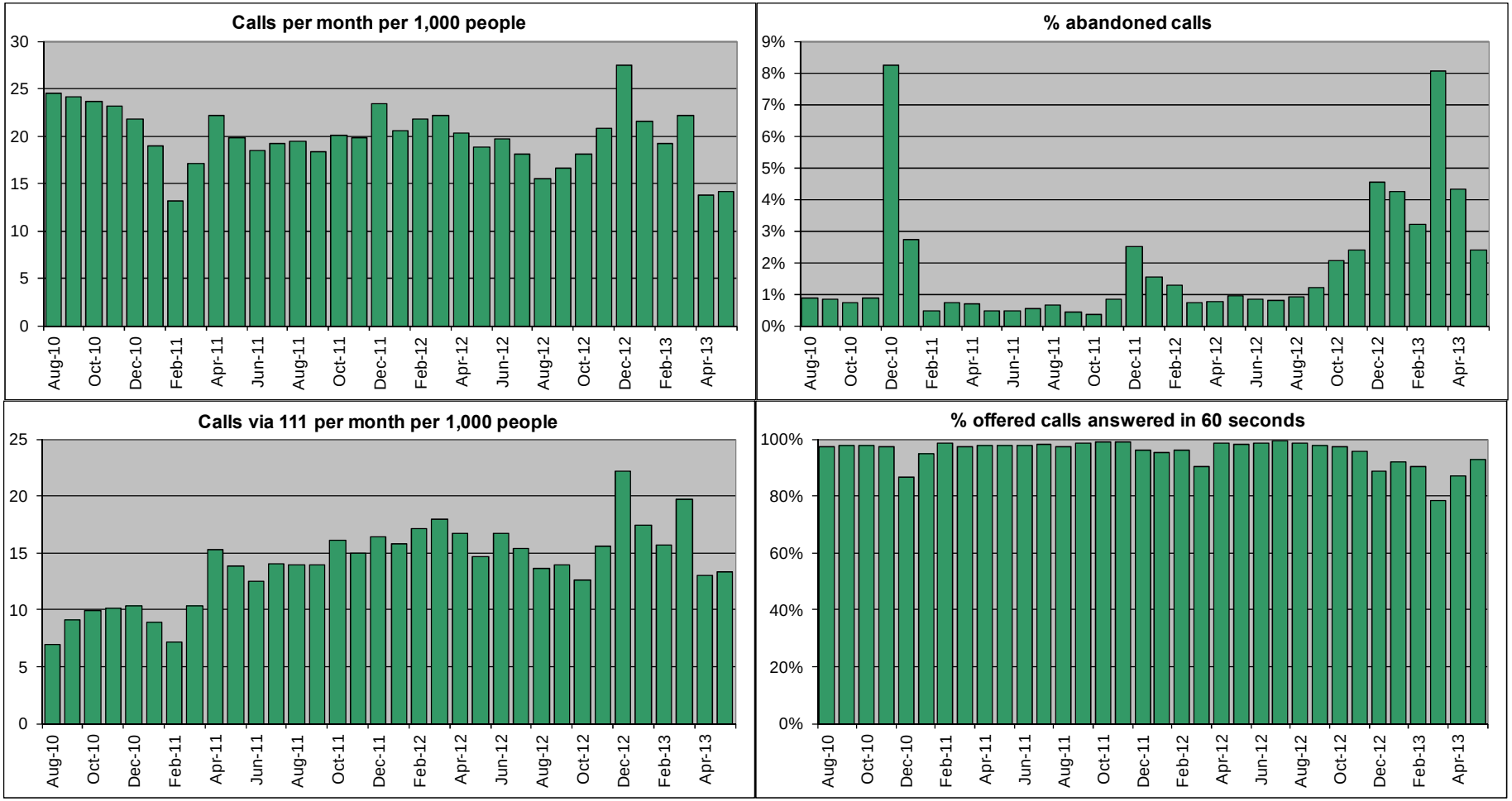


Chart 3: Dispostions immediately following NHS111 calls - individual sites
Data to May 2013



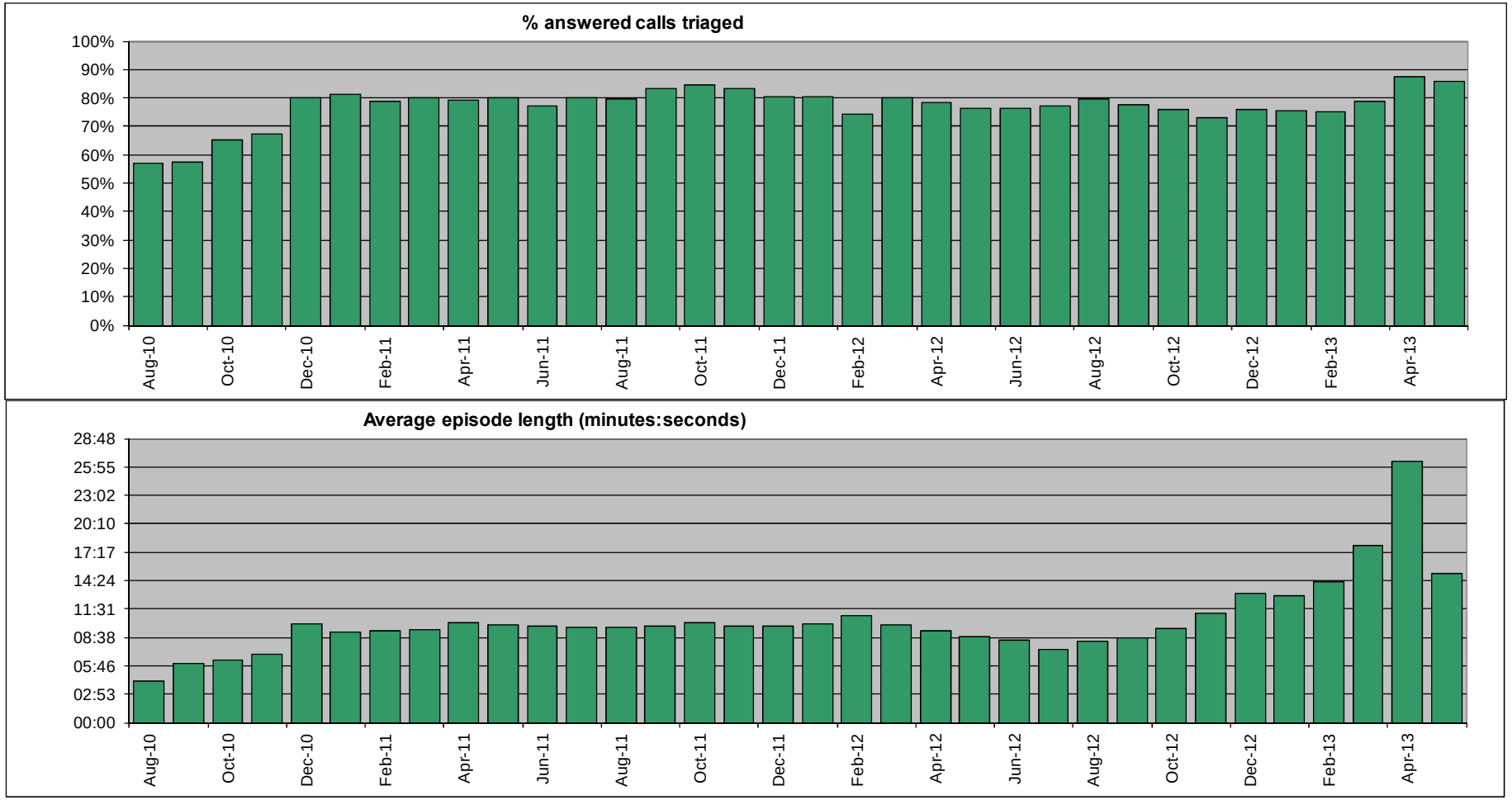
NHS 111 minimum data set - data to May 2013

Chart 4: Volume and access issues: totals over time



NHS 111 minimum data set - data to May 2013

Chart 5: During the call issues: totals over time



NHS 111 minimum data set - data to May 2013

Chart 5: During the call issues: totals over time

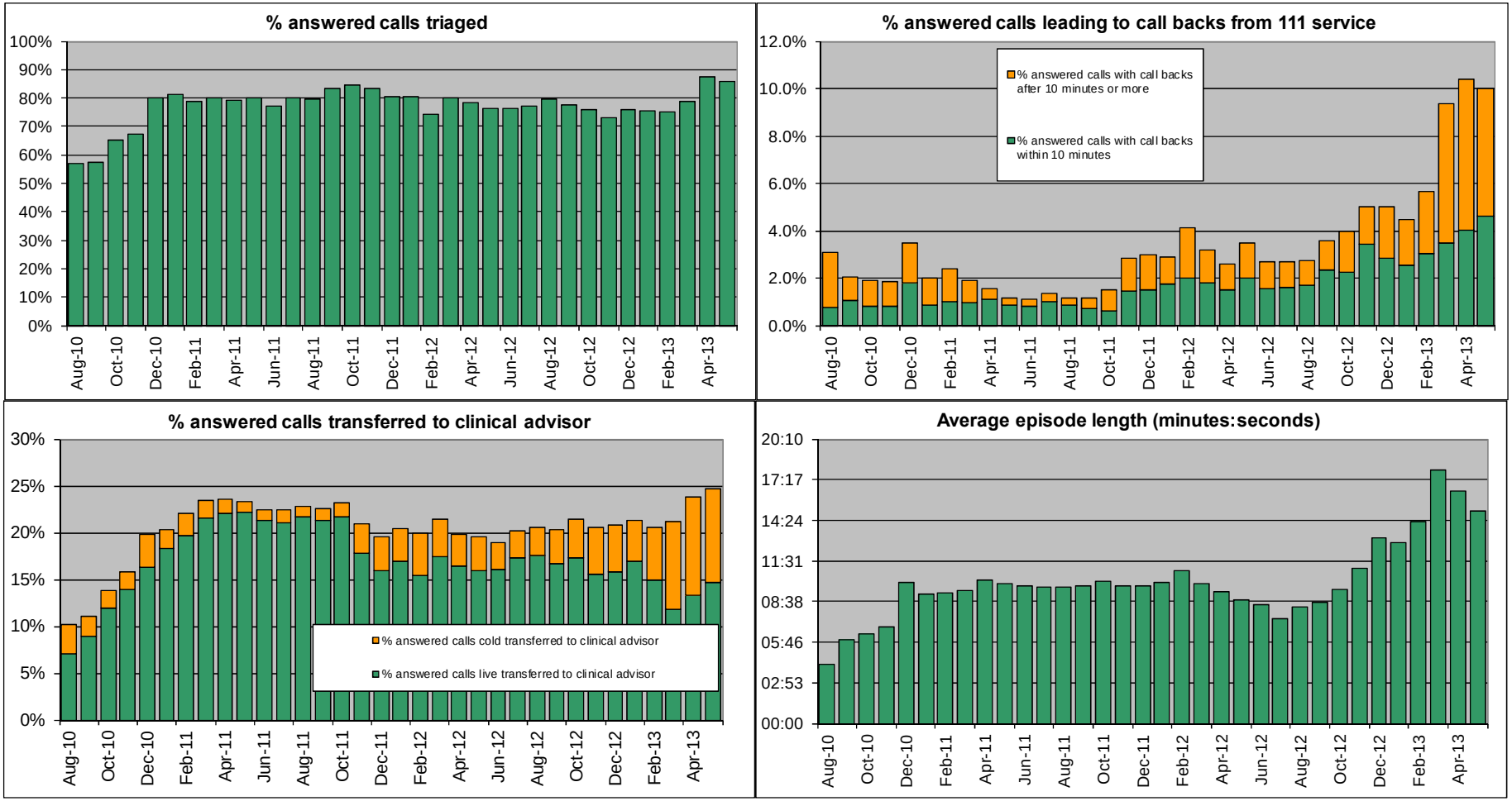
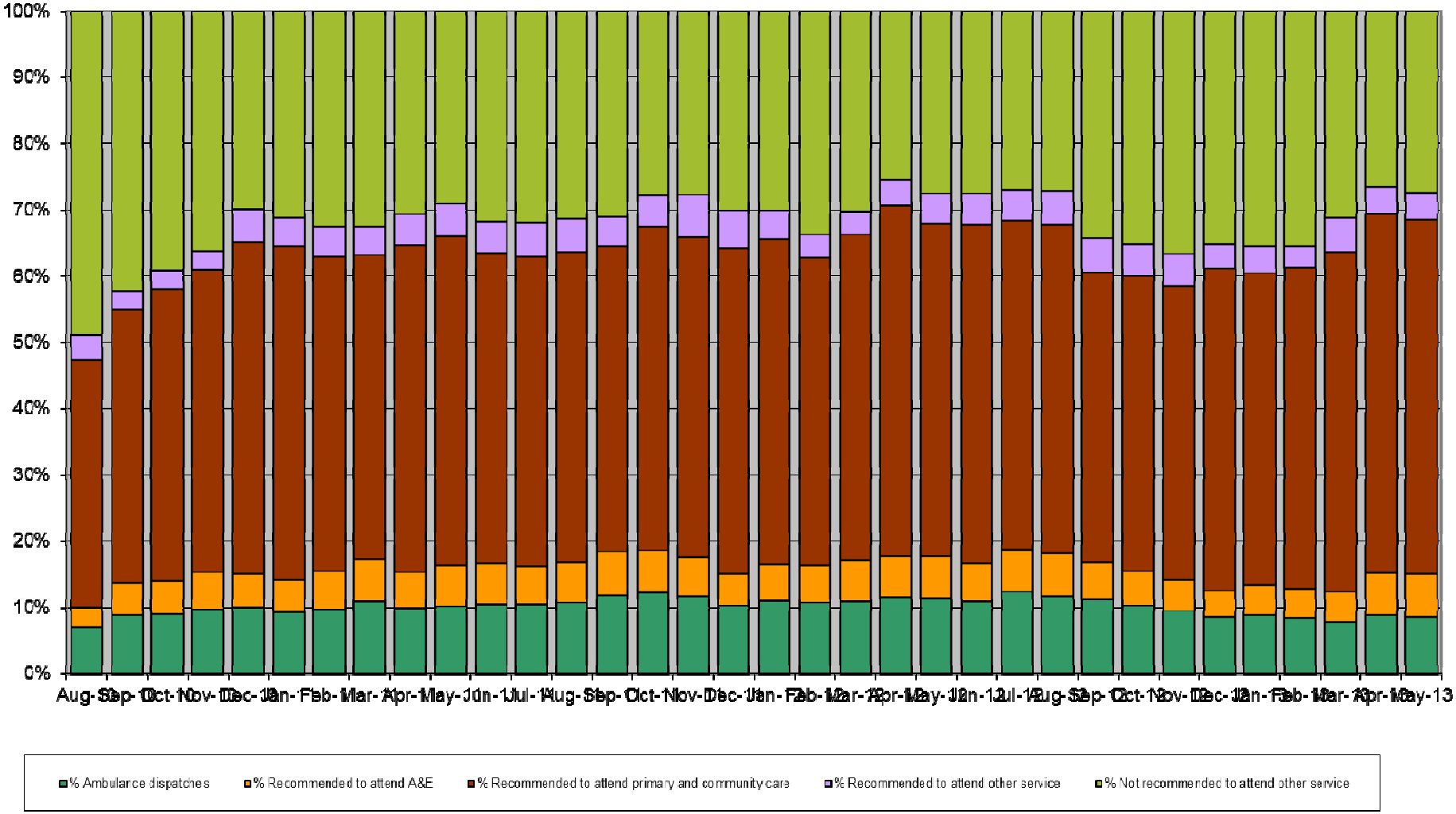


Chart 6: Dispostions immediately following NHS111 calls - data until May 2013



Statistical Notes

Additional Information:

Further details of the NHS 111 minimum dataset for individual organisations is available at:
http://transparency.dh.gov.uk/category/statistics/nhs-111-statistics/

Data Sources:
NHS111 pilot sites, NHS111 Commissioners, Department of Health, NHS Direct

Announced Changes:
We are continuing to work with all data providers involved in this return to further improve data availability and quality. All published data are the latest position available rather than the definitive position. If historical data are revised in any way then this will be reflected in the NHS 111 Minimum Data Set.

Key areas of ongoing work are listed below. Any material changes to the data or presentation of the NHS 111 Minimum Data Set are listed below by month of publication, beginning with the most recent update.

1. **Ongoing data quality work:**

- **Data tagging:** There is currently some variability in how some MDS data items are calculated between pilot sites. We are continually working with providers to understand these variations and a big part of this work are data tagging exercises that take place with each new provider. This work includes mapping the data collection process and identifying where each MDS data item is to be collected. These process maps can then be used to compare how data items are calculated between different providers.

- **MDS Format**: The format in which the data is presented, is currently being reviewed. This is to help incorporate a number of new sites into the statistical release as new sites go live.

2. **Material Changes**

Release date, 5 July, 2013 – May data.

- South Essex and Oxfordshire have only been able to provide a partial return because of data problems. We are working the provider and commissioners on this.

Release date, 7 June, 2013 – April data.

- Systems impact data has now become available for Herts and GY&W.
- South Essex and Oxfordshire have only been able to provide a partial return because of data problems. We are working the provider and commissioners on this.
- Patient Satisfaction Survey Results have also been published for up to March 2013.

Release date, 10 May, 2013 – March data.

- Oxfordshire are still struggling to report on times. We are working with the provider to rectify this.

Release date, 11 Apr, 2013 – February data.

- S&M have had problems providing a full set of data, Caller Not Triaged data cannot be accurately reported at this time. The problem has now been rectified for next month's submission.

Release date, 08 Mar, 2013 – January data.

- Harmoni revised their data to provide more accurate Caller Not Triaged figures. This is now rectified for future submissions.
- Population figures for Lancashire were revised to show a more accurate estimate.

Release date, 01 Feb, 2013 – December data.

- INWL Revised data for their total call backs to accurately reflect calls transferred.
- The most recent patient satisfaction survey results are now available for April – October 2012.
- Systems impact data for INWL is now available.

Release date, 11 Jan, 2013 – November data.

- Both Hillingdon and Croydon sites are unable to provider “Average Live Transfer” and “Average Episode Length” times. We are working with providers to ensure this is corrected.

- Derby revised their calls offered to account for missing calls in the ‘abandoned in under 30 seconds calls’ field.

Release date, 30 Nov, 2012 – October data.

- Both Hillingdon and Croydon sites are unable to provider “Average Live Transfer” and “Average Episode Length” times. We are working with providers to ensure this is corrected.

- The population figure for The North West has been changed to show the most up to date figure.

Release date, 02 Nov, 2012 – September data.

- In Reasons not triaged, we have amended the figures in “reason for non-triage: other” to a balancing figure to ensure all answered calls are accounted for. Previously there were missing calls, which were not recorded in the MDS submission.

- INWL revised call volume data for August 2012, giving a more accurate account of calls offered.

- From September, ‘Calls not triaged: other reason’ is now a balancing figure to ensure all answered calls are accounted for in the MDS. There has therefore been an increase in this data field.

Release date, 04 Oct, 2012 – August data.

- Systems impact data and patient satisfaction survey results have now become available for Derbyshire. This is the first month Derbyshire have been able to provide a full set of data, including answered with 60 seconds.

- The population figure for Derbyshire has been changed to reflect them being in the final stage of their roll out process.

Release date, 31 Aug, 2012 – July data.

- As detailed last month, we have had to use estimated figures for CDD from 23rd June – 11th of July. This problem has now been resolved. (see below for more details).

- CDD have revised the disposition break down of triaged calls, from January 2012 – June 2012. This was due to miscalculation.

- Systems impact data for Isle of Wight has now become available.

Release date, 3 Aug, 2012 – June data.

- We have had to use estimated figures for CDD for part of the month. From 23rd June – 11th of July, Cable and Wireless could not remove phantom calls from CDD, this meant that call volume looked to have doubled. Using estimated figures has given the most accurate data set possible. This problem has now been resolved.

Release date, 6 July, 2012 – May data.

- CDD revised their "recommend to attend primary care" figures for December - May 2012. This is because they uncovered an error with how it was being calculated. This has now been rectified.

- Isle of Wight reported 0 calls under "reasons not triaged". This is due to a misunderstanding of what to record under that field. We are working with the provider to get an accurate figure.

- Data from one new live site will be included in the MDS, Inner North West London. Call level data has been included to the MDS publication.

- Hillingdon and Croydon both revised their call level data for April 2012. While reporting for May, April's figures were discovered to be incorrect. This was due to how they submitted their figures to DH. This has now been rectified.

Release date, 8 June, 2012 – April data.

- CDD revised their "answered through 111" and "answered through other" figures for March 2012. This is because they uncovered an error with how it was being calculated. This has now been rectified.

- Patient experience data from October to March of 2012 has been finalised and a full set of figures included. Derbyshire's data is not currently available. we are working with the provider to get this data. It will be included in the MDS when it has been finalised.

- Data from two new live sites will be included in the MDS, Croydon and Hillingdon. Call level data has been included to the MDS publication.

Release date, 4 May, 2012 – March data.

- This month shows revised data for County Durham and Darlington. The 'Average episode length' figures for Dec – Feb were changed due to erroneous data being found.

- Population data has been updated for Derbyshire to show a more accurate population figure.

Release date, 30 March, 2012 – February data.

- This month shows the refreshed MDS data for: County Durham and Darlington, Lincolnshire, Luton and Nottingham City. Providers revised data from their go live date to December 2011 to ensure the most accurate data possible is being used.

Release date, 2 March, 2012 – January data.

- The presentation of the system impact data on the "Providers-indicators" tab has changed. Some additional context has been added to show the actual A&E attendance and ambulance incident figures. The actual number of NHS111 referrals for the relevant month are also shown. All of these figures are already included in the MDS but they have been introduced into this presentation to provide some contextual information.

- Some corrections were made to the last edition of the MDS. The amended version is available on the NHS111 statistics website and a summary of these amendments included in this workbook.

- Refreshed data from the first four sites (County Durham and Darlington, Lincolnshire, Luton and Nottingham City), from go live to Dec 2011, will be included in the next release of the MDS (March 30).

Release date, 3 February, 2012 – December data.

- Data from a new live site will be included in the MDS, Cumbria and Lancashire – 1st phase. Call level data has been included to the MDS publication.

- Population figures have been updated to reflect those in the ONS mid 2010 estimates for resident populations of Primary Care Organisations (PCOs). These were previously based on mid-2009 figures.

- The time series for Lincolnshire and Nottingham City A&E attendances have been updated. The East Midlands Quality Observatory were providing this data but now it is being provided by Nottingham City PCT. We have been working with analysts from these teams to ensure that we source the most appropriate data. The PCT analytical teams are closer to the data and have a more thorough understanding of the data quality issues surrounding it, for this reason they will now be providing all future A&E data for Lincolnshire and Nottingham City.

Release date, 6 January, 2012 – November data.

- Patient experience data from April to October of 2011 will be finalised and a full set of figures included.

- Data from two new live sites will be included in the MDS, namely Isle of Wight and Derbyshire.

Release date, 2 December, 2011 – October data.

- Patient experience data from April to October of 2011 will be included. The full data set was not available for inclusion at the time of publication, any missing items will be included in the next release.

- To clarify what is happening to calls that have not been answered a data value has been added into the MDS. This figure, titled "Abandoned calls (within 30 seconds waiting time)" shows the total number of calls offered where the caller hung up before reaching 30 seconds following being queued for an advisor. Abandoned calls (after 30 seconds waiting time) are already included in the MDS as this is a NQR standard and a key performance measure of the NHS111 service.

Release date, 4 November, 2011 – September data.

- Renamed "NHS 111 Warm transfer Time" to "NHS 111 live transfer time".

- A new measure for warm transfer time has been included. This is in addition to the "NHS 111 live transfer time" as described above. This measure looks at the transfer time on the telephony system, i.e. the time between when the call handler dials the queue until the clinician answers the phone. This measure gives an indication of whether the ratio of clinicians to call handlers is appropriate e.g. if this figure is high then it would suggest that there were not enough clinicians available to take calls transferred by call handlers.

- GPOOH data from Luton has been split out so we can report on the UCC and WiC attendance levels as well.

Release date, 30 September, 2011 – August data.

- Throughout the data set dispositions are aggregated into five groups. One of these groups "Not recommended to attend other services" includes calls not triaged. A new line has been added to show the percentage of calls not triaged.

- Updated system data has been received for Lincolnshire and Nottingham City. This data has been used to update previous figures.

Release date, 2 September, 2011 – July data.

- Renamed “Warm Transfer Time” to “NHS 111 Warm transfer Time”. The definitions used to describe warm transfer times for each pilot site has also been edited to reflect ongoing work in this area. These definitions can be seen in the “About the MDS” worksheet and in the notes under relevant tables.

- Found some issues with the recording of the number of calls answered from direct 111 dials. Have worked to rectify this issue and updated the data as required. Please note that this issue did not affect the total number of calls received or the total number of calls received through direct 111 dials.

Release date, 29 July, 2011 – June data.

- System data for the most recent pilot sites (Lincolnshire, Luton and Nottingham City) have now been included.

- A further breakdown of “recommended to attend primary care” and “not recommended to attend other service” dispositions has been included.

- A new worksheet titled “About the MDS” has been added to help provide further context to the MDS and the data it contains.

- The definitions page of the MDS has been updated to correct some truncated definitions present in the May edition.

Release date, 1 July, 2011 – May data.

- Update of population figures for each pilot area. These data have been updated using the ONS mid 2009 estimates for resident populations of Primary Care Organisations (PCOs).

- The breakdown of call handling time by clinical and call handling staff has now been included for County Durham and Darlington.

Contacts:
Press enquiries contact:
Press Office
NHS England
Telephone: 020 7210 5010

The Government Statistical Service (GSS) statistician responsible for producing these data is:

Thomas Kent

Commissioning Analysis and Intelligence Team
NHS England
G18 Wellington House
Email: NHS111@dh.gsi.gov.uk

IFS: Ageing population will lead to squeeze on NHS

David Kingman comments on a new projection from the IFS that NHS funding per person is set to fall dramatically as the population ages

The National Health Service could be facing a funding squeeze which will see the amount of money spent per person fall by 9% over the next four years, according to a new projection from the Institute for Fiscal Studies (IFS).

The decline in spending, which would be unprecedented in the history of the NHS, is likely to come about because of the pressure created by an ageing population and the general squeeze on government expenditure as more of the Coalition's public spending cuts come into force. This could have a damaging impact on the health service's ability to provide high-quality care to its patients, and should lead to a broader debate about how we are going to meet the costs of our ageing population, especially during an era of austerity.

Spending to fall by 9% per person

The IFS unveiled this projection as part of their 2014 Green Budget, which included a comprehensive set of projections for how the UK economy is likely to perform over the coming years. A summary of their main findings is available here:

http://www.ifs.org.uk/budgets/gb2014/gb2014_es.pdf

One of the projections for public spending which they drew particular attention to was as follows (p.2):

"…a growing and ageing population will increase pressures [on public spending]. The ONS projects that the overall population will grow by about 3.5 million between 2010 and 2018, with the population aged 65 and over growing by 2.0 million. One implication of this is that, even if NHS spending were 'protected' and frozen in real terms between 2010–11 and 2018–19, real age-adjusted per capita spending on the NHS would be 9.1% lower in 2018–19 than in 2010–11."

The Coalition government has often talked about how spending on healthcare has been "ring-fenced" from the cuts that have fallen on other departments as part of

their public spending austerity programme. However, as the IFS projection shows, this is not really as straightforward as it sounds. In reality, spending on the NHS has been frozen, rather than being cut in the way it has been for most other departments, but as demand on the service has been increasing the net result is that fewer resources are still being divided between more and more patients.

Funding challenge prompts fears over quality

Concerns over the potential impacts of the funding squeeze anticipated by the IFS have also recently been heightened by a separate report from the Nuffield Trust which showed that many NHS trusts are struggling to improve the quality of patient care because of current cash-flow problems.

Launched to coincide with the one-year anniversary of the public enquiry into the failings at the Mid-Staffordshire NHS Foundation Trust, this report (based on a survey of NHS hospital staff and the senior management of a large number of hospital trusts) showed that improving the quality of patient care has become a key goal for many trusts in the wake of the scandal, but there are serious doubts about whether they will be able to deliver on their ambitions in this area because of the funding constraints which they face.

Nearly a third of English NHS trusts are already forecasting that they will end the current year with a financial deficit, a finding which raises fresh doubts about the sustainability of the current NHS financial model.

Of course, everyone would prefer it if the NHS could deliver better and better care with fewer and fewer resources. In the real world, however, given that so many hospitals appear to be struggling to cope under the present set-up and the IFS is predicting that an even tighter squeeze lies ahead, these are worrying times for the NHS.

Can Britain still afford so many health services to be delivered for free at the point of use –- particularly for the large numbers of elderly patients who will be placing ever-increasing demands on the system in the near future? Or do we need to start thinking seriously about finding a new method of funding some of our health services? Such pressing questions will need to be addressed if a worrying situation is not to become a crisis in the next few years.

Posted on: 16 February, 2014

« George Osborne warns housing crisis will still be here in 10 years' time

New research: Young bearing much heavier debt burden than old during recession »

One thought on "IFS: Ageing population will lead to squeeze on NHS"

David Dunn

August 26, 2014 at 7:09 pm

I believe what is stated above is true and cannot be avoided, so my suggestion is to look at the real alternative of a citizens wage , which would enable all citizens to buy whatever health they require within a limit

Speakers

IF can supply speakers and give presentations on our work.

Links

IF is pleased to be working with:

and also most importantly make them a lot more responsible for keeping themselves healthy by good lifestyle choices.

Paying for a health service to prop up the ill, from often self inflicted bad lifestyles should stop and the citizens who are careful and maintain a good diet and exercise regime , should be rewarded by a better pot of money left over from the citizens wage.

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You may use these HTML tags and attributes: `<a href="" title=""> <abbr title=""> <acronym title=""> <b> <blockquote cite=""> <cite> <code> <del datetime=""> <em> <i> <q cite=""> <strike> <strong>`

Post Comment

Office for National Statistics

Expenditure on healthcare in the UK: 2012

Author Name(s): **William Postins and Chris S Payne, Public Services Productivity Branch**

Abstract

Updated estimates for total healthcare expenditure in the UK between 1997 and 2012. Estimates are also given for total expenditure on healthcare in the UK per capita, current and capital expenditure and public and private expenditure on healthcare in the UK and healthcare expenditure in the UK as a share of gross domestic product (GDP). International comparisons of total healthcare expenditure as a share of GDP are made with the G7 countries and the volume consumption of private healthcare expenditure is compared to other household consumption trends based on classification of individual consumption by purpose (COICOP; ESA 95) definition. All expenditure figures are consistent with international definitions provided by the Organisation for Economic Co-operation and Development (OECD, 2011a and OECD, 2000) and presented in current price terms. OECD uses this data to publish international comparisons.

Key Points

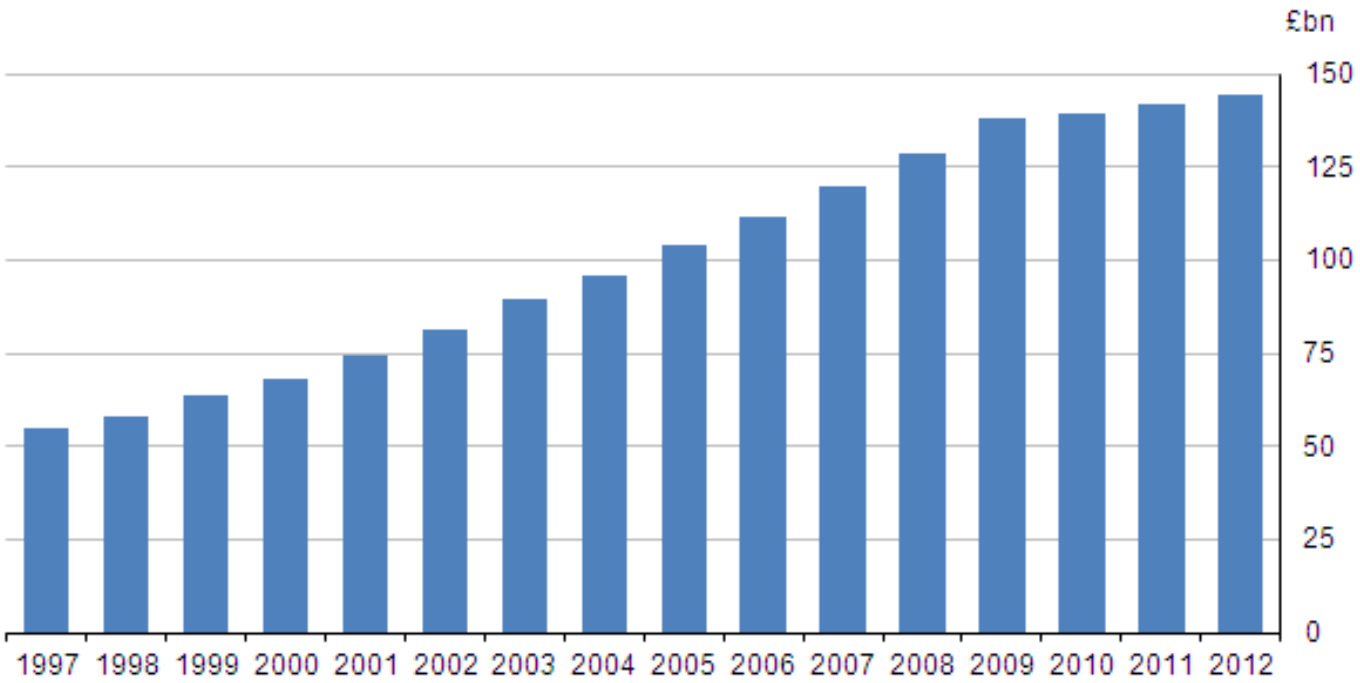
- Total expenditure on healthcare in 2012 was £144.5bn. Healthcare expenditure growth was strong between 1997 and 2009 with an average annual growth rate of 8.0%. Since 2009 growth rates have slowed significantly to an average of 1.6%.
- Private healthcare expenditure fell by -1.4% in 2012 as compared to 2011, while public healthcare expenditure rose by 2.5% over the same period.
- Current expenditure on healthcare accounted for 96.4% of total healthcare expenditure in 2012. The remaining 3.6% of total healthcare expenditure was capital expenditure.
- Capital expenditure on healthcare in 2012 fell by -1.7% as compared to 2011, changing from £5.2bn to £5.1bn.
- Volume of consumption of healthcare by UK households has fallen by -2.4% between 2007 and 2012.
- Total healthcare expenditure per capita in 2012 rose by 1.2% as compared to 2011.
- Total healthcare expenditure as a share of GDP was measured amongst the lowest of the G7 countries (Canada, France, Germany, Italy, Japan, UK, USA) with only Italy spending less as a share of their GDP across the series.

Total healthcare expenditure in the UK, 1997 to 2012

Figure 1 presents total healthcare expenditure in the United Kingdom, representing expenditure from both the UK public and private sector combined.

Figure 1: Total healthcare expenditure

UK, 1997-2012



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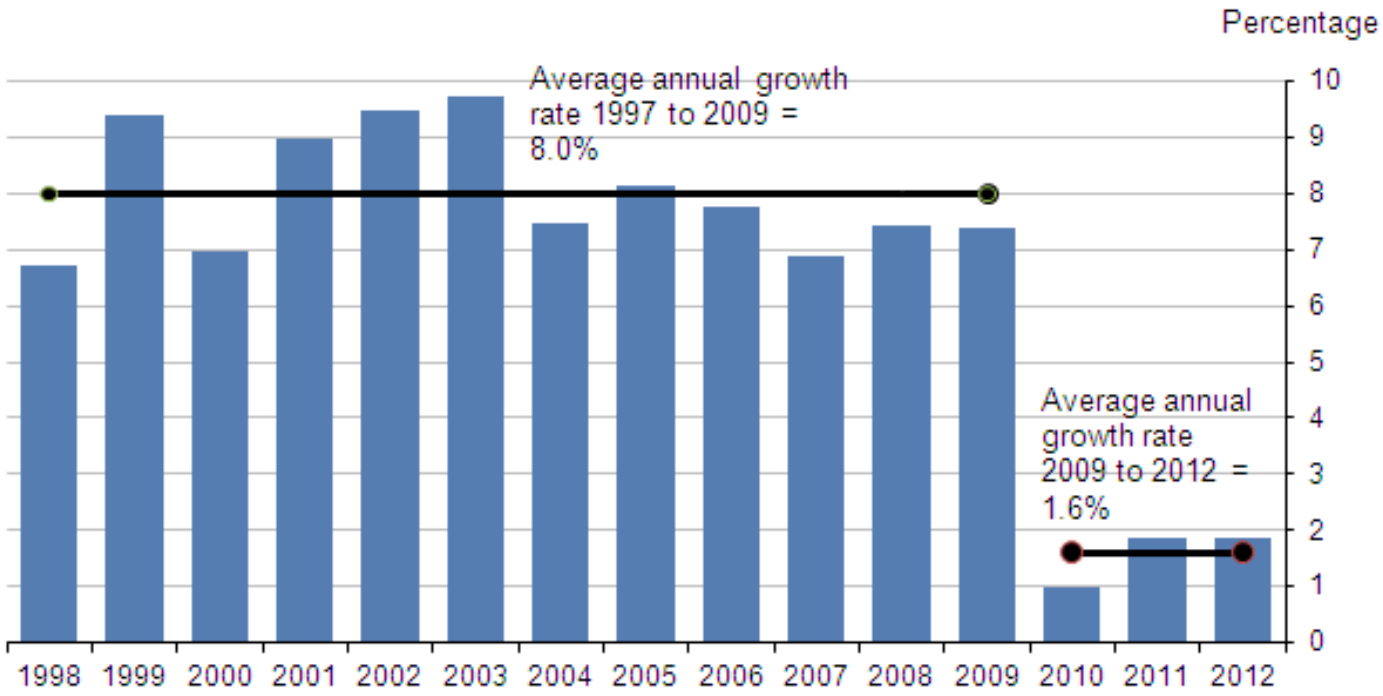
Total healthcare expenditure grew by an average annual increase of 8.0% for the period 1997 to 2009, but has slowed since. Total healthcare expenditure grew by an average annual increase of 1.6% between 2009 and 2012, bringing the overall average annual increase for the period 1997 to 2012 to 6.7%. Total expenditure on healthcare in the UK has risen from £54.6 billion in 1997 to £144.5 billion in 2012.

This reflects an international trend in the slowing of expenditure on healthcare from 2009 to 2012 (OECD, 2013).

Figure 2 shows the growth rates of total healthcare expenditure over the period 1998 to 2012.

Figure 2: Total healthcare expenditure, growth rates

UK, 1998-2012



Source: Office for National Statistics

Notes:

1. Means are geometric.

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The strongest growth in expenditure on healthcare in the UK was seen between 1999 and 2003 where growth rates were nearly all consistently over 9.0% apart from in 2001 where growth was still 7.0%.

After 2003, expenditure on healthcare annual growth rates were still high relative to the latter years of the series. Growth rates ranged from 6.9% to 8.1% from 2004 to 2009.

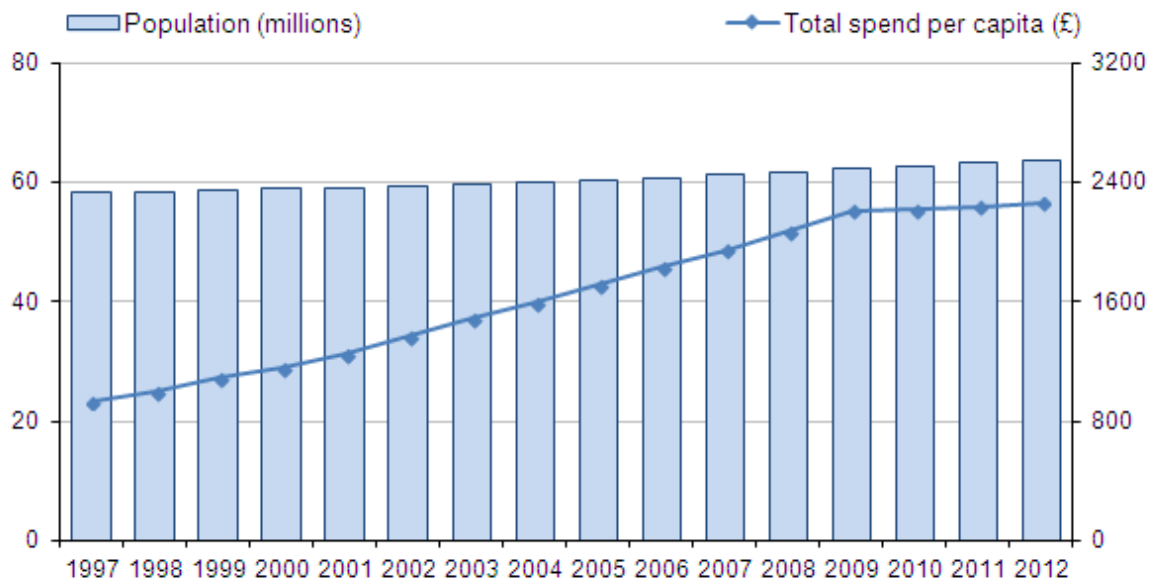
The final years of the series from 2010 to 2012 have seen expenditure on healthcare growth decline to far lower levels, although expenditure on healthcare in the UK has retained positive growth throughout the entire series. Growth rates in 2010, 2011 and 2012 were 1.0%, 1.9% and 1.9% respectively.

Total healthcare expenditure per capita, 1997 to 2012

Figure 3 shows Total Healthcare expenditure per capita between 1997 and 2012.

Figure 3: Total healthcare expenditure per capita

UK, 1997-2012



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Total expenditure on healthcare in the UK per capita has increased every year since 1997 however rates of growth have slowed since 2009. Average annual growth rates for total expenditure on healthcare per capita in the UK stood at 7.4% between 1997 and 2009. From 2009 to 2012 average annual growth has shrunk to 0.8%.

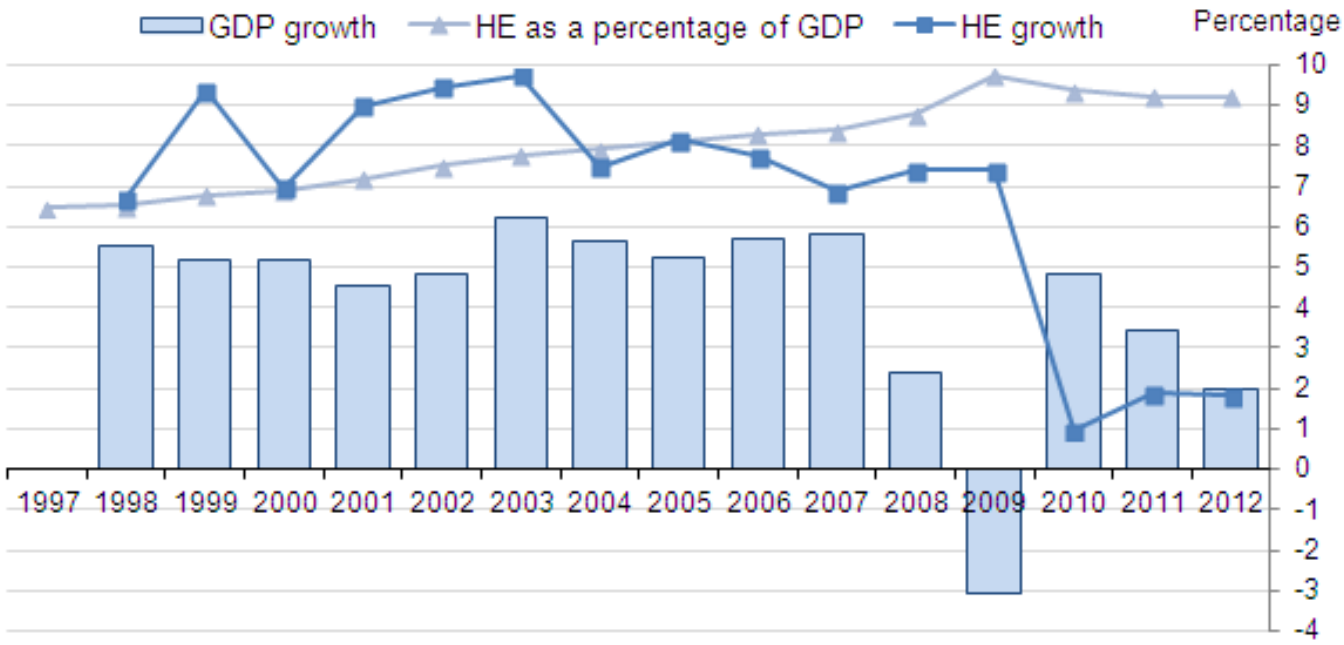
In 2012, total healthcare expenditure per capita rose by 1.2%. In 2008, total healthcare expenditure per capita rose by 6.5%.

Total healthcare expenditure in the UK as a share of GDP, 1997 to 2012

Figure 4 shows total healthcare expenditure in the UK as a share of GDP, GDP annual growth rates, and Total Health Expenditure (HE) annual growth rates from 1998 to 2012.

Figure 4: Total healthcare expenditure in the UK as a share of GDP, GDP annual growth rates, and Total Health Expenditure (HE) annual growth rates, 1998 to 2012

UK, 1997-2012



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Healthcare expenditure as a share of GDP in the UK rose steadily from 6.5% of GDP in 1997 to 9.7% in 2009, and then fell to 9.2% in 2011, where it remained in 2012. Years 2008 and 2009 saw the largest increases of 0.4 percentage points and 0.9 percentage points respectively. This is due to the slow down in GDP growth between 2007 and 2008 and fall in GDP in 2008 and 2009 while healthcare expenditure continued to rise.

Figure 4 shows the change in total expenditure on healthcare in the UK as a share of GDP over the period 1997 to 2012, and figure 5 then compares this internationally against the other G7 countries (Canada, France, Germany, Italy, Japan, UK, USA).

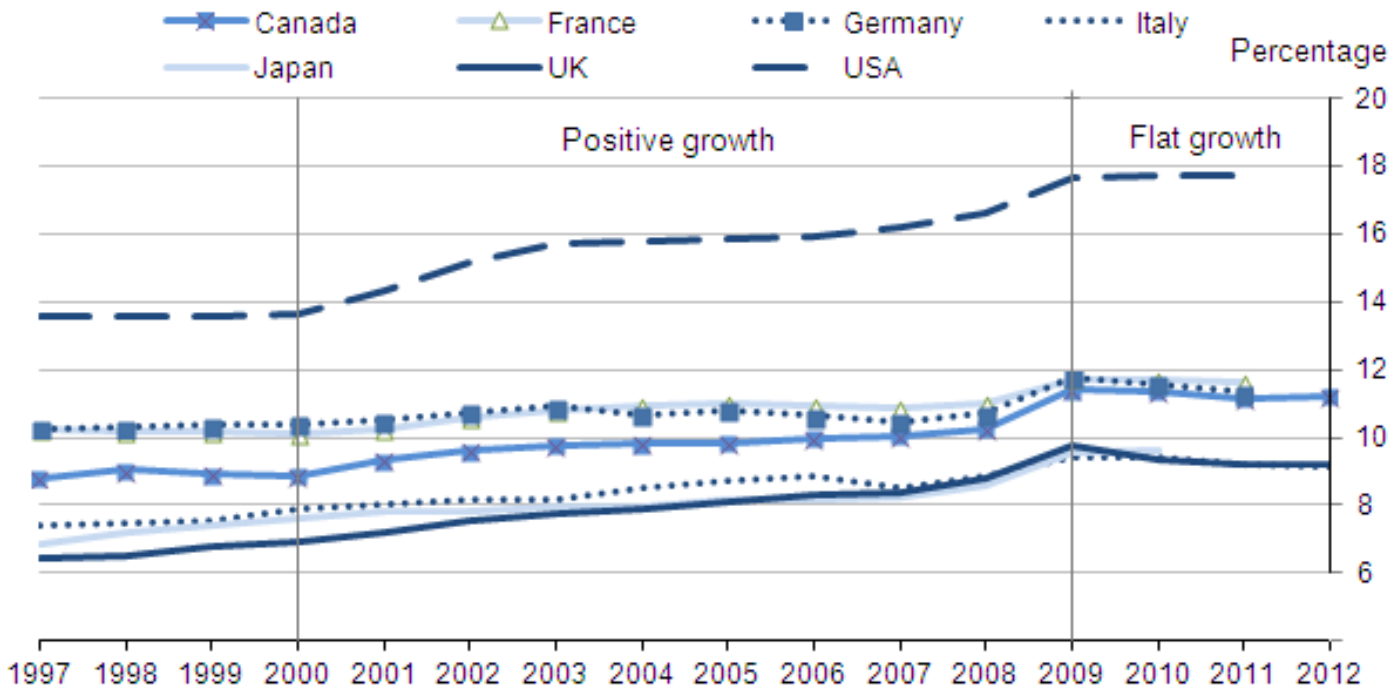
The Organisation for Economic Co-operation and Development (OECD, 2011b) suggests that over the past 50 years healthcare expenditure as a share of GDP has increased for most countries internationally. Total expenditure on healthcare in the UK as a share of GDP followed this trend until 2009.

International comparisons of total healthcare expenditure in the UK as a share of GDP, 1997 to 2012

Figure 5 shows Total healthcare expenditure in the UK as a share of GDP compared with other G7 Countries, between 1997 and 2012.

Figure 5: Total healthcare expenditure as a share of GDP compared with other G7 countries

G7 countries, 1997-2012



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The main driver for the global increase in healthcare expenditure as a proportion of GDP in 2009 was that, following the global financial crisis, GDP in each of the G7 countries fell significantly. This was at a time when levels of healthcare expenditure were still rising, which accounts for the increasing levels of healthcare expenditure as a proportion of GDP.

There is a long term trend for healthcare expenditure as a proportion of GDP to increase, with movements between all G7 countries following the same patterns. 2012 data is only currently available for the United Kingdom, Canada and Italy and the latest data for Japan is 2010.

The higher than average rates of expenditure in the U.S. can be partially attributed to higher costs. This is in particular with regard to the price of pharmaceuticals, hospital services and the cost of physicians (OECD, 2009).

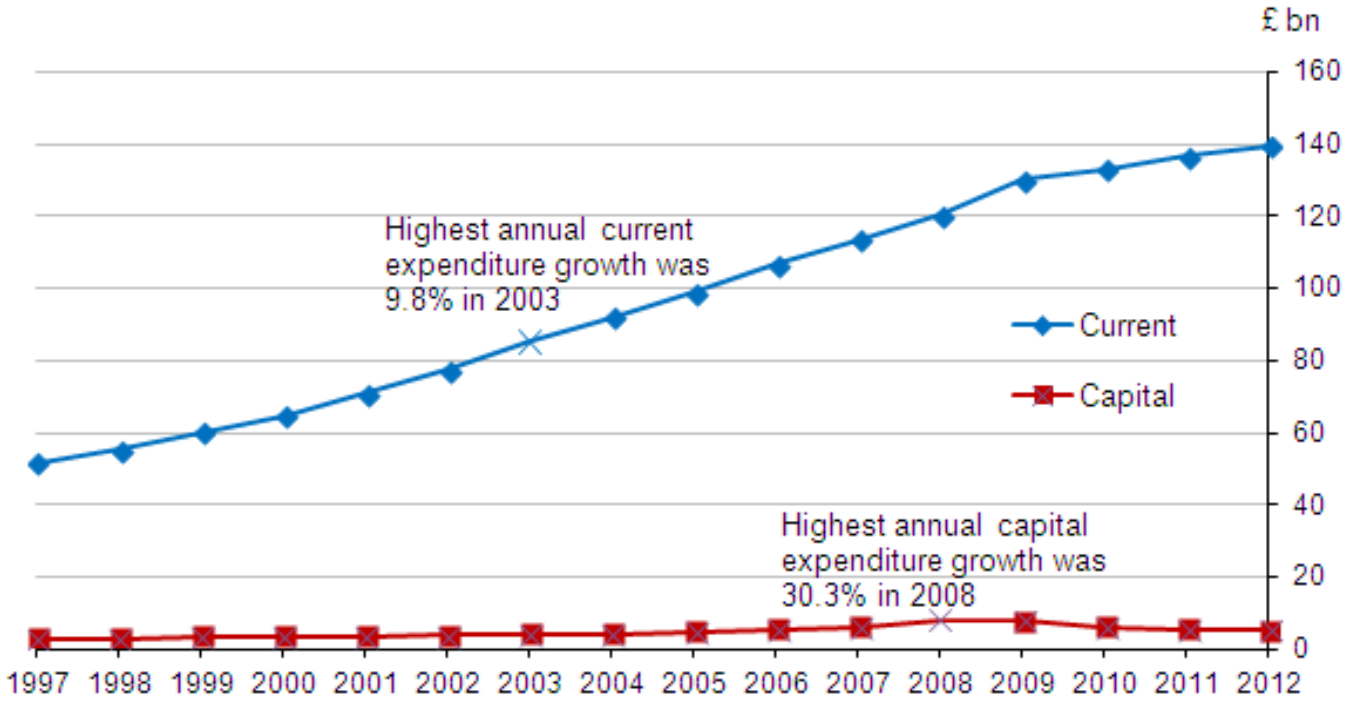
However price may not explain all of the difference in healthcare expenditure between US and the OECD average. For example, high volumes of elective day surgery and outpatient care have been suggested to be a factor where the rate of elective day surgery was approximately 4 times the OECD average in 2006 (OECD, 2009).

Current and capital healthcare expenditure, 1997 to 2012

Figure 6 presents estimates of current and capital healthcare expenditure in the UK, between 1997 and 2012.

Figure 6: Current and capital healthcare expenditure

UK, 1997 - 2012



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Capital expenditure increased from £3.0 billion in 1997 to its peak of £8.0 billion in 2008. It then fell by 35.4% to £5.1 billion between 2008 and 2012. The strongest capital expenditure growth was seen between 2004 and 2008, where expenditure rose from £4.0 billion to £8.0 billion respectively, representing a 100% increase. Over the entire series, capital expenditure has increased at an average annual growth rate of 3.8% between 1997 and 2012.

Current expenditure increased at an average annual rate of 6.8% between 1997 and 2012. An average annual growth rate of 8.0% was seen between 1997 and 2009 but expenditure slowed to an average annual growth rate of 2.3% between 2009 and 2012.

Current expenditure accounted for £51.7 billion in 1997 rising to £139.3 billion in 2012, representing 94.6% and 96.4% of total healthcare expenditure respectively.

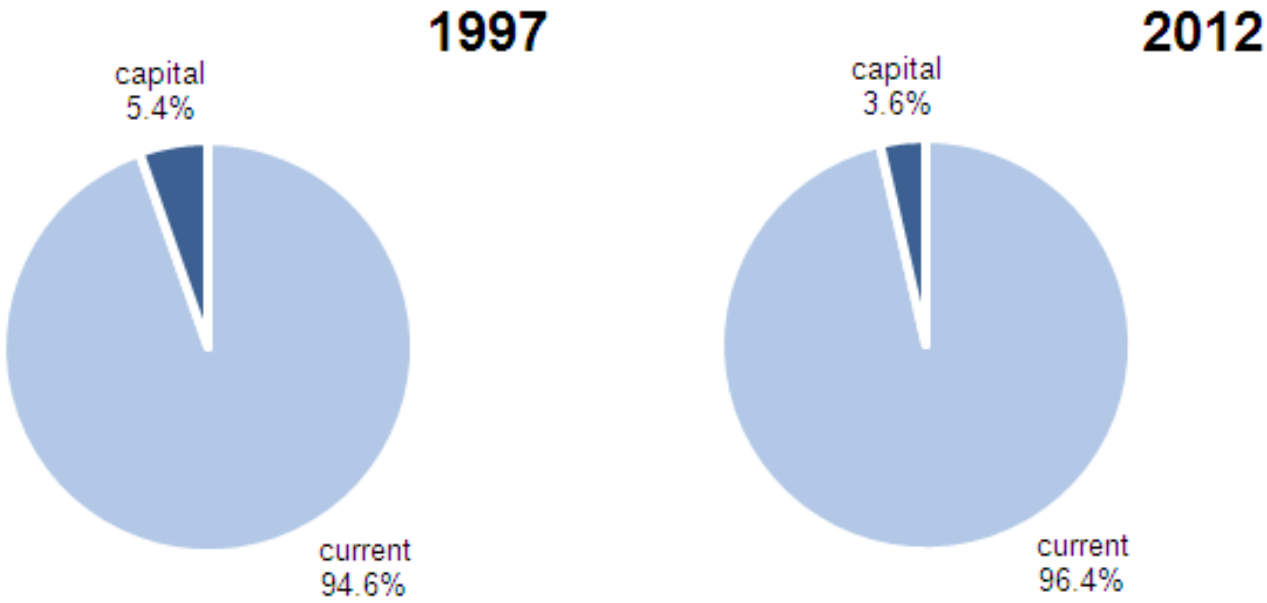
Current expenditure experienced strongest growth in 2003 with an increase of 9.8%, and the weakest growth in 2012 at 2.0%. Capital expenditure saw its strongest growth in 2008 with a rise of 30.3%, and its weakest growth in 2010 with a fall of -19.0%.

Current and capital expenditure shares, 1997 and 2012

Figure 7 shows Capital and Current expenditure shares in 1997 and 2012.

Figure 7: Current and Capital healthcare expenditure shares

UK, 1997 and 2012



Source: Office for National Statistics

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Comparing 1997 to 2012 there has been a small shift towards current expenditure as a share of total healthcare expenditure, increasing from 94.6% in 1997 to 96.4% in 2012. Capital expenditure as a share of total expenditure conversely fell from 5.4% to 3.6% over the same period. There have

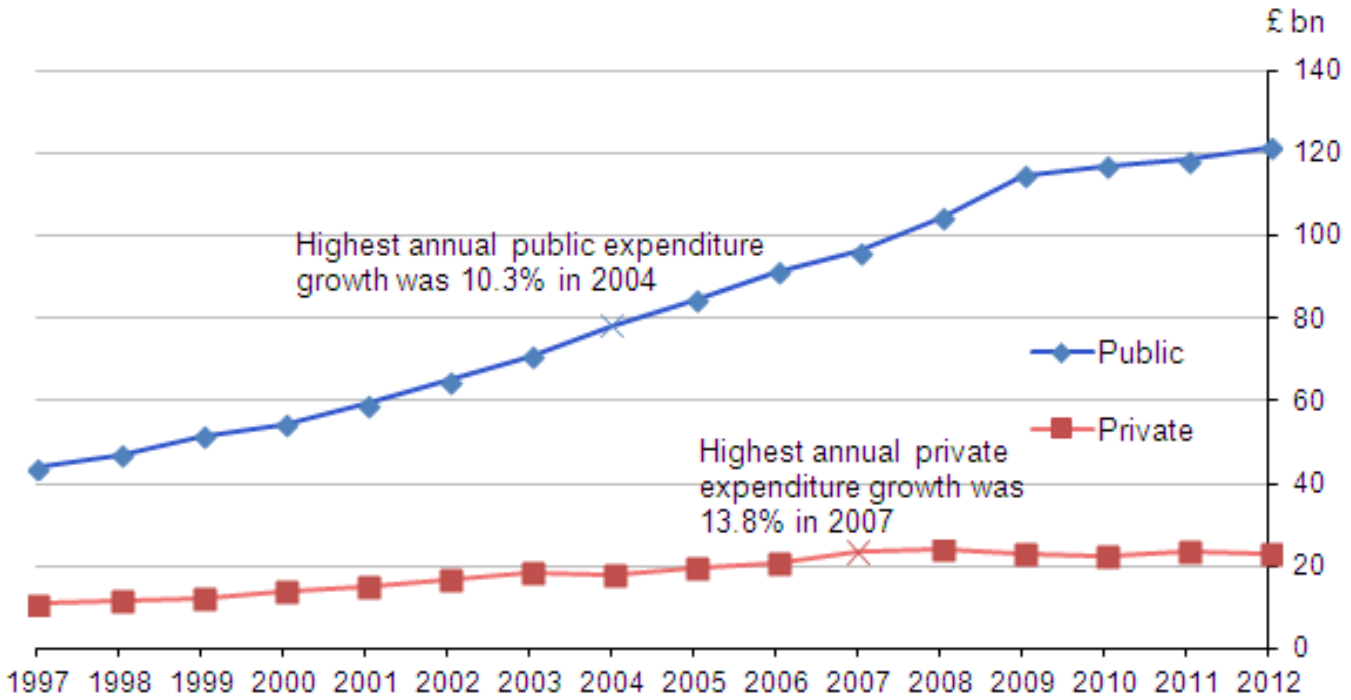
however been small fluctuations between these years. As a share of total healthcare expenditure, capital expenditure had increased relative to current expenditure from 5.4% in 1997 to 5.8% in 1999. It then fluctuated between 4.2% and 4.9% between 2000 and 2006, following which it increased to its peak of 6.2% in 2008. From 2009 to 2012 the share of total healthcare expenditure represented by capital fell from 5.7% to 3.6%.

Public and private healthcare expenditure, 1997 to 2012

Figure 8 presents estimates of public and private healthcare expenditure in the UK, between 1997 and 2012.

Figure 8: Public and private healthcare expenditure

UK, 1997- 2012



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Public expenditure

In 2009, public healthcare expenditure grew by 9.7%: the strongest annual growth rate since 2004 where growth reached 10.3%. Public expenditure on healthcare then slowed after 2009, with annual growth dropping to 1.9% for 2010 and 1.2% for 2011 and then rising to 2.5% in 2012.

Public expenditure on healthcare from 2009 to 2012 increased at an average annual growth rate of 1.9%. This is a lower figure than previous years where average annual growth between 1997 and 2009 was 8.3%. Average annual rate of increase during the period 1997 to 2012 was 7.0%.

The slow-down in growth in public expenditure on healthcare is a trend seen across Europe, and more widely, among OECD member states (OECD, 2013). The OECD report that the fall in average total healthcare expenditure across the OECD has been primarily driven by a collapse in the growth of public expenditure on healthcare since 2009, where average growth has been recorded as close to zero growth in both 2010 and 2011 for OECD member states.

Private expenditure

Private healthcare expenditure is defined as private household spend on medical goods and services (in accordance with European System of Accounts 1995 (ESA 95) Classification of Individual Consumption by Purpose (COICOP) definition), private healthcare insurance, expenditure by Not for Profit Institutions Serving Households (NPISH) and private sector capital.

Private household spending on medical goods and services include goods such as over the counter pharmaceuticals and services such as dental services and private hospital services. NPISH includes charities and other non-profit organisations.

Household expenditure accounts for 68.3% of total private spending, with NPISH taking the next largest share at 23.5% in 2012. Private insurance and capital are estimated to account for the remaining 8.2% of total private expenditure.

Including all these elements, estimates of private expenditure on healthcare more than doubled between 1997 and 2008, rising from £10.7 billion in 1997 to reach £23.8 billion in 2008. However, private expenditure fell by -2.8% in the period 2008 to 2012 to £23.2 billion.

However, although private expenditure on healthcare increased at an average annual growth rate of 5.3% over the entire series between 1997 and 2012, average annual growth from 2009 to 2012 was flat at -0.1%. This is slower growth since the recession than has been apparent for public expenditure.

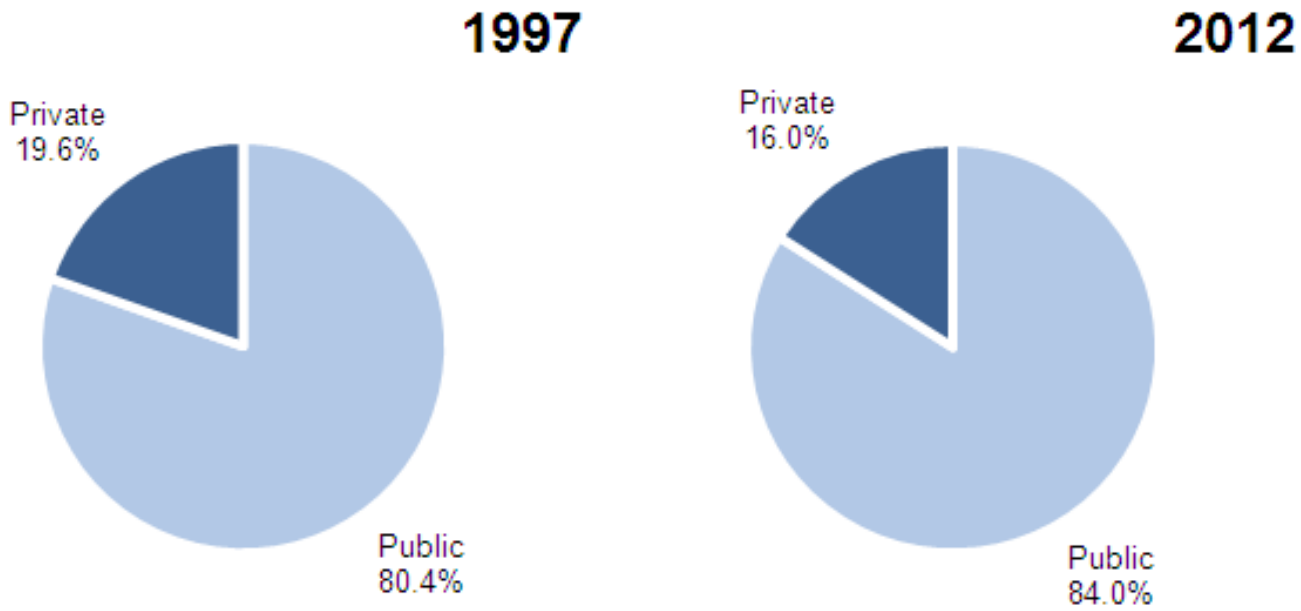
Slow growth in private expenditure on healthcare was driven by private household spending on medical goods and services on healthcare and is not unique to the UK. The OECD (2013) recently reported that private household “out of pocket” expenditure by OECD definition (which forms the majority share of household expenditure under COICOP definition – see methodology section for more information) also slowed down in many OECD countries in 2010 and 2011, as household incomes remained flat or decreased. For the UK overall private healthcare expenditure is estimated to have continued that trend of flat or decreasing growth in 2012. Data across the OECD for 2012 has not been released yet but will be available later in 2014 to make the comparison.

Public and private expenditure shares, 1997 and 2012

Figure 9 shows the public and private healthcare expenditure shares for the first and last years of the series, 1997 and 2012.

Figure 9: Public and Private healthcare expenditure shares

UK, 1997 and 2012



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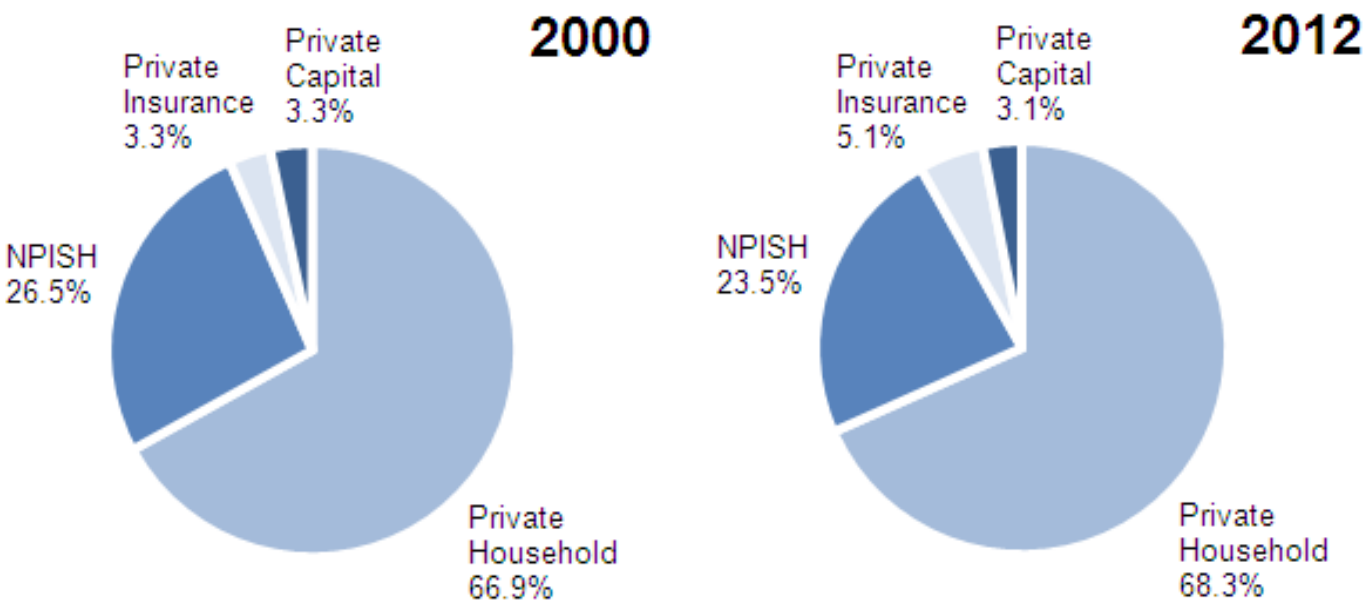
Public expenditure on healthcare accounted for the largest proportion of total UK expenditure on healthcare, representing £43.9 billion (80.4%) of healthcare expenditure in 1997 rising to £121.3 billion (84.0%) in 2012.

Private healthcare expenditure composition, 2000 and 2012

Figure 10 shows the private healthcare expenditure composition for the years 2000 and 2012.

Figure 10: Private healthcare expenditure composition

UK, 2000 and 2012



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Throughout the period from 2000 to 2012 the composition of private expenditure has remained roughly the same. Private household spending on medical goods and services formed the majority of private healthcare expenditure throughout the period 2000 to 2012.

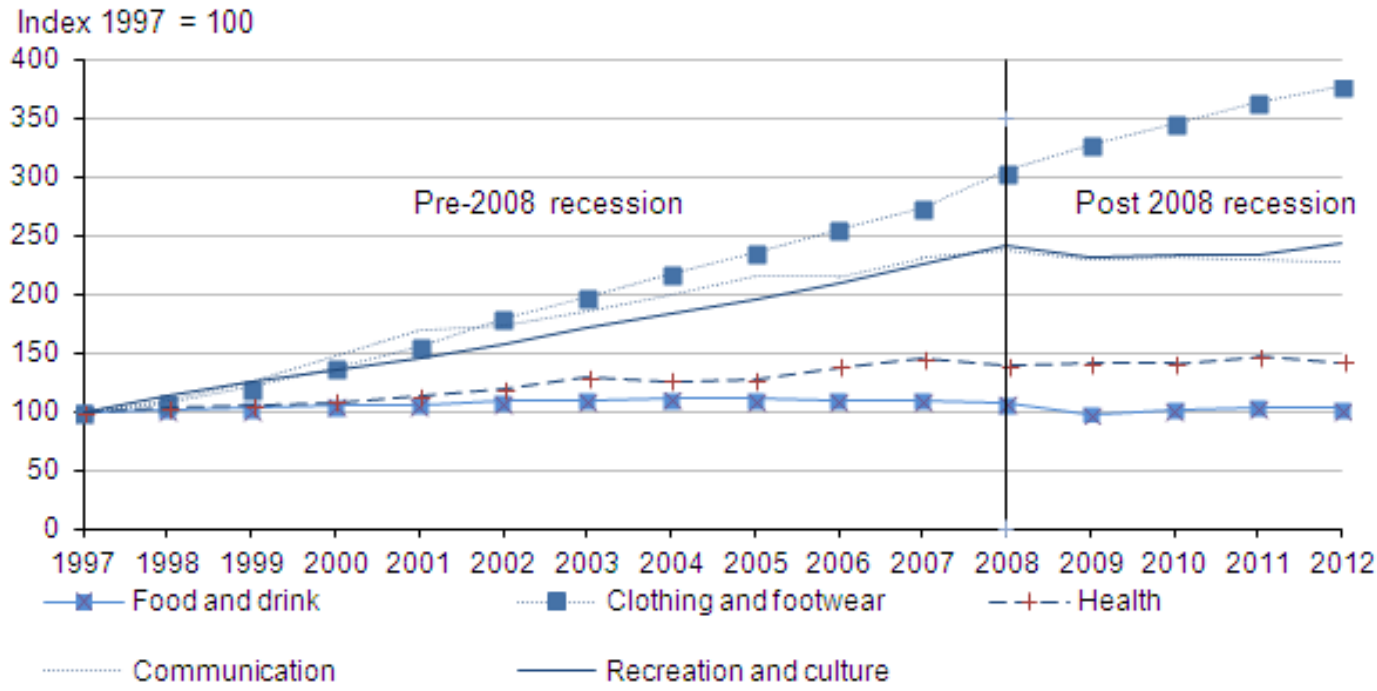
There has been a slight increase in expenditure share for both private household spending on medical goods and services and healthcare insurance spending on medical goods and services, accounting for 1.4 percentage points and 1.8 percentage points respectively. The shares for NPISH and private capital expenditure have fallen slightly from 26.5% and 3.3% in 2000 to 23.5% and 3.1% by 2012.

Volume of private household healthcare consumption, 1997 to 2012

Figure 11 shows the volume of private household healthcare consumption compared to other household consumption trends, between 1997 and 2012. This corresponds to the 68.3% of private expenditure on healthcare identified in Figure 10 in 2012 that is accounted for by households.

Figure 11: Volume of household consumption indices

UK, 1997 - 2012



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To place UK private household expenditure on medical goods and services in context, data taken from the ONS consumer trends report (ONS, 2013a) is presented in figure 11. This data shows the relatively rapid growth in consumption of healthcare related goods and services over the period from 1997 to 2007 when volume growth increases of nearly 50% were recorded. Since 2007 the volume of consumption of healthcare by UK households has fallen by -2.4%.

Items such as clothing and footwear, recreation and culture, and communication have all seen greater growth in consumption between 1997 and 2012 but consumption of communication and recreation and culture has levelled since the 2008 recession. Growth in consumption of healthcare related goods and services has remained low in comparison to these faster growing goods and services consumption trends. When considered over the entire series from 1997 to 2012 healthcare consumption index levels reached approximately 150 index points in 2012 when other goods and services have reached in excess of 200 index points at the same period.

Methodology

The Organisation for Economic Co-operation and Development (OECD, 2011a and 2000) provide international guidelines on which this article's expenditure figures are calculated. These expenditure

figures are provided to OECD annually to enable international comparisons to be made regarding healthcare expenditure, such as Health Data 2012 (OECD, 2012). This is important as it allows the UK healthcare expenditure statistics to be more comparable, more policy relevant and recognised on an international platform.

Methods used for analysis

The System of Health Accounts (SHA) definitions (OECD, 2000) do not include education and training or research and development but they can be classified as ‘related expenditure’.

It should also be noted that the new SHA guidance (OECD, 2011a) changes the focus of the main aggregate of healthcare expenditure to current expenditure only. Capital expenditure may be reported independently. UK Health accounts data is likely to have to comply with this standard by April 2016 under a forthcoming EU regulation.

The estimates of healthcare expenditure in the UK in this article are based on OECD guidance from SHA 2000 and are comprised of estimates from the Department of Health and the UK National Accounts produced by ONS. The National Accounts estimates are also sent to the European Statistical Office, Eurostat, to meet the requirements of the Maastrict Treaty (EU, 1993).

Table 1 outlines the adjustments to the base series of Government current and capital expenditure on healthcare.

Table 1: Components of healthcare expenditure calculation

UK

Component	Adjustment	Source
Government current and capital expenditure on healthcare	Base series	Consistent with data submitted to Eurostat in order to meet requirements defined in the Maastricht Treaty (EU 1993) and published in Blue Book 2013 (ONS, 2013b)
Household expenditure on private healthcare	Added	Published in Blue Book 2013 (ONS, 2013b)
Expenditure on private healthcare by NPISH (mainly charities)	Added	UK estimate provided by the Department of Health
Expenditure on healthcare in prisons	Added	UK estimate provided by the Department of Health
Expenditure on healthcare in the armed forces	Added	UK estimate provided by the Department of Health
Capital expenditure by private sector healthcare providers	Added	Estimated using data consistent with Blue Book 2013 (ONS, 2013b), and data submitted to Eurostat and published on the ONS website
Expenditure on healthcare and training of healthcare	Deducted	UK estimate provided by the Department of Health

Component	Adjustment	Source
personnel by the National Health Service (NHS)		
Expenditure on research and development in healthcare by the NHS	Deducted	UK estimate provided by the Department of Health
Government benefits paid to those providing home healthcare for their relatives	Added (no estimate available)	No source
Occupational healthcare	Added (no estimate available)	No source
Non-NHS expenditure on nursing care in nursing homes	Added (no estimate available)	No source

Table source: Office for National Statistics

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Revisions

Overall revisions to total healthcare expenditure have all been negligible with the greatest change being a -0.7% downward revision to total expenditure on healthcare in the UK in 2009. The main revisions in the report are seen in the private healthcare expenditure series and have happened as a result of supply - use balancing in the national accounts in 2013.

Although revisions are evident throughout the private expenditure series, these revisions are below 0.8% of total healthcare expenditure in the UK for any given year. The revisions are mainly downward in direction and relate specifically to both private insurance expenditure on healthcare and private household expenditure on healthcare in the UK. The largest revision to the private healthcare expenditure estimates is a change of -0.7% to the 2011 estimate.

See Reference Tables 3 and 4 for more information on revisions compared to previously published estimates (ONS 2013c).

Reference tables

Reference table 1: Total, current, capital, public and private healthcare expenditure in the UK growth rates, 1998-2011 (31.5 Kb Excel sheet)

Reference table 2 Current, capital, public and private healthcare expenditure in the UK (ratios), 1997-2011 (29.5 Kb Excel sheet)

Reference table 3 Revisions to total, current, capital, public and private healthcare expenditure compared to the previous article (36 Kb Excel sheet)

Reference table 4 Revisions to total, current, capital, public and private healthcare expenditure as a share of GDP compared to the previous article (37.5 Kb Excel sheet)

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Background notes

1. **Definitions**

   Current expenditure:

   Current expenditure is recurrent expenditure on goods and services consumed within a year, necessary to sustain the production of healthcare services. Some small expenditure on items of equipment, below a threshold cost, is also included as current spending.

   Capital expenditure:

   Capital expenditure is comprised of three components; Government healthcare capital transfers, government gross fixed capital formation and capital expenditure from private sector providers.

   - Capital transfers are classified by national accounts as ‘unrequited transfers where either the party making the transfer realises the funds involved by disposing of an asset (other than cash or inventories), relinquishing a financial claim (other than accounts receivable) or the party receiving the transfer is obliged to acquire an asset (other than cash) or both conditions are met’ (United Nations, 2008).
   - Gross fixed capital formation is measured by the total value of a producer’s acquisitions, less disposals of fixed assets during the accounting period, plus certain specified expenditure on services that add to the value of non-produced assets (United Nations, 2008).
   - Private sector capital expenditure is capital expenditure by private healthcare organisations.

For further definitions of national accounts see the System of National Accounts, 2008 (United Nations, 2008).

Public Expenditure:

Public expenditure on healthcare is made up of all governmental expenditure on healthcare including expenditure in prisons and defence. Research and development and education and training in healthcare are not included (See table 1).

Private expenditure:

Private expenditure is made up of three main components; private households consumer spending on medical goods and services (as reported in Consumer Trends; ONS, 2013a), private healthcare insurance and private healthcare capital. In addition, private healthcare expenditure also includes non-profit institutions serving households (NPISH) which is largely made up of charities.

Private healthcare expenditure is based on final consumption expenditure on health by households and can be found in Blue Book 2013 (ONS, 2013b).

When OECD refer to private expenditure they typically refer to household expenditure only – or the System of Health Accounts definition of “out of pocket” expenditure. This differs from the private households consumer spending on medical goods and services (as reported in Consumer Trends; ONS, 2013a) which contains some insurance expenditure while the OECD ‘’out of pocket’’ expenditure does not. The difference should be taken note of when reading the article when OECD and ONS definitions are compared in the private expenditure on healthcare commentary in order to draw attention to similar post recession trends in private expenditure on healthcare in the UK and across the OECD.

Consumer trends private healthcare expenditure estimates:

The Consumer Trends publication (ONS, 2013a) presents comprehensive estimates of household final consumption expenditure (HHFCE), constructed to conform to the European System of Accounts 1995 (ESA 95) Classification Of Individual Consumption by Purpose (COICOP).

The following table breaks down private health expenditure by COICOP definitions. Category 6 Health represents the household final consumption expenditure on health whereas definitions 6.1-6.3 represent sub-catagories within category 6 health. See table 2 for full breakdown:

Table 2: Private health expenditure by COICOP definitions.

UK

Code	Definition
6 Health	This division also includes health services purchased from school and university health centres
6.1 Medical products	This group covers medicaments, prostheses, medical appliances and equipment and other health-related products purchased by individuals or households, either with or without a prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers. They are intended for consumption or use outside a health facility or institution. Such products supplied directly to outpatients by medical, dental and paramedical practitioners or to in-patients by hospitals and the like are included in outpatient services (06.2) or hospital services (06.3).
6.1.1 Pharmaceutical products	Medicinal preparations, medicinal drugs, patent medicines, serums and vaccines, vitamins and minerals, cod liver oil and halibut liver oil, oral contraceptives. Excludes: veterinary products (09.3.4); articles for

Code	Definition
	personal hygiene such as medicinal soaps (12.1.3).
6.1.2 Other medical products	Clinical thermometers, adhesive and non-adhesive bandages, hypodermic syringes, first-aid kits, hot-water bottles and ice bags, medical hosiery items such as elasticated stockings and knee supports, pregnancy tests, condoms and other mechanical contraceptive devices.
6.1.3 Therapeutic appliances and equipment	Corrective eyeglasses and contact lenses, hearing aids, glass eyes, artificial limbs and other prosthetic devices, orthopaedic braces and supports, orthopaedic footwear, surgical belts, trusses and supports, neck braces, medical massage equipment and health lamps, powered and unpowered wheelchairs and invalid carriages, "special" beds, crutches, electronic and other devices for monitoring blood pressure, etc.; - repair of such articles. Includes: dentures but not fitting costs. Excludes: hire of therapeutic equipment (06.2.3); protective goggles, belts and supports for sport (09.3.2);

Code	Definition
	sunglasses not fitted with corrective lenses (12.3.2).
6.2 Outpatient services	This group covers medical, dental and paramedical services delivered to outpatients by medical, dental and paramedical practitioners and auxiliaries. The services may be delivered at home, in individual or group consulting facilities, dispensaries or the outpatient clinics of hospitals and the like. Outpatient services include the medicaments, prostheses, medical appliances and equipment and other health-related products supplied directly to outpatients by medical, dental and paramedical practitioners and auxiliaries. Medical, dental and paramedical services provided to in-patients by hospitals and the like are included in hospital services (06.3).
6.2.1 Medical services	Consultations of physicians in general or specialist practice. Includes: services of orthodontic specialists. Excludes: services of medical analysis laboratories and x-ray centres (06.2.3); services of practitioners of traditional medicine (06.2.3)

Code	Definition
6.2.2 Dental services	Services of dentists, oral hygienists and other dental auxiliaries. Includes: fitting costs of dentures. Excludes: dentures (06.1.3); services of orthodontic specialists (06.2.1); services of medical analysis laboratories and x-ray centres (06.2.3)
6.2.3 Paramedical services	Services of: medical analysis laboratories and x-ray centres; Freelance nurses and midwives; Freelance acupuncturists, chiropractors, optometrists, physiotherapists, speech therapists, etc.; Medically prescribed corrective-gymnastic therapy; Outpatient thermal bath or sea-water treatments; Ambulance services; Hire of therapeutic equipment. Includes: services of practitioners of traditional medicine.
6.3 Hospital services	Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day-care and home-based hospital treatment are included as are hospices for terminally ill persons.

Code	Definition
	This group covers the services of general and specialist hospitals, the services of medical centres, maternity centres, nursing homes and convalescent homes which chiefly provide in-patient health care, the services of institutions serving old people in which medical monitoring is an essential component and the services of rehabilitation centres providing in-patient health care and rehabilitative therapy where the objective is to treat the patient rather than to provide long-term support. Hospitals are defined as institutions which offer in-patient care under direct supervision of qualified medical doctors. Medical centres, maternity centres, nursing homes and convalescent homes also provide in-patient care but their services are supervised and frequently delivered by staff of lower qualification than medical doctors.

Code	Definition
	This group does not cover the services of facilities, such as surgeries, clinics and dispensaries, devoted exclusively to outpatient care (06.2). Nor does it include the services of retirement homes for elderly persons, institutions for disabled persons and rehabilitation centres providing primarily long-term support (12.4).

Table source: Office for National Statistics

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NPISH estimates:

The estimates that ONS use for NPISH are provided by the Department of Health. The current method used is to forecast data taken from survey results.

Move to SHA 2011:

Following the European Framework regulation (EC) no. 1338/2008, ONS is required to report health expenditure aggregates in accordance with the System of Health Accounts 2011 (OECD 2011a).ONS has initiated a development project to bring the health expenditure estimates in line with SHA 2011 definitions and to provide a full set of Health Accounts.

The UK health accounts development project is due to deliver its first estimates under SHA 2011 guidance in March 2016. There will be clear changes to be incorporated into the new presentation of healthcare expenditure estimates For example, it will no longer necessary to report capital expenditure under the SHA 2011 guidance and a proportion of what was previously regarded as social care may fall into expenditure on long-term healthcare, increasing estimates of expenditure on healthcare in the UK.

2. **The new ONS website**

The launch of the new ONS website in August 2011 has brought changes to the design and format of statistical bulletins and articles. The article main body is available in html and pdf

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4. **Statistical Contact**

   Name: Chris S Payne

   Email: chris.s.payne@ons.gsi.gov.uk

   Tel: +44 1633 65 1660

   Planned date of next article: April 2015

   Media contact details: Telephone 0845 604 1858 (8.30 am – 5.30 pm weekdays)

   Emergency out of hours (limited service): 07867 906553

   Email: media.relations@ons.gsi.gov.uk

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National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health

The financial sustainability of NHS bodies

HC 722 SESSION 2014-15 7 NOVEMBER 2014

Summary

1 This is our third report on the financial sustainability of NHS bodies. Key tests of financial sustainability include changes in the surplus or deficit of the NHS as a whole, spending by NHS bodies as a proportion of their funding, and the number and scale of organisations in financial distress. In the medium to long term, the health service must be financially sustainable for it to provide sustainable services for patients.

2 The Health and Social Care Act 2012 changed the way the NHS was funded in 2013-14. Before then, strategic health authorities and primary care trusts allocated funds to healthcare providers. Most funds are now allocated by GP-led clinical commissioning groups.

3 In 2013-14, against a tight budget settlement, the government protected NHS funding. The Department of Health (the Department) allocated £95.2 billion to NHS England in 2013-14 to pay for NHS services. The largest proportion was spent by 211 clinical commissioning groups to buy services from 98 NHS trusts, NHS Direct and 147 NHS foundation trusts. NHS England directly commissioned £13.4 billion of specialised treatment, such as organ transplants and new drug therapies. These services tend to involve low volumes and high costs. NHS England also commissioned £11.3 billion of primary care services.

4 This report focuses on the NHS trusts and foundation trusts that provide community, mental health, acute and specialist health services. We also look at the financial performance of NHS England and the clinical commissioning groups that purchase those services. The report does not look in detail at primary care, social care, public health or other similar services. We set out our audit approach in Appendix One and our evidence base in Appendix Two. Technical notes explaining how we have treated some of the financial data are in Appendix Three.

Key findings

Trends in the financial performance of NHS bodies

5 **In 2013-14 NHS bodies achieved a net surplus of £722 million, made up of an £813 million underspend by commissioners and a £91 million net deficit by NHS trusts and foundation trusts.** This is one-third of the £2.1 billion net surplus that strategic health authorities, primary care trusts, NHS trusts and foundation trusts achieved in 2012-13. At the end of 2012-13 commissioners' cumulative surplus stood at £1.2 billion. In 2013-14 commissioners needed to use £400 million of their brought-forward surplus, reducing it to £813 million (paragraphs 1.5 and 1.6).

6 **More NHS trusts and foundation trusts reported deficits in 2013-14 than in 2012-13.** Comparing the two years, 18 NHS trusts and 26 foundation trusts moved from reporting a surplus in 2012-13 to a deficit in 2013-14. The gross deficit for all trusts increased from £297.2 million in 2012-13 to £743.3 million in 2013-14. The average deficit decreased from £11.9 million to £11.6 million. Foundation trusts have more financial freedom than NHS trusts, and a short-term deficit is not necessarily evidence of financial weakness. However, only 5 foundation trusts moved from a deficit in 2012-13 to a surplus in 2013-14 (paragraphs 1.7 to 1.9).

7 **Trusts in surplus in 2013-14 were likely to have a lower surplus than they had in 2012-13.** The number of NHS trusts and foundation trusts with a surplus fell from 222 in 2012-13 to 182 in 2013-14 and, for those trusts, their average surplus fell from £4.0 million to £3.6 million (paragraph 1.7).

8 **The average earnings before interest, tax, depreciation and amortisation (EBITDA) margin for NHS trusts and foundation trusts has fallen over the past 4 years.** The EBITDA margin is a key measure of the financial health of NHS trusts and foundation trusts. Monitor (the statutory regulator for NHS foundation trusts) uses, as a guide, 5% as one threshold to test whether an NHS trust is financially strong enough to be licensed as a foundation trust. The average EBITDA margin for NHS trusts fell from 5.4% in 2012-13 to 4.2% in 2013-14. For existing foundation trusts, the average EBITDA margin fell from 5.7% to 5.0%. By the end of 2013-14, 70 foundation trusts (48%) had fallen below the 5% threshold (paragraphs 1.10 and 1.11).

9 **Financial risk in NHS trusts and foundation trusts is increasing.** Monitor and the NHS Trust Development Authority (NHS TDA) use various measures, including financial and continuity of service ratings, to assess the risk to services among provider bodies. At the end of 2013-14 Monitor gave 20 acute foundation trusts (24% of the acute sector) continuity of service risk ratings of 1 or 2 on a 4-point scale (meaning that these trusts are of the most concern). The NHS TDA rated more than half the NHS trusts – 55 of 98 – as having 'formal action required', 'material issues' that had already been identified, or 'concerns requiring investigation' (paragraphs 1.17 to 1.20).

10 **Based on forecasts at 30 June 2014, NHS trusts were forecasting a net deficit in 2014-15 of £404 million and foundation trusts a net deficit of £108 million.** This compares with initial plans of a net deficit of £425 million for NHS trusts, and £20 million for foundation trusts. The deterioration in foundation trusts' forecast position is consistent with their 2013-14 performance. In 2013-14, 19 foundation trusts originally planned a deficit but 41 were in deficit by the year end (paragraph 1.6).

Pressures on the financial sustainability of NHS bodies

11 **Providers and commissioners in financial difficulty have not matched pressures on funding with equivalent reductions in expenditure.** Between 2012-13 and 2013-14 total spending by trusts increased by 4.3%, while income increased by only 3.5%. The difference between changes in income and expenditure was greater for trusts in deficit (-1.9%) than in surplus (-0.3%). A few NHS trusts and foundation trusts reported large surpluses. However, 20 NHS trusts and 9 foundation trusts reported deficits of more than £10 million or more than 5% of their income in 2013-14. In 2013-14 providers were required to deliver 4% efficiency savings and this requirement is expected to continue for the next 4 years. Monitor, NHS England and the NHS TDA plan to make more transparent the additional income providers are paid over and above nationally set prices. This will help show whether providers are achieving real efficiency savings, or relying on increasing their income to break even. If providers do not achieve efficiency savings while remaining within locally agreed contracts and nationally set prices, their financial performance will worsen (paragraphs 2.2 to 2.5).

12 **Despite payment for emergency admissions at a 30% marginal rate, demand continues to increase.** Trusts are paid at a marginal rate of 30% of the full tariff for all emergency admissions above a baseline set from the number of admissions in 2008-09. The Department introduced this payment method to discourage unnecessary emergency admissions. We reported in October 2013 that emergency admissions had increased in 62% of trusts since the introduction of the marginal rate for emergency admissions. Case study trusts told us that demand is increasing, and it is not always possible to discharge patients into the community in a timely way. All the acute trusts we spoke to told us that payment for emergency admissions did not meet their costs. In practice, payment at the marginal rate may not give commissioners strong enough incentives to make alternative community care available. Increasing demand for emergency admissions will also reduce the resources commissioners have to invest in alternative primary or community care (paragraph 2.7).

13 NHS England underspent by £279 million compared with its original plan but, within this net total, it overspent £377 million on directly commissioned specialised services. The overspend was partly due to over-ambitious planning assumptions when responsibility for these services transferred from strategic health authorities. NHS England offset this pressure through use of its reserves (paragraph 2.8).

14 The clinical commissioning groups with the largest deficits are those with the widest gap between their target funding allocation and the income they received. Forty-nine clinical commissioning groups performed less well than originally planned: 12 of these had forecast a surplus but ended the year in deficit. The local auditor of clinical commissioning groups referred 19 bodies in deficit to the Secretary of State for spending more than their authorised resource limit. Nineteen of the 20 clinical commissioning groups with the tightest financial positions had received less than their target funding allocation (by 5.0% on average). Eighteen of the 20 clinical commissioning groups with the largest surpluses had received more than their target funding allocation (by 8.8% on average) (paragraphs 2.9 and 2.10).

15 Despite diversity in local health economies, some common features of the cost base for providers help explain their performance. As an example of local variation, the balance between providers' fixed and variable costs differs between trusts depending on locally negotiated arrangements such as property services and maintenance contracts (paragraph 2.12). Our analysis nonetheless shows:

- The surplus or deficit of an NHS trust or foundation trust is not explained by the financial strength of the clinical commissioning group that gives a provider the largest funding (paragraph 2.11).
- Historic private finance initiative (PFI) debt can make it more difficult to change the way estates and buildings are used. Among organisations with PFI commitments, those with the highest capital charges, as a proportion of their income, were the most likely to report weak financial results in 2013-14 (paragraphs 2.16 and 2.17).
- Some trusts have increased their spending on temporary or locum staff to tackle staff shortages or maintain clinical standards. Four of our 8 case study trusts had done this. Total spending on temporary staff increased by 23% between 2012-13 and 2013-14 (paragraph 2.19).
- Trusts with the best performance in achieving the 4-hour target to admit, transfer or discharge patients from A&E departments are likely to have a higher surplus than others. However, clinical performance does not generally explain financial performance (paragraphs 2.20 and 2.21).

Managing financial risks

16 NHS trusts and foundation trusts under financial stress continue to rely on cash support from the Department. In 2013-14 the Department issued £511 million cash support to 21 NHS trusts and 10 foundation trusts in the form of revenue-based public dividend capital (PDC). This is an increase of £248 million compared with 2012-13. The Department provides revenue-based PDC so that organisations in difficulty have the cash they need to pay creditors and staff. Since 2006-07, the Department has issued a total of £1.8 billion revenue-based PDC, of which £160 million has been repaid (paragraph 3.6 and 3.8).

17 Financial plans submitted by commissioners and providers covering the 2 years 2014-15 and 2015-16 have had to be revised and 2015-16 plans are not yet finalised. Commissioners and providers submitted 2-year operational plans in April 2014. The NHS TDA, Monitor and NHS England did not expect these plans to change. However, in the 5-year plans (covering 2014-15 to 2018-19) submitted at the end of June 2014, more than 50% of foundation trusts changed their 2-year plans, with most of the changes made to their 2015-16 forecasts. Between April and June 2014 nearly 75% of NHS trusts refreshed their plans, although only 8 made material changes to their forecasts. There remains considerable uncertainty about the impact on 2015-16 plans of initiatives such as the Better Care Fund, which both the Department and NHS England expect to reduce demand for acute hospital services. We will revisit this planning process for commissioners and providers in 2015, when relevant data will be more stable (paragraphs 3.17 to 3.19).

18 Trusts are expecting to receive more income than commissioners are expecting to spend on healthcare services. Data are not complete but, in August 2014, income forecasts exceeded planned commissioning spending by an estimated £404 million for 2014-15. Based on provisional figures, the gap for 2015-16 was £2.2 billion, potentially rising to £8.7 billion by 2018-19. These assumptions are consistent with evidence from our case studies, in which we found trusts were not confident that commissioners would be able to reduce demand for healthcare. Trusts forecasting deficits are assuming that the Department will continue to provide cash support (paragraphs 3.20 and 3.21).

19 Relationships between local bodies are not mature, and it is not clear where responsibility for strategic change will lie. Commissioners and providers told us the new structure felt fragmented, particularly at regional level. Senior staff we interviewed in NHS trusts and foundation trusts thought no organisation was responsible for taking a strategic view across the whole local health economy, but they were trying to bring about the transformational changes needed. Providers felt the patient services they offered would be at risk in the event of a failure by the system to plan effectively, and recognised the importance of working with clinical commissioning groups. Havering Clinical Commissioning Group, for example, told us it is working with 2 local clinical commissioning groups to coordinate strategic change and reconfigure services across the local health economy (paragraphs 2.22 and 3.23 to 3.25).

Conclusion on value for money

20 Headline measures of financial sustainability worsened between 2012-13 and 2013-14, largely due to growing financial stress in the NHS trusts and foundation trusts that provide hospital, mental health and community services. The total net surplus of NHS commissioners and providers was lower in 2013-14 than in 2012-13. NHS England expects clinical commissioning groups to achieve a surplus, but 19 of them did not do so. Among NHS trusts and foundation trusts, the average EBITDA margin was lower, more of them were in deficit and those not in deficit reported a lower average surplus. An increasing proportion were assessed by regulatory bodies as high risk.

21 These trends are not sustainable. An increasing number of providers and commissioners are in financial difficulty. Some NHS bodies have not made large enough cost savings, or contained the increasing demand for services within their available funding, whilst meeting quality and access targets. Parts of the NHS are achieving efficiencies by reconfiguring services to best meet patients' needs within available resources. However, commissioners' and providers' plans for 2014-15 and 2015-16 were delayed and 2015-16 plans are not yet stable. As in previous years, the Department provided cash support to the most challenged organisations in 2013-14 and some bodies are still planning that cash support will continue to be available. Until the Department explains how it will work with NHS England, NHS TDA and Monitor to address underlying financial pressures, quickly and without recourse to annual cash support, we cannot be confident that value for money, in terms of financial and service sustainability, will be achieved over the next 5 years.

Recommendations

22 The Department should work with regulators and oversight bodies to strengthen processes for testing and aligning the assumptions of commissioners and providers. The NHS faces challenges in meeting demand within resource limits. Unless there is alignment between the assumptions the Department, Monitor, NHS TDA and NHS England make about key factors such as activity growth, income, spending plans and productivity then this will increase uncertainty and financial risk. As part of the annual planning process, oversight bodies need to understand the assumptions commissioners and providers have included in setting contracts in order to assess the risk associated with achieving them. This will help avoid pressures being dealt with in an unplanned or uncoordinated way.

23 Monitor, the NHS TDA and NHS England should make more transparent use of the 1–2 and 3–5-year forecasts to improve understanding of financial sustainability across the NHS. This should help the Department assess whether overall spending within the NHS is likely to be in line with available resources and what levels of ongoing cash support may be needed by challenged organisations as part of any reconfiguration or financial recovery plan. It should also encourage better informed strategic decision-making in local health economies.

24 **The Department and oversight bodies should strengthen the support they provide to help NHS commissioners and providers review and redesign services more quickly.** This may involve providing more guidance and advice, identifying the incentives and capability needed to implement changes and working with local partners to make the case for change. The NHS is coming to the end of its first 5-year efficiency challenge, but some commissioners and providers are only now carrying out strategic service reviews.

25 **The Department should consider, as an alternative to short-term in-year funding to financially distressed bodies, tapered financial support for investment or restructuring matched to clear plans over a longer period and with a clear end point.** Providing non-recurrent support to bodies in financial distress may be necessary in the short term to ensure safe services to patients. However, some providers are becoming increasingly reliant on extra in-year financial support. Because this funding would not otherwise be available to them, it risks creating disincentives and delays to finding sustainable solutions that would represent better value for money in the long term.

26 **NHS England and Monitor, in their review of how urgent and emergency care should be paid for in future, should assess the financial impact of any changes on trusts and commissioners.** A number of acute providers cited the payment structure for emergency admissions as a factor contributing to their challenged financial positions. The review and future payment system should consider all parts of the healthcare system, including commissioners, primary and community care, so that responsibility and incentives across the system are shared.

27 **NHS England should reinforce to clinical commissioning groups the requirement that they set out in planning documents how they have considered the impact of their decisions on other parts of the local health economy.** There are examples of clinical commissioning groups starting to do this. But the Committee of Public Accounts has previously raised concerns whether devolved commissioning decisions would take a sufficiently strategic and joined-up approach to meet patient needs. NHS England should promote best practice. It should also be prepared to challenge more robustly commissioners' plans that do not clearly consider the impact on the wider health economy and explain how competing demands for limited resources from different providers and commissioners will be resolved.

28 **The Department should work with oversight bodies to collect consistent financial data from providers.** Trusts do not collect and record cost data consistently enough or in enough detail for systematic analysis. This limits the ability of providers and oversight bodies to undertake in-depth time series analysis, modelling, efficiency assessments and benchmarking.

Ambulance Quality Indicators

This contains background material for the Ambulance System Indicators (AmbSYS) and Clinical Outcomes (AmbCO) for all eleven Ambulance Trusts in England.

Data

The following webpages are / were updated monthly, with the latest Statistical Notices, spreadsheets and text files:

Ambulance Quality Indicators Data 2014-15

Ambulance Quality Indicators Data 2013-14

Ambulance Quality Indicators Data 2012-13

Ambulance Quality Indicators Data 2011-12

The following interactive spreadsheets, updated monthly, show Time Series data from April 2011 to the latest published month. Users can select whether to view data for all England, an individual trust, or a commissioning region:

Ambulance Systems Indicators Timeseries to October 2014 (XLSX, 503KB)

Ambulance Clinical Outcomes Timeseries to July 2014 (XLSX, 312KB)

CSV Data

Download AmbSYS. Full Extraction till October 2014 (CSV, 120KB)

Download AmbCO. Full Extraction till July 2014 (CSV, 77KB)

Dashboard

This dashboard of Systems Indicators and Clinical Outcomes contains identical data to the Time Series files above, but presents the data in a macro-driven layout with a map and an overview flowchart through the ambulance call process. It contains an embedded Narrative PDF with further information, and Ambulance Services are able to download this spreadsheet and place a version on their own websites with an updated narrative.

Download Amb.CQI Dashboard April 2011 to October 2014 (XLS, 4726KB)

Supporting information

This Statement describes the Quality of the statistics, along with a revisions policy, and information on user engagement:

AQI Quality Statement (PDF, 241KB)

The following document contains the specification guidance for data suppliers on what NHS England require:

AQI Guidance V1.31 (DOCX, 173KB)

The following timetables contain dates for data collection and publication:

2014-15 Ambulance Quality Indicators Publication Timetable (DOCX, 31KB) (Revised on 27 October. 2014)

2013-14 Ambulance Quality Indicators Publication Timetable (DOC, 42KB)

2012-13 Ambulance Quality Indicators Publication Timetable (DOC, 40KB)

Similar data from other sources

The Ambulance Services publication by the Health and Social Care Information Centre contains AQI data, and statistics from the KA34 data collection 2004-05 to 2012-13, which are similar but not directly comparable with the AQI data.

Weekly Category A response times from 7 November 2010 to 29 May 2011 are still available on an archive website: Ambulance Weekly Sitreps.

Rest of UK

Wales ambulance data from the Welsh Government.

Scotland ambulance data in Quality Improvement Indicators documents from the Scottish Ambulance Service.

Northern Ireland ambulance data from the NI Department of Health, Social Services and Public Safety.

Contact Details

We welcome questions and feedback on these Ambulance Quality Indicators, sent by any method, to:

Ian Kay, Analytical Services (Operations), NHS England, Room 5E24, Quarry House, Leeds LS2 7UE

i.kay@nhs.net

0113 824 9411

6 January, 2015

Winter pressures daily situation reports for 8 to 14 December 2014

19 December, 2014

Delayed Transfers of Care: monthly situation reports, November 2014

19 December, 2014

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Association of Ambulance Service Chief Executives (AACE)

AACE provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. Its primary focus is the ongoing development of English ambulance services and the improvement of patient care.

To visit the AACE website, click here

To view the AACE Annual Report for 2013/2014, click here

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Ambulance station closures will make way for bigger hub

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TO BE SHUT Portsmouth station on Eastern Road and, inset, Gosport station in Privett Road.

by Sam Bannister
sam.bannister@thenews.co.uk

Published on the
22 May 2012 15:19

A DECISION to close four ambulance stations to make way for a central hub – without consulting the public – has been criticised by council leaders.

Stations at Portsmouth, Havant, Gosport and Fareham will all shut under plans by the South Central Ambulance Service (SCAS).

Instead, staff will start their shifts at a new location still to be decided near the top of Portsea Island.

Paramedics will then move to 'standby points' in their areas from where they will respond to 999 calls.

SCAS say patients will not see a difference in emergency cover.

But councillors are angry they were not told about the plans. And there are also concerns about response times, with paramedics starting work miles away from the patches they cover.

Fareham Borough Council leader Sean Woodward said: 'It would have been nice to have been consulted about it. People will be worried about this until we get to the bottom of exactly what is being proposed.

‘While it will mean no time taken to get to Portchester, clearly you can’t get from somewhere like Hilsea to Sarisbury in the same time. I would want to know what a standby point is and where they are going to be.’

Gosport Borough Council’s health spokesman Cllr Peter Edgar said there should be a consultation exercise to put the public’s minds at rest.

He said: ‘It’s an absolute disgrace they haven’t gone to the public about it. This is a signifcant change and they should have gone to the public and health scrutiny committees.

‘There are questions that need to be answered and could only be answered in a consultation.’

The decision was made by the SCAS trust board at a meeting at its headquarters in Bicester, Oxfordshire.

It agreed to set aside up to £1.8m to ft out the new ambulance hub. A unit at Northarbour Road in Cosham, has been identifed but a deal has not yet been reached.

Head of operations at SCAS Neil Cook said: ‘Because we’re not changing the service there is not a need for us to negotiate with the public. We have brought this to all our councils over the years.

‘If you ring 999 you will get an ambulance or a car the same way you do now.’

He said shifts will overlap to make sure there is coverage in each area at all times.

Mr Cook said in around 84 per cent of call-outs, ambulances are sent from mobile locations, adding: ‘Very few go from base and those that do are usually at the start of a shift or on a meal break. We have got a good ambulance service and I want to improve that.

‘It’s going to be good for staff and good for patients and I’m hopeful that if anything they will see an improvement.’

Plan will see new standby points for paramedics

THREE of the stations in Portsmouth, Gosport and Fareham will be disposed of while South Central Ambulance Service will surrender the lease on its Havant base.

The ambulance service (SCAS) will then set up a number of formal standby points in each area to give staff access to facilities they need.

These will be strategically placed throughout each area, with the idea being that ambulances are in easy reach of the entire patch.

Many of the ambulance stations that are set to close are no longer ft for purpose.

In Gosport, ambulances are unable to ft inside the station because they are too tall.

And the Portsmouth station in Eastern Road is more than 50 years old.

Being based on the often congested Eastern Road also presents problems with access to the city.

SCAS says a central hub would make it easier for vehicle maintenance, staff training and accessibility to all the areas in south-east Hampshire.

Any changes are not expected to begin for another 12 to 18 months.

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31 January 2013 Last updated at 16:16

West Midlands ambulance stations to be sold off

Six ambulance stations are to be put up for sale in the West Midlands next week.

West Midlands Ambulance Service expects its Coventry hub to be ready by April

The ambulance service expects to net more than £2.5m from the sale of three stations in Shropshire, two in Warwickshire and one in Worcestershire.

It is part of its £9.6m Make Ready scheme, which will see the creation of a number of hubs and community stations across the region.

The service said the sale of stations would be used to help fund the project.

Shropshire already has a couple of hubs which act as 24-hour vehicle and ambulance preparation depots in Shrewsbury and Donnington.

The county's stations to be put up for sale are those on Morda Road in Oswestry, Abbey Foregate in Shrewsbury and Queens Way, Whitchurch.

Community stations, which West Midlands Ambulance Service (WMAS) lease, are already operating in, or are planned for, the three towns.

'Assistants kitting vehicles'

Coventry and Warwickshire will be served by two hubs in Coventry and Warwick which are expected to be ready by April and July respectively.

Offers are being invited for the stations in Elliot Way, Nuneaton, and Brownsover Lane, Rugby, from next week.

The service has said it will not move out until two community stations are built in both towns.

Evesham's ambulance station in Davies Road is to be sold but the location of a community station in the town is yet to be decided.

Two traditional stations in Spetchley Road, Worcester and Barnsley Hall Drive, Bromsgrove, are being refurbished to become Worcestershire's hubs at a cost of £1.45m.

WMAS said the remainder of its traditional stations will also be sold off in due course.

Nigel Wells, from WMAS, said the scheme would be better for patients.

Mr Wells said: "We're having these community paramedic sites out in the community so the cars will already be out there.

"We already move the ambulances across the county all day long and they

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will go out from this hub fully equipped, fully checked and fully supplied.

"At the moment we've got paramedics kitting vehicles and their time is better serving patients so we're going to have a team of ambulance fleet assistants kitting these vehicles.

"Across the region this is a £9.6m project so there's no savings there.

"The only savings we will see are in operating costs."

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9 May 2012 Last updated at 12:44

More West Midlands ambulance stations to be put up for sale

Five more ambulance stations in the Black Country are to be sold as crews move to new premises.

West Midlands Ambulance Service NHS Trust said the traditional ambulance stations would be replaced with community stations, some of which are shared with other emergency services.

The stations to be sold are Park Lane, Tettenhall and Penn in Wolverhampton and two in Bilston and West Bromwich.

Five stations put on the market by the trust in January are still for sale.

'Maintenance hubs'

The trust said the buildings were on sale for between £80,000 and £235,000.

The move to community ambulance stations follows a model successfully pioneered by Staffordshire Ambulance Service more than 10 years ago, the trust said.

They said crews would spend less "down time" cleaning and restocking and would pick their ambulances up from one of two maintenance hubs which will prepare, service and maintain the fleet.

The trust said the money saved would be channelled into "frontline ambulance provision".

Ambulance unions have said they are "working very closely with the service" to mitigate any problems around working practices for the staff involved.

Five stations in Wombourne, Stourbridge, Oldbury, Halesowen, and Cradley Heath were put up for sale by the trust in January.

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18:00: Good evening BBC Local Live will be back from 08:00 on Wednesday with the latest news, sport, travel and weather for Birmingham and the Black Country.

For the latest on Walsall Manor Hospital declaring a major incident **read more on BBC News.**

17:50: Overnight weather forecast **It will be a cold evening and night** with largely clear skies and light winds allowing a patchy frost to develop.

Isolated mist and shallow fog patches may also form in the south east of the region for a time.

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27 July 2012 Last updated at 11:40

Worcestershire ambulance 'superhubs' approved

Plans to sell three ambulance stations and create two new "superhubs" in Worcestershire have been approved.

West Midlands Ambulance Service said that stations on Spetchley Road, Worcester and Barnsley Hall Drive, Bromsgove would get a £1.45m upgrade.

Both will acquire a 24-hour vehicle and ambulance preparation depot.

Three stations, in Kidderminster, Evesham and Redditch, will be replaced with an increased number of lower-cost community stations.

The ambulance service said the lower-cost stations would "ensure a faster response to emergencies".

These include three community ambulance stations in Redditch, three in Kidderminster and three in Worcester, in addition to the hub in Spetchley Road.

'Prolonged delay'

Ambulances prepared at the hubs in Worcester and Bromsgrove will disperse to community ambulance stations around the county from where they will respond to medical emergencies.

Advanced community paramedics will also be trained to treat patients in their own homes instead of at A&E. The ambulance service said this would reduce "unnecessary trips to hospital".

However, Ray Salmon, regional organiser for Unison, is concerned about the affect the changes could have on both staff and patients.

He said: "For some patients, for example stroke or cardiac cases, there may be a need to get them to hospital as soon as possible.

"If the rapid-response vehicle then has to call for an ambulance, particularly in rural areas, there's going to be a prolonged delay before they actually get to the patient, and overall that will impact on the quality of care that the patient receives."

The changes are part of the Make Ready scheme which is due to be fully implemented in Worcestershire next year.

Ambulance trust chairman Sir Graham Meldrum said: "It will undoubtedly bring real benefits for patients by allowing us to invest even more money in frontline services.

"Once fully implemented, Make Ready will free up resources that can be re-invested in patient care."

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Evesham ambulance site is subject of a care-home application

The former ambulance station could become a care home

First published Sunday 24 November 2013 in News

EVESHAM'S ambulance station site could become a care home if re-development plans are successful.

The building in Davies Road is currently still in use by the emergency services but is being sold off due to funding cuts.

It is under offer from an unnamed buyer after being put on the market in January for £600,000.

Plans submitted by Restful Homes Development, which is not confirmed as the

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company to have made the offer on the building, would see it transformed into a 66-bed care home.

The application was welcomed by Evesham Town Council, with Councillor Gerry O'Donnell saying he was happy to see more homes for the elderly.

"I would support this," he said.

"I don't think it has got a huge environmental impact.

"It is right across from the college so I don't see any problem and I have not received any representations."

Coun Robert Raphael said: "It is a three-storey building so I do have concerns over privacy and potential blocking out of light but I am sure that Wychavon council will look into that."

When the ambulance base closes, it will relocate to a community station in Abbey Lane, which is currently being refurbished.

This will not happen until the Abbey Bridge in the town centre is re-opened.

A spokesman for West Midlands Ambulance Service said the service currently had a temporary station at the fire station and at the site in Davies Road so it could respond on either side of the river while the bridge is out of action.

At the new Abbey Lane station there will be a rapid response vehicle, an advanced paramedic and the facility for an ambulance.

The spokesman added that an ambulance would not be based permanently at the station with assessments made on where it is needed most at the time.

The care home proposals will be considered by Wychavon District Council's planning committee at a later date.

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5 August 2013 Last updated at 18:26

East Midlands Ambulance Service: Corby station will 'remain open'

An ambulance station earmarked for closure in Northamptonshire will "remain open", the East Midlands Ambulance Service (EMAS) has confirmed.

Andy Sawford has campaigned against the closure of the Corby station

Corby MP Andy Sawford told the BBC the town's station was saved after a U-turn on Friday.

In a statement, EMAS said the station would not be closed, but it would continue with its "Being the Best" programme.

Under the review, five other stations in the county are to shut.

Plans are currently under way for Daventry, Mereway, Rushden, Towcester and Wellingborough stations to close, with Northampton and Kettering set to become ambulance hubs for the whole area.

Mr Sawford said: "It's good news for the whole county that Corby is staying open.

"To go down to just two stations was wrong. What I didn't want to happen was for ambulances to be starting at Kettering at best, and at worst further away, when people ring 999."

EMAS's chief executive Phil Milligan resigned last week following a difficult year for the organisation.

It has been criticised over its handling of the station review, as well as failing to hit response-time targets.

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23 August 2013 Last updated at 10:32

Lincolnshire ambulance station plan set to go ahead

EMAS said it would now continue with plans to restructure the service in Lincolnshire

East Midlands Ambulance Service (EMAS) has said plans to reform its Lincolnshire services have been given the go-ahead by an independent panel.

Plans to reorganise the county's services were referred by the secretary of state to an independent review body in June.

The county's Health Scrutiny Committee had raised concerns over plans to cut ambulance stations from 18 to three.

EMAS interim chief executive Jon Sargeant said plans would now continue.

'Disappointed' with decision

"We've heard back from the Independent Reconfiguration Panel (IRP) and they have decided that the process doesn't need to go to fuller review so we are now free to continue with our programme," said Mr Sargeant.

"We're just looking at restarting work in Lincolnshire and we're working very closely with Lincolnshire County Council."

Councillor Christine Talbot, chair of the Health Scrutiny Committee for Lincolnshire, said: "I am disappointed that the issues we raised won't be looked into further but the IRP have at least recognised there are problems with the performance of EMAS.

"I'm very pleased that the IRP believe the scrutiny committee had reason to have concerns over this and that EMAS should provide further clarification on how it expects improvements in performance to actually be

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- 2012-13 budget £148 m
- Gets to 91.8% of life-threatening emergencies within 19 minutes (target 95%)

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achieved.

"We now need to look to future working with EMAS to get the best possible outcomes for Lincolnshire from their ambulance service and we're committed to monitoring the changes and keeping this high on the agenda."

EMAS has been fined £11m over three years for missing response time targets.

In March, its five-year plan to create three "super-hubs", 19 smaller stations and 108 community points was approved by its board.

The service said the new structure would improve response times.

The super-hubs are planned for Lincoln, Boston and Grantham.

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25 March 2013 Last updated at 16:53

East Midlands Ambulance Service stations plan approved

Plans to reduce the number of ambulance stations in the East Midlands from 65 to 28 have been approved.

A new structure has been revealed for East Midlands Ambulance Service

The new structure will create nine "super hubs" and 19 smaller stations, plus 108 community points, where ambulance staff will be based between calls.

The East Midlands Ambulance Service (EMAS) board, which approved the plans, said they will improve response times.

But unions described the measures as "a cull".

The plans, which were subjected to lengthy consultation, will come into effect over the next five years.

EMAS faced opposition from residents in towns including Grantham and Hinckley who feared losing their ambulance stations.

'No jobs lost'

Chief executive of EMAS, Phil Milligan, said: "The way we operate now is not delivering the performance people deserve. The changes will improve response times by up to 4%."

Under the plans, the "super hubs" will maintain vehicles, while the small community points, located in GP practices or town halls, will contain rest facilities for staff.

No jobs are being lost as a result of the closures, the service said.

But Mark Hill, of Unison, said: "With 28 stations for the whole of the East Midlands, ambulances in rural areas are going to be travelling a lot further to reach patients."

Neville Jones, 38, from Brackley, Northamptonshire, said he did not believe the changes would help EMAS meet their eight minute response time target for life-threatening emergencies.

Mr Jones said he waited approximately 30 minutes for an ambulance after he helped a heart attack victim in 2011.

The incident occurred half a mile from Brackley ambulance station but the Brackley ambulance was attending an incident in Northampton.

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When an ambulance arrived, the man was pronounced dead at the scene.

Mr Jones said: "I'm pretty horrified about the level of service we get."

EMAS has apologised to Mr Jones in a letter.

Mr Milligan said: "Once these vehicles leave the ambulance station they can be deployed anywhere within the county."

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Stamford ambulance station will close

East Midlands Ambulance Service

Stamford crews will work from a base in Bourne in radical shake-up of services

Stamford ambulance station will close and crews covering the area will begin their shifts in Bourne following a decision to twin the town's station.

Published on the 18 October 2013 11:00

Picks of the day

The East Midlands Ambulance Service, known as Emas, approved the twinning of the station as an interim measure, at a trust board meeting on September 30.

Emas insists the twinning programme, which will see Stamford and Bourne's staff sharing one base in Bourne, and Melton's and Oakham's staff sharing one base in Oakham, will not impact on response to 999 calls or levels of service.

It will mean staff from Stamford and Melton travelling to their twinned stations to start their shift, picking up their vehicles and then either responding to a 999 call or moving to a 'strategic stand-by point' and awaiting their next call.

The move is the frst step in the changes Emas will make as part of its Being the Best programme which will see nine central hubs, 19 stations and 108 smaller community ambulance posts created in a bid to improve response times.

As part of the twinning programme half the stations involved, including the Stamford station in Ryhall Road will close.

The twinning programme was due to be completed by December 8 however the Emas board insisted the project could not start until community ambulance stations, were in place.

The move comes as a temporary reprieve for Bourne and Oakham with the station in South Road, Bourne, and Station Road, Oakham, now expected to stay operational for a number of years.

Emas is still consulting on how many years it will take to carry out the changes however if the longest, 10 year, option is chosen, the arrangement will remain in place until new permanent ambulance stations are built in Market Deeping in 2020 and Melton in 2019.

At that time the Bourne and Oakham stations will close.

An Emas spokesman said: "Two station twinnings have already taken place in Nottinghamshire with no derogation of local ambulance service or provision. There will be no difference to local people.

"Twinning is an interim measure which helps us deliver the aims of our Being the Best plans. We continue to respond to local 999 calls as we do now - by getting the nearest available ambulance resource to them as quickly as possible."

The spokesman added: "We understand that change is never easy and at Emas we are experiencing signifcant developments in all areas of our service."

There will be no frontline job losses as a result of the twinning project.


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NHS spending doubles on private ambulances used for 999 calls

Senior medics and safety campaigners fear patient safety is being jeopardised by relying on private firms to answer emergency calls as expenditure doubles in three years

An investigation by The Telegraph reveals that the amount spent by the NHS on private and voluntary services to provide 999 care has risen from £24m to £56m in three years Photo: ALAMY

By Laura Donnelly, Health Editor
3:00PM BST 09 Apr 2014

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Spending on private firms to provide 999 ambulances across swathes of Britain has doubled in three years, an investigation has found.

Senior medics and safety campaigners said they fear patient safety is being jeopardised by a heavy reliance on commercial firms to answer emergency calls.

An investigation by The Telegraph reveals that the amount spent by the NHS on private and voluntary services to provide 999 care has risen from £24m to £56m in three years.

The College of Emergency Medicine last night said the routine use of the firms was “incredibly wasteful and potentially dangerous” – with too little oversight of private firms which provide the service.

Ambulance trusts said they had litttle choice, warning of a “national shortage of paramedics”.

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Freedom of Information disclosures reveal that seven of England's 10 ambulance trusts have increased spending on commercial firms and voluntary ambulances since 2010.

In London, around 4,000 emergency calls a month now receive a response from a private ambulance, after an 11-fold increase in spending on such firms from £829,000 in 2010 to £9.2 million in 2013.

In the South East Coast area, spending rose from £1.5 million to £9.5 million, while in East of England, it increased from £4.5 million to £11.2 million.

The firms are staffed by former NHS paramedics and ambulance technicians, "moonlighting" health service staff, and others who privately undergo training courses to become a technician, which gives them more basic skills than a paramedic.

There are dozens of such firms in Britain, but until recently most have been used by the health service as "patient transport" transferring non-emergency patients to and from hospital.

When in opposition, Conservative shadow health ministers said it was "beyond belief" that blue-light NHS services had begun to be contracted out to private agencies.

Five years ago, one quarter of ambulance trusts used private and voluntary agencies for 999 calls.

Now all ambulance services are using such firms.

Patients groups' last night said they were "deeply concerned" by the trend, fearing that some of the firms did not adequately train staff, while others had a poor record for hygiene and safety.

Dr Cliff Mann, President of the College of Emergency Medicine, which represents Britain's emergency doctors, said: "When trusts began using private firms for 999 calls they said it was only as a 'last resort' but the scale here is nothing is like that – it's deeply concerning."

"It is incredibly wasteful – because trusts have to pay a premium to use these agencies – and it's also potentially dangerous because they aren't part of the normal system of monitoring so it's harder to know how safe they are."

Katherine Murphy, Chief Executive of the Patients Association said she was "shocked" by the scale of the spending, and feared that the use of private firms was putting patient safety at risk.

Andy Burnham, Labour shadow health secretary said the trend was "worrying".

He said: "When people dial 999, they don't expect a private ambulance to turn up. But that is increasingly what is happening. The tendering out of blue-light 999 services provides proof that the Government sees no limits on the extent of privatisation in the NHS."

Jason Killens, Director of Operations, from London Ambulance Service said: "Our first choice is always to use our own staff to respond to emergency calls. However, with increasing demand and a national shortage of paramedics, we also contract carefully selected private ambulance crews to respond to incidents."

Other ambulance trusts said they were attempting to recruit more staff in

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order to reduce the use of private ambulances.

A spokesperson for NHS England said: “Local ambulance trusts are responsible for providing a high quality, safe service for patients, appropriate to specific local needs.”A Department of Health spokesman said: “This Government has stipulated for the first time that they register with the Care Quality Commission and must meet the same essential standards of quality and safety that all ambulances do.”

28 November 2014 Last updated at 08:02

Seven mental health patients died waiting for beds

By Michael Buchanan
BBC News

Seven mental health patients have killed themselves in England since 2012 after being told there were no hospital beds for them, the BBC has learned.

An investigation of coroners' reports and NHS trust papers with the journal **Community Care** found another patient denied a bed later killed his mother.

It comes as mental health beds are being cut in England - figures show more than 2100 have gone since 2011.

The NHS England said spending on mental health was increasing in real terms.

The investigation by BBC News and Community Care has also revealed an email that a chief executive of a mental health trust wrote to NHS England in frustration this summer after one of her senior officials came to tell her that: "Yet again there were no mental health beds in London in either the NHS or private sector."

Wendy Wallace, head of Camden and Islington NHS Foundation Trust, bemoaned NHS England's lack of interest in the problem. She wrote: "I could not envisage a situation where all the acute beds in London were full and there was not even an investigation into the situation nor a plan of action."

The investigation established that since 2012 seven people across

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England have taken their own lives having been told no beds were available. They were:

- Pauline Binch, 64, from Nottingham
- Stephanie Daniels, 32, from Manchester
- Michael Knight, 20, from Norfolk
- Mandy Peck, 39, from Essex
- Anthony Quigley, 53, London
- Terence Mullin, 53, from Liverpool
- An unnamed man from Sheffield

In addition, Peter Holboll from London admitted the manslaughter of his mother, Tamara, having been told no beds were available.

A ninth person, Amanda Vickers, 47, from Cumbria, died after being denied a bed in a crisis house, a facility used to treat patients outside hospitals.

Case study

Pauline Binch waited nine days for a bed - her husband John said "she'd still be alive today if they'd found her a bed."

Pauline Binch, from Nottingham, started to develop mental health problems in 2010. The 64-year-old took an overdose in June, July, August and September 2013.

Following the fourth attempt to take her life, on 24 September her psychiatrist said that an inpatient admission was required and a request was sent to a bed manager.

No bed was available between 24 and 29 September. On 30 September a bed did become available but the trust could not contact Pauline and that evening the bed was given to another patient. A bed was not found on 1, 2 or 3 October.

At 20:45 BST on 3 October, Pauline's body was discovered at her home.

The investigation into her death concluded: "Bed managers were aware of the severity of risk in PB's case but (with the exception of several hours on 30 Sept 2013) could not find a bed to admit her to." Her husband John told the BBC "she'd still be alive today if they'd found her a bed".

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Last year **the BBC revealed** that 1,711 beds had been closed between April 2011 and August 2013.

New figures, revealed through freedom of information requests from 52 of England's 58 mental health trusts, show that since last August a further 468 beds have been cut.

That means that since April 2011, when there were 18,924 beds available, a total of 2,179 beds have been cut.

Other data from the trusts show that the wards that remain are over-occupied.

Adult acute admission wards are running at an average monthly occupancy level of 101% for the past two years.

The Royal College of Psychiatrists says the occupancy level should be 85%.

It is possible for trusts to exceed 100% as they fill beds temporarily freed-up when patients are allowed out for a short time although filling those beds runs the risk of no bed being available if the patient on leave has a relapse.

Ms Wallace said: "If you need admission to a mental health bed, your need is very high.

"Unless we get some attention, unless we get some understanding of what's happening in the system, and some resources to be able to deal with it, it won't improve."

Flagship policy

Much of the anger within the mental health system is directed towards NHS England which is accused by many of failing to understand or prioritise mental health.

Last year, they suggested to clinical commissioning groups, who buy mental health services, that they cut budgets to mental health trusts by a greater percentage than for physical health hospitals.

The Department of Health and the care and support minister Norman Lamb MP are putting much hope for a change in mental health provision on the **Mental Health Crisis Care Concordat** - their flagship policy for improving care.

But just a month before a deadline for areas to sign up to the agreement, just one third of areas have done so while just 6% have announced plans on how they will put it into practice.

Mr Lamb said: "We've made huge progress but we want to go further to make sure everyone gets the care they need and to ensure that mental health gets treated fairly in the allocation of resources.

"We are going further than ever before to put mental health on a par with physical health."

NHS England's director for people with long-term conditions Dr Martin McShane said: "Spending on mental health is now going up in real terms after years when services were under real pressure.

"One result [of the increase in spending] is big falls in the number of people in mental health crisis ending up in police cells.

"As we expand services patients are also able use NHS-funded beds in the independent sector.

"But the-long term solution is not just about beds, or buildings, as

highlighted in Sir Stephen Bubb's recent report, but about finding the right solution for each patient."

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Funding social care

As the population ages, can we find a fairer system of paying for care so older people do not have to sell their homes?

Full print version, including charts and tables (PDF 141 KB)

In 1997 Tony Blair told the Labour Party conference "I don't want [our children] brought up in a country where the only way pensioners can get long-term care is by selling their home." Local authorities have been able to require people to sell their homes to pay for residential care since 1948. Thirteen years after Tony Blair's speech, local authorities continue to do so.

The impact of demographic change (including an ageing population, expanding numbers of very old people and changes in the willingness of family members to provide informal care for elderly relatives) has placed a strain on social care services and increased demand for residential care. This demand is expected to continue to grow: the number of people in care homes is projected to rise from 345,000 in 2005 to 825,000 in 2041. Public expenditure on long-term care is projected to rise by more than 300% in real terms over that period.

Problems with the current system

Help with residential care costs is currently means-tested. Individuals with assets of over £23,250, including the value of their property, have to fund their own care. Social care recipients with less than £14,250 have all their care home costs paid for by social services. Individuals falling between the two thresholds will have a proportion of the care costs paid for by the state. **The system is seen as inherently unfair, penalising those who have saved for their old age, whilst those who have been less prudent are eligible for state-funded care.**

The number of people who have to sell their homes to pay for care is unknown, although it is estimated that 155,000 people, or 41% of care home residents, are self-funders, up from 35% in 2006. With care home fees averaging £25,000 a year, those with modest amounts of capital will be making a disproportionate contribution to their care. And continued state-funding for increasing numbers of individuals who cannot afford to pay the high cost of care is financially unsustainable.

The politics of social care

Given the need to reform the current system to cope with demographic changes and the emotive issue of older people having to sell their homes to pay for care, it is no surprise that social care has become a key political issue. The three main political parties, social care experts and organisations representing the elderly have failed to reach a consensus on how to fund a more equitable system. Labour's proposal to introduce a compulsory £20,000 levy on people's estates was dubbed a 'death tax' by the Conservatives. The subsequent White Paper proposed a complete overhaul of the social care system by introducing a National Care Service built on NHS principles by 2015, coupled with free accommodation costs after two years in a care home. With the average care home stay at 18 months to two years, many would not benefit from the policy. Those whose stay extended beyond two years would have paid an average of £50,000 in fees before they qualified and therefore could still have to sell their homes.

The Conservatives proposed a voluntary one-off payment of £8,000

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This briefing was written at the start of the 2010 Parliament; for more recent briefings from the Commons Library on this subject see Commons Library Briefing Papers

from every pensioner on retirement in return for free residential care. This was criticised by care groups as insufficient. The Liberal Democrats called for a cross-party commission to consider ways to fund care. An attempt at cross-party talks earlier this year went ahead without the Conservatives, who do not support a compulsory levy.

The Personal Care at Home Act 2010, which received Royal Assent before Parliament dissolved, may go some way to averting the need for some elderly social care recipients to enter residential care by increasing the numbers who receive personal care in their own homes. But with only 130,000 people expected to benefit from this policy, should it be rolled out, and a lack of consensus on how to pay for those who still need residential care, many older people will have to keep waiting for the future envisaged by Tony Blair 13 years ago.

Social care definitions

- **Care home: any establishment providing accommodation with personal or nursing care.**
- **Care homes registered to provide nursing care are sometimes referred to as 'care homes that provide nursing care' or 'nursing homes' to differentiate them from other homes. Nursing care in care homes is provided by NHS-registered nurses.**
- **The provision of personal care services varies between local authority areas but usually covers help with personal hygiene, continence management, assistance with eating, personal assistance and simple treatment.**

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Elderly care crisis claims a million family homes

More than one million families have been forced to sell their home in just five years to meet the cost of paying for residential care, new figures have revealed.

Email

Number of homes sold to pay for care 'could be higher than previously thought' Photo: IAN JONES

By **John Bingham**, Social Affairs Editor
10:00PM BST 03 Sep 2013

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The estimate, based on polling measuring families' individual experiences, is far higher than Government projections have previously suggested.

But charities and pensions experts said it represented one of the first realistic attempts to quantify the scale of the hidden care funding crisis in the UK.

And they claimed that it showed that the Government's long-awaited overhaul of the social care system in England – including the introduction of a cap on bills – does not go far or fast enough to address the crisis thousands of families are facing.

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Jeremy Hunt, the Health Secretary, described the figure as “concerning” but insisted that it served to underline the need for the Government’s reforms.

The estimate, in research by the insurance company NFU Mutual, comes less than a fortnight after a separate study found that another two million people – or a quarter of retired home owners – are already actively planning to sell their home to fund their old age.

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The new research, including polling by ICM commissioned by NFU Mutual, also concludes that as many as three quarters of people who go into residential care in old age might eventually have to sell their home to pay for it.

And it warns that millions of younger people who are currently relying on an inheritance to fund their own retirement could be facing serious financial problems if they do not make alternative plans urgently.

The research also highlighted how more than half of councils have been forced to cut spending on residential care in the last four years despite efforts to shield the sector from the effect of cuts in budgets across the board.

It came as the care minister, Norman Lamb, spoke about how Britain has become a “neglectful society” in which it is becoming accepted for the elderly to spend their final years in isolation because of the way families have become dispersed

He said that while the state had a vital role to play in supporting people in old age, it would never be enough unless people also “step up”, providing basic “kindness and companionship”.

Under the current system in England anyone with assets, including their home, worth more than £23,500 gets no financial support if they have to go into a care home.

The average cost of a room in a care home now stands at just over £28,000 a year but for those needing more intensive nursing care, annual bills regularly reach well over £40,000.

Sweeping reforms of the social care system, based on the landmark recommendations of a commission chaired by the economist Andrew Dilnot, are currently going through Parliament.

They will cap the amount people should have to pay for care at £72,000 – more than twice the level originally envisaged by the Dilnot Commission.

It also does not take into account what people in care will have to pay for accommodation nor any money they have paid for personal care before they were deemed frail enough for social services to step in.

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Overall officials estimate that only one in eight elderly people will ever qualify for the cap.

But, crucially, under the reforms anyone faced with selling their home to pay for care will instead be able to defer the payments by effectively mortgaging their house to the state until their death.

Mr Hunt said: "This Government's ambitious cap on care costs will make England one of the first countries in the world where people do not end up having to sell their homes to pay for care.

"These concerning figures show how much difference this plan will make to the lives of people who've worked hard and saved to pass on an inheritance to their children."

But Dr Ros Altman, a pensions expert and former government policy adviser on ageing, said: "I don't think anybody has properly woken up to the scale of the crisis that we face in social care.

"We have got a pensions crisis because we have millions of people who haven't enough money saved for their pension – the social care crisis is far worse.

"We have tried to adopt an ostrich approach to this, burying our heads in the sand and hoping but will go away.

"Latterly the Government has tried to do something and it is starting to wake up to the scale of the problem but I don't it has woken up to the urgency of the situation.

"We are going to have many more years of people having to find tens of thousands of pounds a year to pay for their care.

"Families have got to realise that whether or not they will inherit money might well depend on the lottery of whether they end up needing care.

"It is a lottery depending on what is wrong with you and where you live which means that you could get all of your care funded by the state or none of it and you won't know in advance."

Overall one in seven people polled were clinging to the belief that they will be able to supplement their pension with income from an inheritance even though that could be wiped out by care costs.

Almost a fifth of those polled said that either they or their partner's parents had had to go into a care home – half of them in the past five years

Of those more than three quarters said that almost all of their parent's assets, including their home, had been eaten up by care expenses.

Overall it estimated that 1.1 properties across the UK have had to be sold in the past five years to pay for care.

Regularly quoted Government estimates claim that only around 40,000 people a year in England have to sell the family home to pay for care every year – or 200,000 in five years.

But the Government figure is based largely on the numbers who go into care homes with only enough savings to last a few months and do not include those who sell their homes first.

The higher estimate by the NFU Mutual is echoed by recent research by the Prudential which found that more than a quarter of retired home owners are already preparing to sell their family home to fund care or general retirement expenses.

Sean McCann, a personal finance specialist at NFU Mutual, said: "Younger generations could be in for a long wait if they're banking on an inheritance to fund their retirement.

“People should be making their own retirement plans rather than factoring in property and wealth that could be whittled away by the cost of care and inheritance tax.”

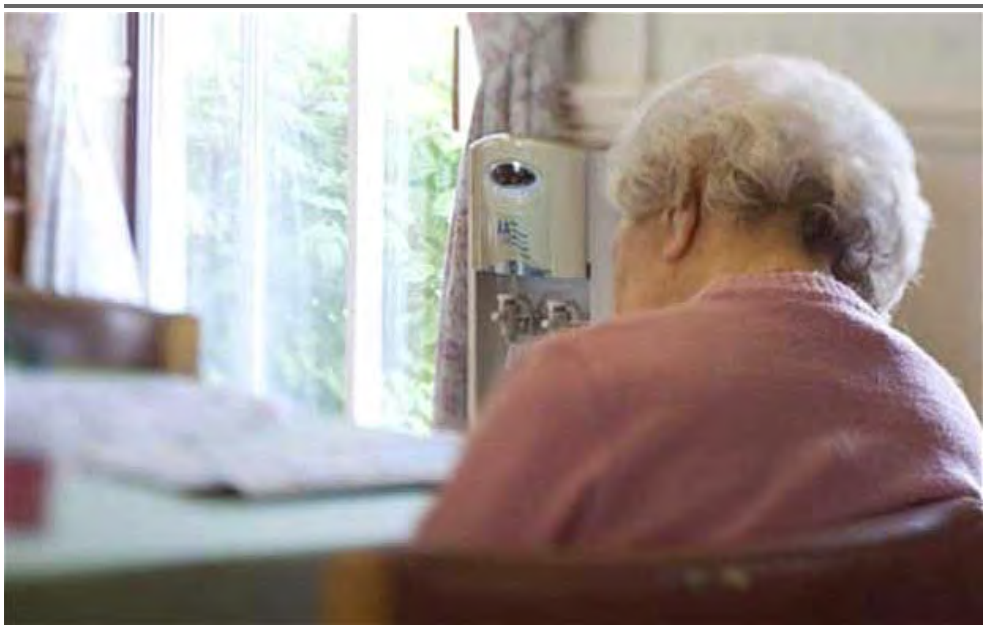
Michelle Mitchell, director general of Age UK said: “Selling homes to pay for care costs is just one of the many problems of our crumbling care system and these figures underline just how deep the problem is.

“There are too many older people who worry that they will lose everything they have worked for and, as this research highlights, there can be serious financial implications for the next generation too.

“The implementation of a cap on care costs in 2016 should help, but as local authority budgets continue to be stretched more and more older people are having to take on an ever greater share of the burden of funding social care, either through being pushed out of the system because of tightened eligibility conditions or because of higher fees and charges."

Care home bills rise by £2,400 in two years

The growing pressure on middle class nursing home residents to prop up the care system is exposed in new figures showing how bills have leapt by more than £2,400 per head in just two years.



Care home bills rise by £2,400 in two years

By John Bingham, Social Affairs Editor
7:30AM BST 30 Aug 2013

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According to a new study, the average cost of a place in a care home in England now stands at £28,367 - more than double the income of a typical pensioner.

Bills have risen by more than nine per cent in the last two years, at a time when the fees councils pay to care homes for those who are unable to fund their own care has not risen at all in many areas.

According to research by Prestige Nursing, a care agency, the average cost of a room in a care home in England has risen by £963 or 3.5 per cent in the last year – just above inflation.

But over two years the total increase is 9.3 per cent or £2,414.

In the South East, the most expensive region, the average annual bill stands at £32,048, more than £7,400 more than that in the cheapest area, the North East.

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Anyone with assets worth more than £23,500 gets no financial help from the state with their care cost. For those below that level some or all of their fees are paid by their local authorities.

But separate research has shown that those who have to pay their own way are billed around £12,000 a year more than a local council would pay for an identical place.

Care home operators say that they have no choice other than to charge a higher rate for self-funders or face going out of business because cash-strapped councils have been squeezing the rates they pay.

A recent study by the Association of Directors of Adult Social Services appears to confirm this, showing that 45 per cent of councils admitted that they had not increased the amount they pay care homes even in line with inflation this year.

Michelle Mitchell, director general of Age UK, said: “As the cost of care continues to rise we fear that many older people will simply decide that they cannot afford care support and will struggle on alone with the possibility of a disastrous result.

“Older people’s health and dignity are being put at risk as many end up struggling financially as they subsidise a social care system on the brink.

“The underfunding of social care is already having a devastating impact on frail older people and their families.

More and more are having to pay a greater share of the cost of social care, either because they have been pushed out of the system as a result of tightened eligibility thresholds or because of increased fees and charges.

“This is an area of real concern.”

Jonathan Bruce, Managing Director of Prestige Nursing Care, said: “As the cost of care continues to outpace pensioner income, pensioners’ shrinking savings pots are contributing to the worrying financial conundrum of how later life care can be funded.

“In trying economic times, relying on family members to foot the bill isn’t always a viable option, while the governments’ purse strings are tighter than ever with £11.5billion of spending cuts planned.

“While the government’s proposed care cap will help some older people, they will still have to incur a significant financial outlay to reach the cap.”

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Department of Health

Commission on Funding of Care and Support

Our report

Fairer Funding for All – The Commission's Recommendations to Government

On 4 July the Commission reported to Government with its finding and recommendations for a new funding system.

The report highlighted that the current funding system is in urgent need of reform: it is hard to understand, often unfair and unsustainable. People are left exposed to potentially catastrophic care costs with no way to protect themselves.

Our recommendations set out how Government could dramatically improve the system and make it one we can be proud of. They include the following proposals:

- Individuals' lifetime contributions towards their social care costs – which are currently potentially unlimited – should be capped. After the cap is reached, individuals would be eligible for full state support. This cap should be between £25,000 and £50,000. We consider that £35,000 is the most appropriate and fair figure
- The means-tested threshold, above which people are liable for their full care costs, should be increased from £23,250 to £100,000
- National eligibility criteria and portable assessments should be introduced to ensure greater consistency
- All those who enter adulthood with a care and support need should be eligible for free state support immediately rather than being subjected to a means test.

The Commission estimates that its proposals – based on a cap of £35,000 – would cost the State around £1.7billion.

This website is no longer being updated

The Commission on Funding of Care and Support reported back to Government in July 2011. This website provides links to the key information gathered by the commission and to its final recommendations.

Andrew Dilnot, chair of the Commission, said:

> *The issue of funding for adult social care has been ignored for too long. We should be celebrating the fact we are living longer and that younger people with disabilities are leading more independent lives than ever before. But instead we talk about the 'burden of ageing' and individuals are living in fear, worrying about meeting their care costs.*
>
> *"The current system is confusing, unfair and unsustainable. People can't protect themselves against the risk of very high care costs and risk losing all their assets, including their house. This problem will only get worse if left as it is, with the most vulnerable in our society being the ones to suffer.*
>
> *"Under our proposed system everybody who gets free support from the state now will continue to do so and everybody else would be better off. Putting a limit on the maximum lifetime costs people may face will allow them to plan ahead for how they wish to meet these costs. By protecting a larger amount of people's assets they need no longer fear losing everything.*

To accompany the report there are two additional published volumes – Volume II Evidence and Analysis, and Volume III Supporting Documents.

All of these documents are available below along with a presentation illustrating the recommendations that the Commission gave at the launch event on 4th July.

Letter to the Chancellor and the Secretary of State for Health (PDF: 149KB)

Reply to Chancellor and the Secretary of State for Health (PDF: 56KB)

Fairer Care Funding – Report (PDF: 2,343KB)

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Fairer Care Funding Pamphlet (PDF: 2,666KB)

Volume II Evidence and Analysis (PDF: 3,254KB)

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Presentation of Report Recommendations (PDF: 160KB)

Policy briefing note (PDF: 196KB)

You can also view the press notice.

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Ministers scrap £20m scheme to keep elderly warm

Ministers 'shameful' for scrapping £20m scheme to keep pensioners warm

Photo: Alamy

By Laura Donnelly, Health Correspondent

10:00PM GMT 25 Dec 2013

85 Comments

Ministers have been accused of “shameful” behaviour after quietly scrapping a scheme to help vulnerable elderly people keep warm - just weeks before its own review found it was universally popular.

For the past two winters, councils have been allocated £20 million to provide emergency boiler repairs, hot meals to frail pensioners leaving hospital, snow-clearing and advice about pay fuel bills.

In October a Government report acclaimed the scheme - which helps up to 200,000 people a year, mostly elderly - as a “universally popular” way to provide help to those in crisis.

But by then, funding for the scheme had already been stopped, a parliamentary answer has disclosed.

Public health experts said it was “appalling” that the Warm Homes, Healthy People fund had been axed, after the coldest winter for 50 years and amid fears that the NHS is struggling to cope.

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Last month figures disclosed that the number of winter deaths rose by one third last year - with 31,000 excess deaths.

Prof John Ashton, president of the Faculty of Public Health, said: “It is shameful to be scrapping this scheme when we know this country has such a huge problem with winter deaths.”

He said the funds involved were “peanuts” but that it made no sense to pull money from a scheme which had demonstrated its success and popularity.

Prof Ashton said: “Given all the fears about an NHS winter crisis, and the recent figures on winter deaths, it seems crazy not to concentrate efforts on ensuring warm homes for the elderly. We know that in the week after every cold snap we see a surge in deaths, and that shouldn’t be inevitable.”

Age UK said the scheme had proved an “extremely necessary resource” which helped thousands of at risk pensioners last year.

Mervyn Kohler, special advisor to the charity, said: “This was a really good scheme that made a really practical difference to people - providing emergency food and survival packs, checking people were getting the help to which they were entitled.

“This was about providing help to people who are cold, frail and worried. It is really perverse to take it away when the evaluation made clear just how successful it was.”

The evaluation of the scheme, published in October by Public Health England, an executive agency of the Department of Health, said: “In line with findings from the previous evaluation, the Warm Homes, Healthy People scheme continues to be universally popular. Local authorities and their partners used innovative ways to try to reduce excess winter morbidity and mortality in line with the Cold Weather Plan for England.”

The report said the initiatives funded by it had helped social isolation and household budgets, as well as fulfilling its key aim to protect the vulnerable from the cold.

Under the scheme, pensioners in Bedfordshire were provided with emergency food parcels, while an emergency shopping service was set up in North Staffordshire for those who could not get out in bleak weather.

Ministers said local authorities should determine their own priorities, having been put in charge of an annual £2.7 billion public health budget since April, with funds that used to go to the NHS.

Directors of public health at councils said the money from the central budget did not stretch far enough, especially in rural areas, which receive less funding per head of population.

Prof Rod Thomson, director of public health at Shropshire council, said :“The loss of this funding is significant for us, particularly because we have such a limited budget; this is going to affect a lot of people and in rural areas there are a lot of people living in homes that are hard to heat.

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We have got people suffering fuel poverty who are clearly going to have a tougher winter - this grant would have made a big difference to them and to their health."

He said the rural county receives £29 per head of population under the overall grant - while councils in Kensington and Chelsea and Westminster receive more than £130 per head.

Mike Leaf, director of health improvement for Lancashire County Council, said: "We felt this was a really important source of funding; it wasn't something we were expecting them to pull."

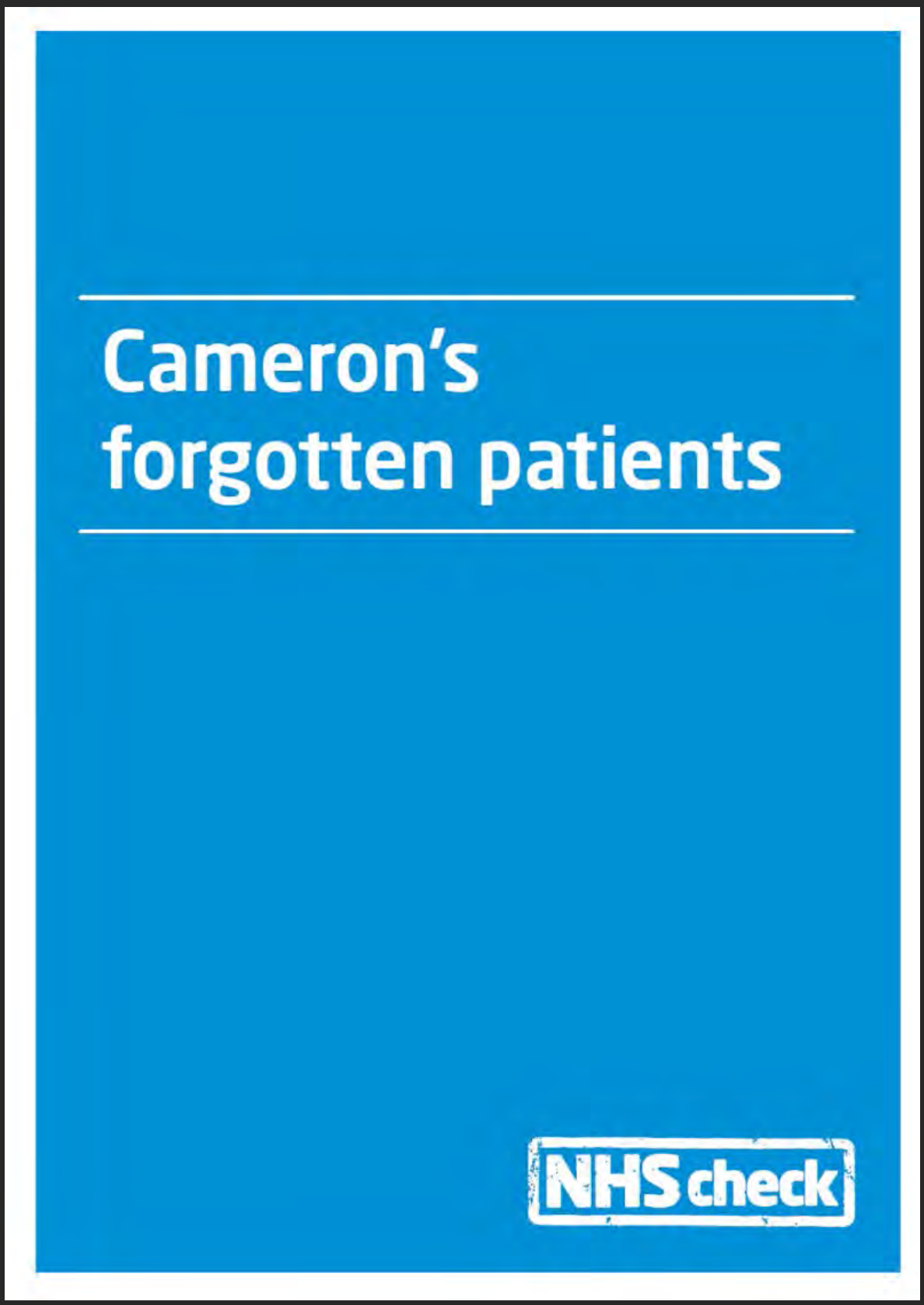
Previous evaluations said that up to 200,000 people received interventions under the scheme. Of those, 62 per cent were pensioners and 12 per cent were young children in deprived or fuel-poor homes, studies found.

Luciana Berger, Shadow Minister for Public Health, accused the Government of forcing people to choose between heating and eating.

She said: "It doesn't make sense to be scrapping programmes to help keep people warm when there has already been a 40 per cent spike in the number of people suffering from hypothermia on David Cameron's watch."

A Government spokesman said: "We are working to help people keep warm this winter, at the same time as helping them keep their bills as low as possible. That's why we have cold weather payments, winter fuel payments worth up to £300, an enlarged state pension and the Warm Homes Discount which is helping two million households, including well over 1 million of the poorest pensioners, by taking £135 off their bills. We are also helping people by legislating to force energy companies to put customers on the best deal.

"We have ring-fenced public health funding for local authorities in order that they can focus on the needs of their communities, including helping people whose health may be harmed by cold weather."



March 14, 2013

Cameron's forgotten patients

by Martin Rathfelder

This is NHS Check report no 4 originally published by Labour's Shadow Health Team in November 2012

Revealed:

- **An estimated 52,000 patients in England were denied treatment and kept off NHS waiting lists last year due to cost-based restrictions**
- **Official statistics show huge fall in operations in the eight treatments most commonly subject to new restrictions**
- **Overall, 47 PCTs in England have restricted one or more of the eight treatments**
- **Patients left in pain, discomfort, unable to work or paying to go private as cataract, varicose vein and carpal tunnel syndrome operations all affected**
- **Evidence of accelerating postcode lottery across nhs in england undermines claims by ministers that rationing by cost is not happening**

KEY FINDINGS

The table below shows the impact of restrictions imposed since the election:

ELECTIVE ADMISSIONS	YEAR				
	2008/09	2009/10	2010/11	2011/12	Real number change since change of Gov
Cataracts	305,946	323,167	325,204	319,860	-3307
Varicose Veins	34,687	34,554	31,674	25,712	-8842
Carpal Tunnel Syndrome	54,083	53,642	52,518	48,906	-4736

Tonsillectomy	47,942	48,169	45,007	44,581	**-3588**
Lesion of Skin	214,842	227,716	223,109	204,774	**-22942**
Dupuytren's Contracture	9,609	9,231	8,899	8,477	**-754**
Myringotomy	34,162	33,571	31,882	29,748	**-3823**
Hysteroscopy	50,626	53,182	51,412	49,194	**-3988**

- These figures for hospital episode statistics (HES) for patients admitted to hospital, analysed by the House of Commons Library, show a fall of 51,815 across all eight most commonly restricted treatments.
- These are the first falls for many years in numbers of operations – against a background of growing demand.
- Labour's NHS rationing survey in June showed almost half of Primary Care Trusts or Clinical Commissioning Groups have restricted or decommissioned services in the years 2010-11 and 2011-12. It found 125 different services had been rationed across the NHS, with 22 being entirely stopped in some parts of the country.
- Of the 100 respondents found to be restricting access to the above treatments in June:
  - 24 PCTs restricting tonsillectomy
  - 21 PCTs restricting varicose veins treatment
  - 16 PCTs restricting cataract referral
  - 14 PCTs restricting Dupuytren's contracture
  - 14 PCTs restricting surgery for carpal tunnel syndrome
  - 14 PCTs restricting skin tag removal
  - 13 PCTs restricting myringotomy
  - 13 PCTs restricting hysteroscopy

Clinical commentary on restricted treatments:

Cataracts

Cataracts imply declining sight which can be an enormous problem for elderly people and is responsible for falls and injuries requiring hospital treatment. Such absolute restrictions have no clinical imperatives. There is now evidence that early cataract surgery is beneficial to patients, and the over reliance of Visual Acuity as a measure is outdated. Delaying surgery leads to more ophthalmic complications, making surgery more risky, and in the event proves costlier.

Varicose veins

30% of adult population will develop varicose veins at some stage of their life. 5-10% of the population will develop complications or troublesome symptoms such as eczema or ulcers interfering with the life style.

Carpal tunnel syndrome

Carpal tunnel syndrome is a constriction of ligaments in the wrist affecting the nerves and can be painful and disabling. There is still access to surgery but it is being made more difficult to obtain. It must be assumed that this is on grounds of cost rather than efficacy.

Tonsillectomy

Accepting the de facto evidence that **tonsillectomy** abolishes attacks of tonsillitis, consider an adult having three attacks of tonsillitis per year, aged of 30, who elects to have a tonsillectomy. The operation costs about £720. The primary care consultation and prescription costs for antibiotics and painkillers are close to the index cost of the operation.

Dupuytren’s contracture

Dupuytren’s contracture means a restriction on people’s normal use of their hand. This is a planned operation, but where the contractures are severe even undertaking basic tasks such as making a cup of tea or a meal are impaired. Surgery is indicated where other methods have failed; any delay will make the contractures get progressively worse, and it is likely then that at some stage surgery will no longer be possible.

Myringotomy

Myringotomy and grommet insertion is performed to allow air to circulate freely in the middle part of your ear. This is usually performed to help with hearing loss due to fluid in the middle ear or relieve pain due to poor air flow in the middle ear. Any restriction of surgery on a child who has been deemed to require this procedure will undoubtedly affect their development and ability to concentrate in school, and cause long-term harm.

Hysteroscopy

A hysteroscopy can be used to help diagnosis cases where a woman’s symptoms suggest that there may be a problem with the womb. Symptoms might include:

- heavy or irregular periods
- bleeding in between normal periods
- pelvic pain
- unusual vaginal discharge
- repeated miscarriage
- infertility

A hysteroscopy can also be used to remove abnormal growths from the womb.

BACKGROUND

In June, Labour’s first NHS Check supplied the lists of bureaucratic restrictions that had been ushered in around the country – crude cost-cutting as the Government cut the NHS budget two years

running. That report detailed the PCTs imposing restrictions and the nature of the treatments being restricted. Today's report shows the human impact that the rationing of these treatments is having.

In 2011 the then Health Secretary Andrew Lansley announced that he was banning Primary Care Trusts from rationing operations on grounds of cost.

"PCTs have to manage resources carefully but they must do so without restricting patient choice. That's why I am taking firm action today and banning these unfair measures imposed on patients."

Department of Health press release, 14 November 2011,

When presented with the evidence of rationing based on cost Ministers denied the existence of some of the restrictions and denied the impact of others.

The former Secretary of State, Andrew Lansley said:

"Time and again, he (Andy Burnham) says, 'Oh, they are rationing.' They are not."

Andrew Lansley, Annual Report to Parliament on 4th July 2012, House of Commons Hansard, 4 July, c923

In response to the GP Magazine report showing 90% of PCTs/CCGs are restricting procedures, the then Health Minister Simon Burns said:

"Last year we made it clear that it is unacceptable for the NHS to impose blanket bans for treatment on the basis of costs. That is why we banned PCTs from putting caps on the number of people who could have certain operations.

"If local health bodies stop patients from having treatments on the basis of cost alone we will take action against them."

Simon Burns statement 18th June 2012

These new NHS figures provide evidence that people are facing difficulties in accessing routine treatments that were previously readily available, with some patients forced to consider private care where the NHS has entirely stopped the service. Other independent voices have also expressed the same concerns for patients.

The RNIB found:

"Restrictions on access to cataract surgery by 57 per cent of PCTs in England are forcing thousands of people to live with serious and unnecessary sight loss according to new research carried out by the Royal National Institute of Blind People (RNIB).

"There is regional variation, for example, patients in North East England can have surgery as soon as the cataract affects their lives. In the South East some patients need to have a visual acuity as low as the third line down on an eye chart before they

are able to access surgery."

RNIB press release, 24 May 2012,

An investigation by GP Magazine found:

"GPs increasingly have to fight to obtain NHS treatment for their patients as managers raise the limits on access to care, a GP investigation has found."

GP online, 19 November 2012,

This random rationing and accelerating postcode lottery is undermining a universal, comprehensive National Health Service.

Newly formed Clinical Commissioning Groups, taking control of primary care services from April 2013, will have full discretion to restrict and decommission treatments – resulting in the differences between areas growing wider.

Health Minister Earl Howe recently reiterated the Government's belief that:

"GPs are the group of professionals who have the closest understanding of their patients and are able to take a measured and professional assessment of health needs in a particular geographic area […]. The rationing of services on the basis of cost alone is wrong. It compromises clinical values and patient care. […] By transferring commissioning powers to GPs we are empowering them to make these decisions and work with their local patients to ensure that they get the care that they need".

Interview with GP Magazine, Thursday 22nd November 2012

Minister can no longer deny what is happening and must take urgent action before thousands more patients are left in pain and discomfort.

In light of the new evidence uncovered, Labour calls on the Government to:

1. **Honour commitments to end cost-based rationing by overruling PCTs imposing such restrictions and reversing any rationing decisions which leave patients in pain, restrict mobility, limit their ability to live independently or have a major psychological impact**
2. **Stop decisions on rationing being taken without proper public consultation with patients and honour their claims to ensure full patient involvement and "no decision about me – without me".**

Annexe A – Corresponding restrictions and clinical explanation

Treatment/ service	Number of PCTs	Names of PCTs restricting/decommissioning	Nature of restriction/ decommissioning

Treatment of tonsillectomy	24 of 100 PCTs/CCGs	Ashton, Leigh and Wigan; Blackpool; Bury; Tameside and Glossop; North Lancashire; Central Lancashire; East Lancashire; Blackburn with Darwen; Doncaster; East Riding of Yorkshire; Hull Teaching; Bassetlaw; Derbyshire County; Derby City; Walsall Teaching; Wolverhampton City; Dudley; Sandwell; Havering; Barking and Dagenham; Redbridge; Waltham Forest; Bath and North East Somerset; Cornwall and Isles of Scilly	The restrictions on Tonsillectomy are often based upon the number of clinically significant sore throats in the preceding year or preceding 2 years. Normally 7 or more episodes in the last year, OR 5 or more episodes in each of the last 2 years.NHS Gloucestershire will also fund tonsillectomy where there have been 3 or more episodes in each of the last 3 years.

Clinical explanation: Accepting the de facto evidence that **tonsillectomy** abolishes attacks of tonsillitis, consider an adult having three attacks of tonsillitis per year, aged of 30, who elects to have a tonsillectomy. The operation costs about £720. The primary care consultation and prescription costs for antibiotics and painkillers are close to the index cost of the operation.

Varicose veins	21 of 100 PCTs/CCGs	Ashton, Leigh and Wigan; Bury; Tameside and Glossop; Doncaster; Bassetlaw; Walsall Teaching; Wolverhampton City; Dudley; Sandwell; Havering; Bromley; Greenwich Teaching; Barking and Dagenham; Lambeth; Southwark; Lewisham; Redbridge; Waltham Forest; Bexley Care Trust; Plymouth Teaching; Bath and North East Somerset;	Treatment of varicose veins is normally only be funded if certain clinical criteria are met including a varicose ulcer or a major episode of bleeding from the varicosity. NHS Derbyshire will only be fund treatment if the patient is a non-smoker or has confirmed abstinence for at least 6 weeks prior to the procedure.

Clinical explanation: 30% of adult population will develop varicose veins at some stage of their life. 5-10% of the population will develop complications or troublesome symptoms. Eczema, ulcer and troublesome symptoms interfering with the life style are the ones recommended for treatment as they are classed as symptomatic varicose veins.

Cataract referral	16 of 100 PCTs/CCGs	Bury; Bassetlaw; Havering; Barking and Dagenham;	NHS Bassetlaw introduced a policy for "value based procedures" in 2011/12 which imposed a threshold– meaning

		Hammersmith and Fulham; Ealing; Brent; Hounslow; Hillingdon; Harrow; Kensington and Chelsea; Westminster; Redbridge; Waltham Forest; Swindon; Bristol;	the PCT will only fund Cataract Surgery where there is a VA (visual acuity) of 6/12 (corrected) in the worst eye. Barking and Dagenham, Havering, Redbridge and Waltham Forest PCTs issued guidance in April 2011 to not refer patients for consideration of cataract surgery with a VA of 6/9 or better.

Clinical explanation: Such absolute restrictions have no clinical imperatives. There is now evidence that early cataract surgery is beneficial to patients, and the over reliance of VA as a measure is outdated. Delaying surgery leads to more ophthalmic complications, making surgery more risky, and in the event proves costlier.

Treatment of benign skin lesions	14 of 100 PCTs/CCGs	Ashton, Leigh and Wigan; Blackpool;Tameside and Glossop; North Lancashire Teaching; Central Lancashire; East Lancashire; Blackburn with Darwen; Bassetlaw; Walsall Teaching; Wolverhampton City; Dudley; Sandwell; Suffolk; Milton Keynes PCT; Buckinghamshire PCT; Oxfordshire PCT.	Removal of skin lesions is being restricted largely for cosmetic purposes. Doncaster PCT will normally only approve interventions be for visible lesions (face and hands) of a significant size.Removal will still be considered where malignant transformation is suspected, the skin lesion is causing pain, disability of physical discomfort or there is a high risk of the lesion becoming infected.

Clinical explanation: The scale of rationing is worrying. If this many PCTs/CCGs have imposed restrictions or decommissioned this service then the risk is to the individual is likely to be underestimated.

Dupuytren's contracture	14 of 100 PCTs/CCGs	Tameside and Glossop; Bassetlaw; Warwickshire; Hammersmith and Fulham; Ealing; Brent; Hounslow; Hillingdon;	In NHS Bassetlaw, needle fasciotomy for Dupuytren's contracture is only considered if the patient is over the age of 45 and has loss of extension in one or more joints exceeding 25 degrees, or the patient is under the age of 45 with a greater than 10 degree loss of extension in 2 or more joints. NICE guidelines

		Harrow; Kensington and Chelsea; Westminster; Plymouth Teaching; Swindon; Gloucestershire;	indicate the procedure would be more appropriate in older people and other PCTs restricting Dupuytren's contracture make no reference to age.

Clinical explanation: This is a planned operation, but where the contractures are severe even undertaking basic tasks such as making a cup of tea or a meal are impaired. Surgery is indicated where other methods have failed; any delay will make the contractures get progressively worse, and it is likely then that at some stage surgery will no longer be possible.

Carpal Tunnel Syndrome	14 of 100 PCTs/CCGs	Tameside and Glossop;Hull Teaching; Bassetlaw; Hammersmith and Fulham; Ealing; Brent;	In April 2011, NHS Hull issued guidance to not routinely commission cases with moderate symptoms.Other PCTs have required the patient to have had a certain period of conservative therapy before treatment.
		Hounslow; Hillingdon; Harrow; Kensington and Chelsea; Westminster; Plymouth Teaching; Swindon; Gloucestershire;	Some PCTs will consider treatment if the patient is experiencing severe symptoms that interfere with activities of daily living.

Clinical explanation: Carpal tunnel syndrome is a painful and disabling, and is sometimes occupation related. There is still access to surgery but it is being made more difficult to obtain. It must be assumed that this is on grounds of cost rather than efficacy.

Myringotomy with or without grommets	13 of 100 PCTs/CCGs	Ashton, Leigh and Wigan; Blackpool;Bury; Tameside and Glossop; North Lancashire Teaching; Central Lancashire; East Lancashire Teaching; Blackburn with Darwen;	Myringotomy is normally only funded for children over a certain age where otitis media with effusion (OME) persists after a period after a set period of time.PCTs also require the child to have hearing loss of at least 25dB and evidence of a disability as a result of this hearing loss with either a delay in speech development, educational or behavioural problems attributable to the hearing loss.
		Doncaster; East Riding of Yorkshire; Bassetlaw; Bath and North East Somerset; Cornwall and Isles of Scilly;	Treatment is also considered if the child has a significant second disability that may itself lead to developmental problems. PCTs will only fund grommets in adults with OME if there is significant negative

			middle ear pressure measured on two sequential appointments AND significant ongoing associated pain.

Clinical explanation: Any restriction of surgery on a child who has been deemed to require this procedure will undoubtedly affect their development, and cause longer term harm.

Hysteroscopy	13 of 100 PCTs/CCGs	Blackpool; North Lancashire Teaching;Central Lancashire; East Lancashire Teaching; Blackburn with Darwen; Hammersmith and Fulham; Ealing; Brent; Hounslow; Hillingdon; Harrow; Kensington and Chelsea; Westminster;	PCTs will only usually commission Hysteroscopy for Heavy MenstrualBleeding (HMB) if the following criteria are met: • As an investigation for structural and histological abnormalities where ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive. Where dilatation is required for non-hysteroscopic ablative procedures, hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device.

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11 July 2014 Last updated at 08:22

Staff and bed shortages force maternity closures

By Nick Triggle
Health correspondent, BBC News

Many NHS trusts in England had to shut their maternity units in the past year, with the most common reason being a lack of staff or beds.

Data obtained by the BBC under the Freedom of Information Act showed 62 trusts out of 121 respondents - or 51% - temporarily closed units in 2013.

In 2008, Conservative Party research found **42% of trusts** shut their maternity units at least once.

Health minister Dr Dan Poulter said units closed on "limited occasions".

He said the government had "increased choice in maternity care", saying the number of midwifery-led units had almost doubled since 2010.

"There will always be very limited occasions when a maternity unit cannot safely accept more women into their care and may need to close temporarily.

"Any decisions to redirect women are made by clinicians as part of a carefully managed process," he said.

Dr Poulter said the NHS, which has 162 trusts in England, remains "one of the safest places in the world to give birth".

Pressures

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The latest figures come after the Conservative research in 2008 found that one in 10 trusts had been forced to close their unit 10 times or more.

The 62 trusts identified this time represented 51% of those that responded to the BBC Freedom of Information request. Some 12% had closed their units 10 times or more.

Many were for just for a few hours, but there were examples of wards closing their doors to new patients for more than 48 hours until pressures had eased.

Nottingham University Hospitals NHS Trust closed the most times, with 97 closures across two hospitals - the Queen's Medical Centre 48 times and Nottingham City Hospital on 49 occasions.

Highest number of closures

Trust	Number of closures
Nottingham University Hospitals NHS Trust	97
Leeds Teaching Hospitals NHS Trust	89
University Hospitals of Leicester NHS Trust	86
Heart of England NHS Foundation Trust	50
Queen Elizabeth Hospital King's Lynn NHS Trust	24

This was followed by Leeds Teaching Hospitals NHS Trust, with 89 closures across its two hospitals - Leeds General Infirmary, 60 times, and St James's University Hospital, 29 times.

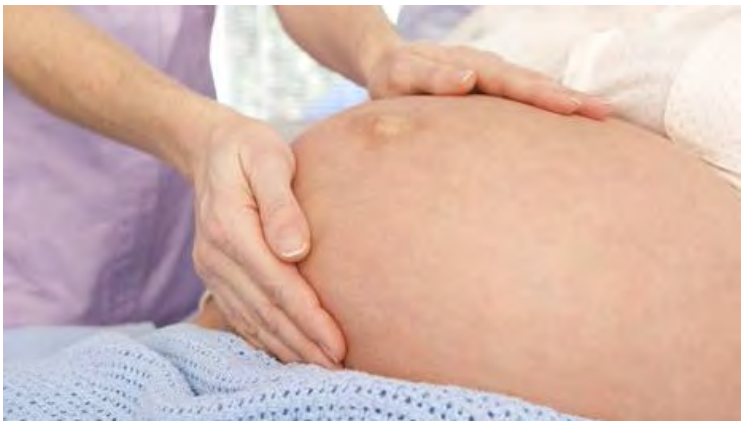
In Wales, six out of seven health boards responded. Four had experienced closures.

Scotland and Northern Ireland did not report any closures.

'Hugely disruptive'

The findings come after a poll last year by the Care Quality Commission showed the maternity system in England was under strain.

A quarter of women reported being left alone during labour and birth at a time that worried them.



There are currently nearly 22,000 midwives in the NHS in England - a rise of more than 1,700 in four years.

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But the Royal College of Midwives (RCM) believes there is a shortage of 4,500 because the birth rate is at its highest since the early 1970s.

However, the demands being placed on the service are also related to the larger number of complex births being seen because of factors such as obesity and multiple births linked to fertility treatment.

RCM chief executive Cathy Warwick said: "Birth is unpredictable and sometimes units get a rush of births that is unavoidable and cannot be planned for.

"However, if units are regularly and persistently having to close their doors to women it suggests there is a serious underlying problem."

Elizabeth Duff, of the National Childbirth Trust, said: "This failure of maternity services can mean women get passed from pillar to post when having a baby. This is hugely disruptive to labour."

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Bed Availability and Occupancy Data – Overnight

The KH03 is a quarterly collection from all NHS organisations that operate beds, open overnight or day only. It collects the total number of available bed days and the total number of occupied bed days by consultant main specialty. Prior to 2010-11 the KH03 was an annual return collecting beds by ward classification.

Guidance and further information is available here.
Data on beds open day only is available here.

Beds open overnight

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22 March 2011 Last updated at 13:13

NHS satisfaction 'at record high'

Public satisfaction with the NHS has reached record levels, according to a leading health economist.

Two thirds of the British public are satisfied with the NHS

Writing on the **BMJ website**, Professor John Appleby said 64% of people were either very or quite satisfied with the NHS.

Critics have questioned why the government is reorganising the NHS when the public is happy with it.

The Department of Health said reform was necessary to sustain the future of the NHS.

Professor John Appleby was quoting data from the latest annual British Social Attitudes Survey.

It shows satisfaction is at the highest level since the survey began in 1983 and much higher than their levels of 39% in 2001.

Professor Appleby, of the King's Fund think tank, said: "The NHS must have been doing something right to earn this extra satisfaction, something even Conservative supporters have noticed, and something probably not unadjacent to the large rise in funding since 2000."

Reform

Much of the NHS budget is to be handed to GPs as part of healthcare reforms in England.

In the survey, satisfaction with GPs was at 80%, just short of its peak in the 1990s.

A Department of Health spokesperson said: "We welcome the findings which show public satisfaction levels are good, particularly with GPs. Our reforms will empower GPs, not bureaucrats, to commission services.

"If we want to sustain the NHS in the future, we need to modernise it now."

Last week the British Medical Association called on the government to halt to its overhaul of the NHS.

"With survey results like this you have to question why the government feels it is necessary to embark on such a radical and costly re-organisation of the NHS right now, particularly when you take into account the financial pressure the service is already under", a spokesperson said.

Shadow Health Secretary John Healey said: "The evidence is there for all to see that Labour left the NHS with the highest ever levels of public satisfaction, even among Conservative voters.

"It is also clear that the NHS is re-emerging as a worry for the public, and

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taken alongside recent criticism from the BMA, LibDem conference and a GP among his backbenchers, it is difficult to see how David Cameron can claim support for his overhaul of the NHS."

Professor Appleby concluded: "Future British Social Attitudes surveys will reveal how satisfied the public remain as funding for the NHS is squeezed and the government's proposed reforms take shape on the ground."

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12 June 2012 Last updated at 07:02

Record fall in 'NHS satisfaction'

By Nick Triggle
Health correspondent, BBC News

Public satisfaction with the NHS has dropped by a record amount, the British Social Attitudes Survey suggests.

The poll indicates satisfaction fell from 70% to 58% last year - the largest annual drop since it started in 1983.

The King's Fund think tank sponsored the NHS questions put to more than 1,000 people and said their answers appeared to be a comment on reforms and spending squeezes and not care quality.

The British Social Attitudes Survey has been running since 1983

The government said the survey contradicted its poll among patients.

The survey formed part of the wider British Social Attitudes Survey, which covers a whole host of policy areas.

The 1,096 respondents to the health questions were asked "how satisfied or dissatisfied" they were with the way in which the National Health Service was run.

The King's Fund released the findings on the NHS as it has taken on responsibility for funding that element of the research after the government pulled out last year.

'Shock'

Prof John Appleby, chief economist at the King's Fund, said the poll was important because it had tracked satisfaction over such a long period of time.

"It is not surprising this has happened when the NHS is facing a well-publicised spending squeeze.

"Nevertheless, it is something of a shock that it has fallen so significantly.

"This will be a concern to the government given it appears to be closely linked with the debate on its NHS reforms."

The King's Fund said it had reached that conclusion because performance measures, such as waiting times and hospital infection rates, remained low.

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Analysis

When asked what they think of their care, most patients are grateful for their treatment and give the NHS a thumbs up.

This is illustrated by the results of the latest annual patients survey, which reveals nine in 10 would rate their care as good, very good or excellent.

Understandably, ministers have highlighted that research to suggest that all is rosy in the health service.

But that does not mean that the findings of the British Social Attitudes Survey are not important.

They are in effect an emotional stock-take of what the public thinks the present and future holds for the health service.

The NHS - like the rest of the public sector - is facing a tough challenge.

Rising demands and a squeeze on finances means the pressure is on - and this drop in satisfaction suggests the public are worried.

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When the figures are broken down in more detail they show similar patterns.

Satisfaction fell among supporters of all three main political parties - although unsurprisingly if dropped most among Labour voters.

'People are worried'

The falls were similar when England was compared with Scotland and Wales combined.

While the NHS reforms apply only to England, the King's Fund suggested there could be some "leakage" into the public consciousness elsewhere.

Shadow health secretary Andy Burnham said the survey results "clearly reflect David Cameron's disastrous decision to reorganise the NHS at a time of financial distress. Patients are beginning to see the signs of a service in distress."

He said A&E waiting times over winter, reports of patients on trolleys in corridors, redundancies, and "reports of services being restricted" were "leading people to feel worried about the future of the NHS".

And Mike Farrar, chief executive of the NHS Confederation, added: "These results give us a sharp indication that the public have become worried and confused about what is going on with the NHS."

But Health Minister Simon Burns said the findings contradicted the government's own research which showed satisfaction rates remained high.

In particular, he highlighted the annual patient survey which showed that 92% of patients said their experience was good, very good or excellent.

"The British Social Attitudes Survey targets the general public rather than targeting people that have actually used the NHS, so responses are influenced by other factors.

"By its nature it is not as accurate a picture as the data from patients."

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The NHS Litigation Authority

Factsheet 3: information on claims 2013-14

Background

1. The NHS Litigation Authority (NHS LA) handles negligence claims on behalf of NHS organisations and independent sector providers of NHS care in England who are members of the NHS LA's schemes. The NHS LA was established in 1995 as a Special Health Authority and is a not-for-profit arms length body of the Department of Health.

2. Indemnifies providers of NHS care in England:

   - NHS and NHS Foundation Trusts.
   - CCGs (since 1 April 2013).
   - Independent sector providers of NHS care (since 1 April 2013).

3. Operates clinical and non-clinical risk pooling indemnity schemes which NHS organisations join, on a voluntary basis, as scheme members.

4. The NHS LA's approach to pricing is to financially incentivise those organisations which have fewer less costly claims, thereby supporting the reduction of harm and better staff and patient safety.

5. **The indemnity schemes are:**

   a. **Clinical Negligence Scheme for Trusts (CNST)** - for clinical claims brought by patients receiving NHS care arising from incidents since 1995.

      - CNST cover is unlimited and the NHS LA funds the total cost of claims.
      - Since April 2013 independent sector providers of NHS healthcare have been entitled to join CNST to be indemnified for the NHS care they provide.

   b. **Risk Pooling Schemes for Trusts (RPST) - operating since 1999:**

      i. **Property Expenses Scheme (PES)** - for non-clinical claims including 'first party' losses such as property damage and theft where the incident occurred on or after 1 April 1999.

      ii. **Liabilities to Third Parties Scheme (LTPS**) - for non-clinical claims such as public and employers' liability claims.

   - Cover is unlimited in value, however some areas of cover are subject to an excess for which the member is responsible.
   - The NHS LA funds the cost of claims above the excess.

- Since April 2014 any previous claims resolved and closed below the excess, or any new claims below the excess, are handled by the NHS LA free of charge.

- These claims are not included in the figures in this factsheet, unless the member body chooses to pay the NHS LA a handling fee to handle sub-excess claims on its behalf.

c. **Existing Liabilities Scheme (ELS)** - is centrally funded by the Department of Health and covers clinical claims against NHS organisations where the

- incident took place before 1 April 1995.

d. **Ex-RHA Scheme (Ex-RHAS)** - is a relatively small scheme covering clinical

- claims made against the former Regional Health Authorities which were abolished in 1996. This is centrally funded by the Department of Health.

Information

Our database contains information on all claims (including potential claims or "incidents" where a formal letter of claim has not been received but a patient has indicated their intention to pursue a claim) notified to the NHS LA by member NHS bodies, whether open or closed. The following charts include information on both open and closed claims but exclude "incidents". It should be noted that, until the "call-in" of lower value claims in 2000 and 2002,[1] lower value clinical negligence claims were handled in-house by trusts and the NHS LA may not therefore have complete data relating to these claims. The charts indicate whether or not these "below excess" claims are included in the data.

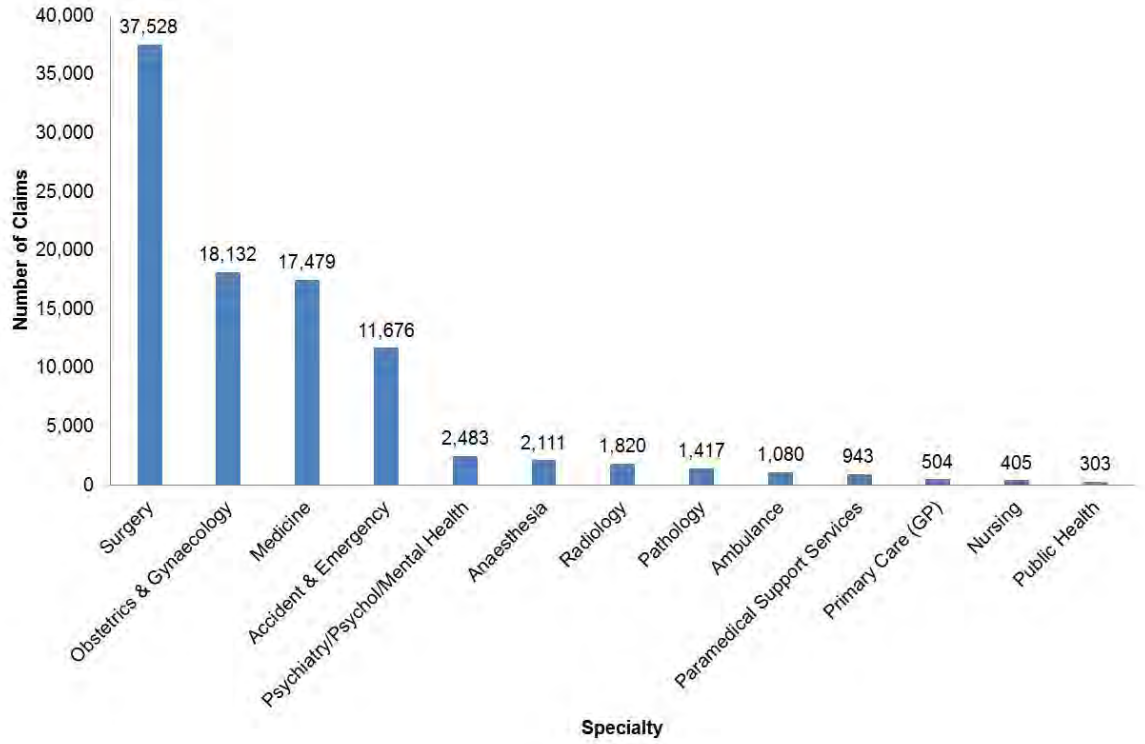
Headline figures

In 2013/14, the NHS LA received 11,945 claims (including potential claims) under its clinical negligence schemes and 4,802 claims (including potential claims) in respect of its non-clinical schemes. The figures for 2012/13 were 10,129 and 4,632 respectively. The NHS LA had 28,029 "live" claims as at 31 March 2014, and CNST claims are now settled in an average of 1.26 years, counting from the date of notification to the NHS LA to the date when compensation is agreed or the claimant discontinues their claim.

[1] 1 April 2000 for ELS claims and 1 April 2002 for CNST claims: on these dates, the NHS LA took over responsibility for all existing and new claims, regardless of value

Total number of reported CNST claims by specialty as at 31/03/14

(since the scheme began in April 1995, excluding "below excess" claims handled by trusts)



Total value of reported CNST claims by specialty as at 31/03/14

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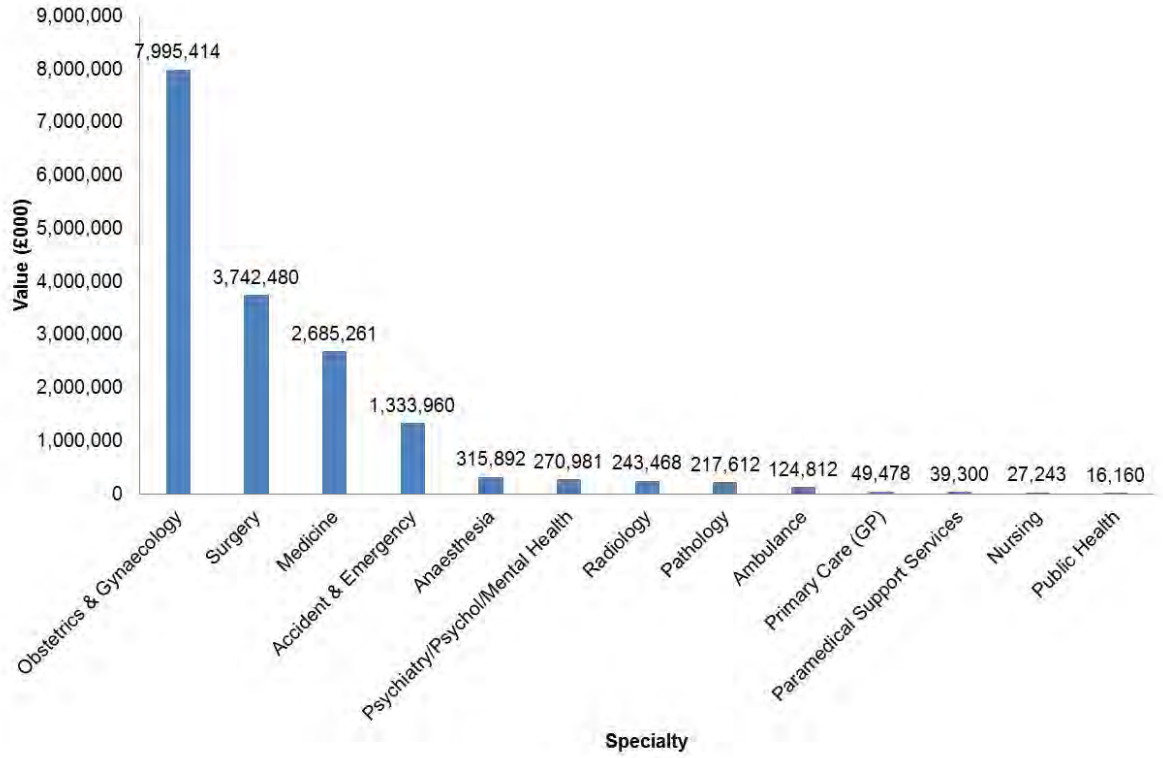
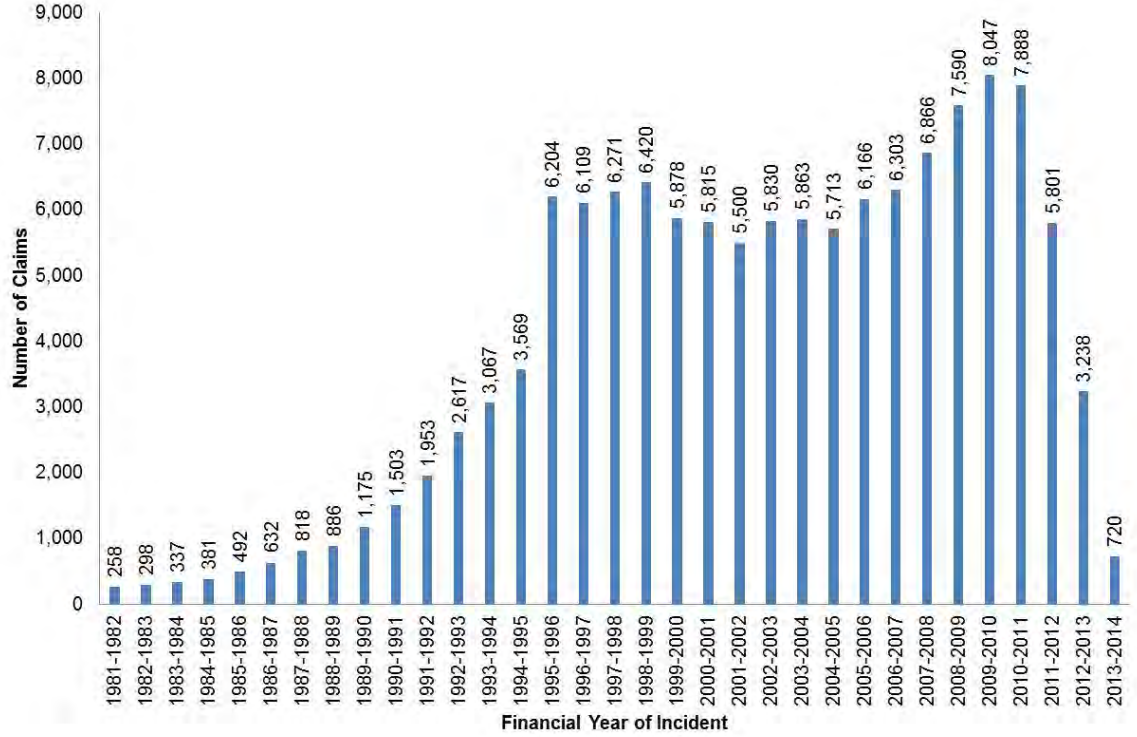


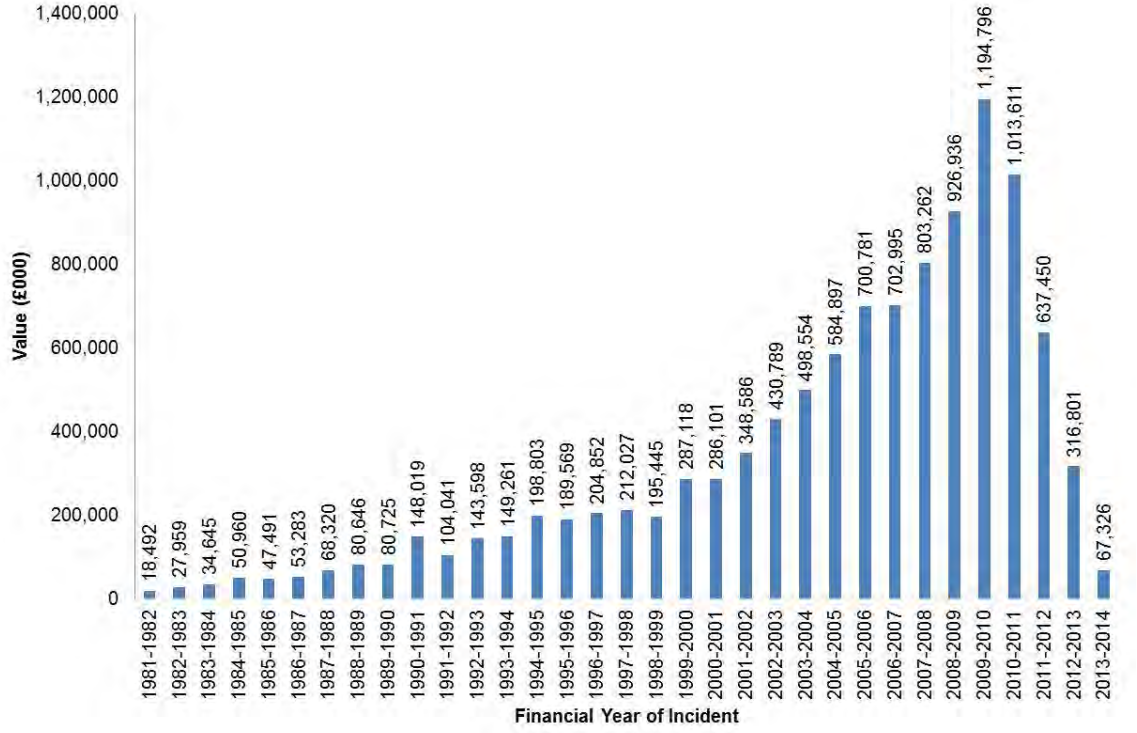
Total number of clinical negligence claims by financial year of incident as at 31/03/14

(since 1980/81, all clinical negligence schemes, including "below excess" claims handled by trusts)



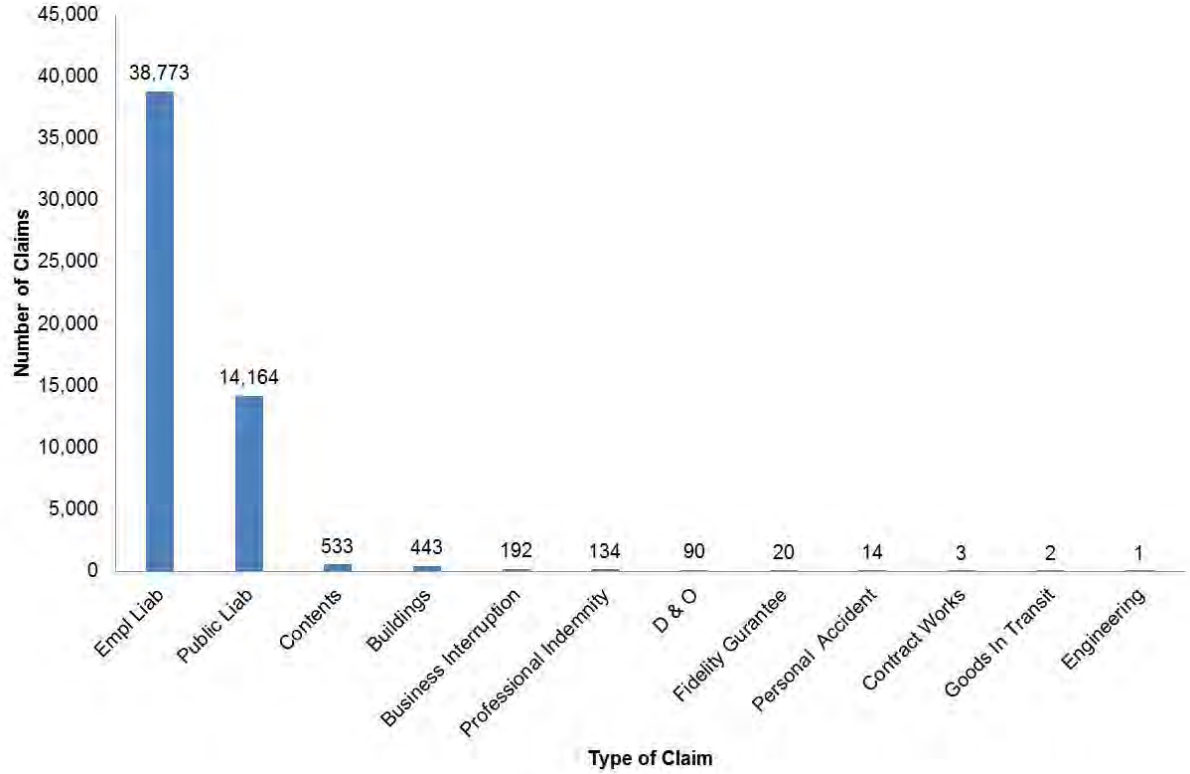
Outstanding value of clinical negligence claims by financial year of incident as at 31/03/14

(all open claims relating to incidents from 1980/81 onwards, from all clinical negligence schemes, regardless of value)



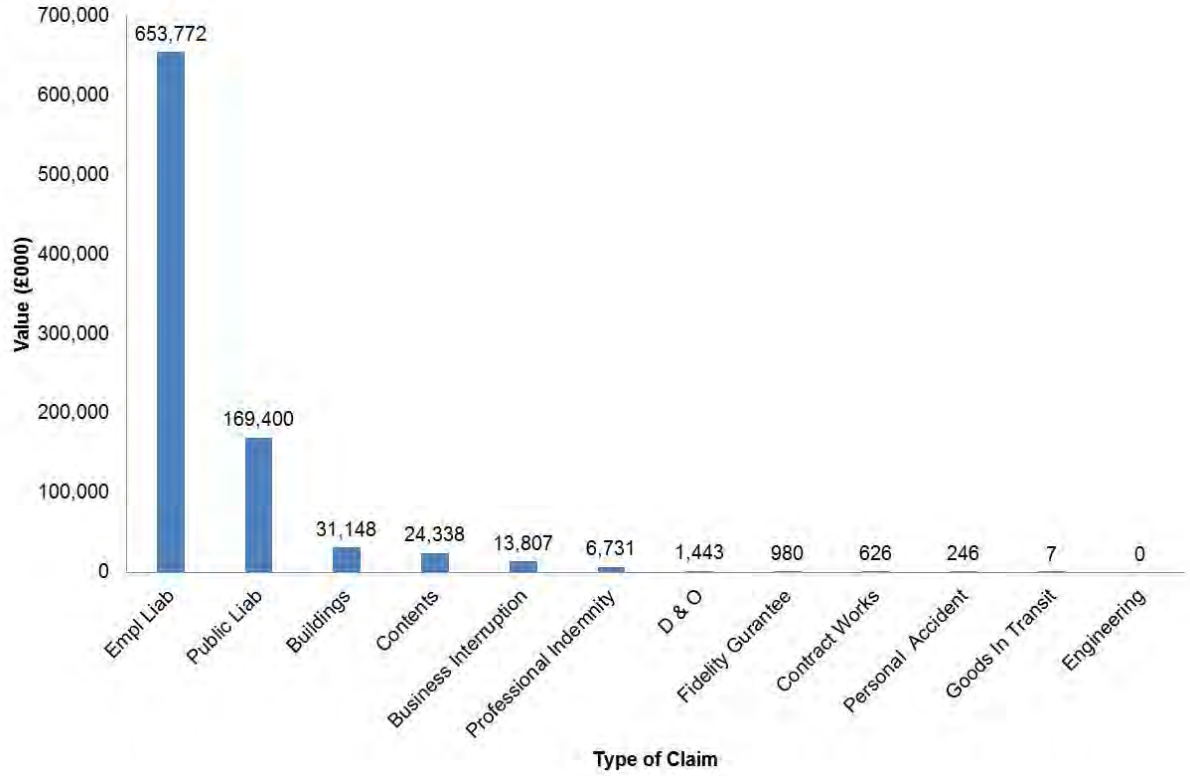
Number of Reported RPST Claims by Type as at 31/03/2014

(since the schemes began in April 1999)



Total Value of Reported RPST Claims by Type as at 31/03/2014

(since the schemes began in April 1999)



Status of claims for clinical negligence made against the NHS received since 01/04/2004 as at 31/03/14

Status	Number	Percentage
Resolved without a Damages Payment	22,642	30.72%
Resolved with a Damages Payment	31,758	43.08%
Resolved as a Periodical Payment	574	0.78%
Outstanding Claims Notified, Yet to be Resolved	18,742	25.42%
Total ('files opened')	**73,716**	**100.00%**

NHS LA
September 2014

NHS Litigation Authority

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Factsheet 2: financial information

| Introduction

This factsheet provides information about the number and type of claims handled by the NHS Litigation Authority, a not-for-profit arms length body of the Department of Health, responsible for handling both clinical and non-clinical negligence cases on behalf of NHS organisations and independent providers of NHS care in England. Information about other aspects of the NHS LA's activities is contained in further factsheets in this series, available on our website at www.nhsla.com. Our recent *Annual Reports* are also available on our website.

| The schemes managed by the NHS LA

1. Indemnifies providers of NHS care in England:
    - NHS and NHS Foundation Trusts.
    - CCGs (since 1 April 2013).
    - Independent sector providers of NHS care (since 1 April 2013).
2. Operates clinical and non-clinical risk indemnity pooling schemes which NHS organisations join, on a voluntary basis, as scheme members.
3. The NHS LA's approach to pricing is to financially reward those organisations which have fewer less costly claims, thereby incentivising the reduction of harm and supporting better staff and patient safety.
4. The indemnity schemes are:
    a. **Clinical Negligence Scheme for Trusts (CNST)** - for clinical (patient) claims arising from incidents since 1995.
        - CNST cover is unlimited and the NHS LA funds the total cost of claims.
        - Since April 2013 independent sector providers of NHS healthcare have been entitled to join CNST in their own right.
    b. **Risk Pooling Schemes for Trusts** (**RPST)** - operating since 1999:
        i. **Property Expenses Scheme (PES)** - for non-clinical claims including 'first party' losses such as property damage and theft where the incident occurred on or after 1 April 1999.
        ii. **Liabilities to Third Parties Scheme (LTPS)** - for non-clinical claims such as public and employers' liability claims.
            - Cover is unlimited in value, however some areas of cover are subject to an excess for which the member is responsible.
            - The NHS LA funds the cost of claims above the excess.

- Since April 2014 any previous claims resolved and closed below the excess, or any new claims below the excess, are handled by the NHS LA free of charge.

c. **Existing Liabilities Scheme (ELS)** - is centrally funded by the Department of Health and covers clinical claims against NHS organisations where the incident took place before 1 April 1995.

d. **Ex-RHA Scheme (Ex-RHAS)** - is a relatively small scheme covering clinical claims made against the former Regional Health Authorities which were abolished in 1996. This is centrally funded by the Department of Health.

e. **Industrial disease claims** arising from activities in the NHS on behalf of the Department of Health.

| Outstanding liabilities

As at 31 March 2014, the NHS LA estimates that it has potential liabilities of £26.1 billion, of which £25.7 billion relate to clinical negligence claims (the remainder being liabilities under PES, LTPS and DH Non Clinical). This figure represents the estimated value of all known claims, together with an actuarial estimate of those incurred but not yet reported (IBNR), which are claims which may be brought in the future but have not yet (and may not) be brought and which may settle or be withdrawn over future years.

| Expenditure under each Scheme

In 2013/14, the NHS LA made payments totalling **£1,244 million** in respect of all schemes. A breakdown of these payments between schemes, together with comparable data for previous years, is given overleaf. **It should be noted that these figures relate only to expenditure incurred by the NHS LA itself**.

Until April 2000, when all outstanding ELS claims were “called in” to the NHS LA, NHS organisations handled (and funded) lower value ELS claims themselves, and paid “excesses” on the higher value claims handled on their behalf by the NHS LA. Similarly, until the call-in of CNST claims in April 2002, member organisations paid part of the cost of claims made under CNST. Excesses are still payable on the non-clinical schemes (LTPS and PES). The cost of these excesses, being carried by individual NHS organisations, is not included in the NHS LA’s figures.

Payments made by NHS LA in respect of negligence claims against the NHS

Payments made in the financial years 08/09 to 13/14

	13/14	12/13	11/12	10/11	09/10	08/09
Scheme	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
CNST	1,051,173	1,117,655	1,095,302	729,072	650,973	614,342
ELS	31,711	140,002	179,112	132,700	135,064	150,806
Ex-RHA	3,419	1,223	2,957	1,626	954	4,078
DH Clinical	106,235					
TOTAL	**1,192,538**	**1,258,880**	**1,277,371**	**863,398**	**786,991**	**769,226**
LTPS	40,188	46,949	48,128	42,435	33,952	33,975
PES	3,853	3,650	4,262	5,546	6,424	3,914
DH Non Clinical	7,534					
TOTAL	**51,575**	**50,599**	**52,390**	**47,981**	**40,376**	**37,889**
GRAND TOTAL	**1,244,113**	**1,309,479**	**1,329,761**	**911,379**	**827,367**	**807,115**

Payments made in the financial years 02/03 to 07/08

	07/08	06/07	05/06	04/05	03/04	02/03
Scheme	**£'000**	***£'000***	**£'000**	**£'000**	**£'000**	**£'000**
CNST	456,301	*424,351*	384,390	329,412	293,384	175,277
ELS	171,562	*153,246*	168,203	169,414	128,071	269,345
Ex-RHA	5,462	*1,794*	7,716	4,068	1,059	1,562
TOTAL	**633,325**	***579,391***	**560,309**	**502,894**	**422,514**	**446,184**
LTPS	24,986	*29,697*	26,692	21,280	7,395	14,480
PES	2,730	*4,186*	4,586	3,839	2,735	6,866
TOTAL	**27,716**	***33,883***	**31,278**	**25,119**	**10,130**	**21,346**
GRAND TOTAL	**661,041**	***613,274***	**591,587**	**528,013**	**432,644**	**467,530**

Legal costs

The following table sets out the amounts paid out by the NHS LA for legal costs relating to clinical negligence claims closed in 2013/14 with damages paid. The figures are broken down into costs incurred by the NHS and by claimants: however they relate only to costs paid by the NHS LA and hence do not include costs met by claimants themselves or by the Legal Services Commission.

Legal costs incurred in connection with claims closed in 2013/14			
	Claimant costs	**Defence costs**	**Total**
CNST	216,627,265	46,114,687	262,741,952
DH Clinical	10,270,061	2,532,854	12,802,915
ELS	6,738,593	2,660,167	9,398,759
Grand total	**233,635,918**	**51,307,708**	**284,943,626**

NHS England

Never events data summary for 2012/13

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NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**00868**
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Annual publication of never events reported as occurring between 1 April 2012 and 31 March 2013

Never events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. For more detail on never events, see:

www.england.nhs.uk/ourwork/patientsafety/never-events/

This report provides a summary of never events that occurred between 1 April 2012 and 31 March 2013.

Data on never events that were reported in the previous year, that is between 01 April 2011 and 31 March 2012, were published in October 2012 as part of the Never Events Policy Framework: an update to the never events policy, October 2012 **http://www.idsc-uk.co.uk/docs-2012/never-events-policy-framework-update-to-policy.pdf** (Appendix 1)

In April 2013, NHS England became responsible for the never events policy framework. Never events data for 2012/13 has therefore been collected from the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) by the Patient Safety Team at NHS England and is summarised in the tables below. The data from these two systems are not directly comparable due to differences in the way incidents are identified and reported as never events. These data sets do overlap though i.e. many of the incidents reported to the NRLS are also reported to STEIS. As in previous years, the data from STEIS is considered to be the more accurate reflection of the number of never events reported (Tables 1 and 2)

For the first time, NHS England is also providing more detail on the most common never events which occur in relation to surgery. Out of the 290 incidents reported to STEIS during this period, 255 relate to surgery and have been summarised in Tables 3 – 5

Since April 2013, NHS England has also been establishing a new process to improve the timeliness and accuracy of the compilation of never event data. This will enable the routine and regular publication of the data from now on. The data from the first two quarters of 2013/14 is published in a separate document alongside this one.

Table 1 – Never events reported to the NRLS between 01 April 2012 and 31 March 2013

Never Event type	Apparent (free text appears to describe a never event)	Possible (some suggestion of a never event in free text)	TOTAL apparent or possible never events located in the NRLS
Retained foreign object post procedure	102	22	124
Wrong site surgery	47	7	54
Wrong implant/ prosthesis	23	1	24
Misplaced naso- or oro-gastric tubes	12	8	20
Escape of transferred prisoner	0	2	2
Air embolism	1	3	4
Inappropriate administration of daily oral Methotrexate	3	1	4
Maladministration of Insulin	2	0	2
Falls from unrestricted windows	0	1	1
Opioid overdose of an opioid-naïve Patient	0	1	1
Wrongly prepared high-risk injectable medication	0	1	1
TOTAL	**190**	**47**	**237**

Table 2 – Never events reported to STEIS between 01 April 2012 and 31 March 2013

Never Event type	Declared as a never event on STEIS and DOES appear to fit NE definition	Declared as a never event on STEIS but DOES NOT appear to fit NE definition	TOTAL Declared as a never event on STEIS
Retained foreign object post procedure	130		
Wrong site surgery	83		
Wrong implant/ prosthesis	42		
Inappropriate administration of daily oral Methotrexate	12		
Misplaced naso- or oro-gastric tubes	9		

Maladministration of Insulin	4		
Wrongly prepared high-risk injectable medication	3		
Transfusion of ABO-incompatible blood components	2		
Air embolism	2		
Escape of transferred prisoner	1		
Falls from unrestricted windows	1		
Wrong gas administered	1		
TOTAL	**290**	**39**	**329**

Table 3 – Retained foreign object post procedure between 01 April 2012 and 31 March 2013

Sub theme	**Number**
Vaginal swab, tampon, cotton wool	47
Surgical swab	34
Instruments	11
Guide wire – central line	6
Laparoscopic specimen bag (with specimen)	5
Surgical drain	4
Glove remnant	3
Pins	2
Surgical needle	2
Drill guide	2
Guide wire – chest drain	2
Throat pack	2
Unknown	2
Part of/ broken instrument	2
Hypodermic needle	1
Nasal tampon (used for a laparoscopic procedure)	1
Anterior Cruciate Ligament (ACL) implant	1
Guide wire – femoral line	1
Guide wire – shoulder surgery	1
Silicone tubing	1
TOTAL	**130**

Table 4 – Wrong site surgery between 01 April 2012 and 31 March 2013

Sub theme	Number
Wrong side/ laterality	26
Wrong tooth/ teeth removed	21
Wrong procedure	12
Wrong lesion	9
Wrong level spinal surgery	8
Wrong digit	5
Wrong organ removed	1
Unnecessary procedure	1
TOTAL	**83**

Table 5 – Wrong implant/ prosthesis between 01 April 2012 and 31 March 2013

Sub theme	Number
Ophthalmology lens	29
Knee prosthesis	6
Hip prosthesis	5
Plates +/- screws	2
TOTAL	**42**

Appendix 1 – Never events reported to NRLS and STEIS between 01 April 2011 and 31 March 2012

Never event	Number of never events reported to SHAs 2011/12	Number of Incidents flagged as never events in the NRLS 2011/12
Wrong site surgery	70	41
Wrong implant/prosthesis	41	15
Retained foreign object post-operation	161	86
Misplaced naso- or oro-gastric tubes	23	15
Other types	31	6
Total	**326**	**163**

NHS England

Provisional publication of Never Events reported as occurring between 1 April and 30 November 2014

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations	Patients and Information
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Provisional publication of Never Events reported as occurring between 1 April and 30 November 2014

Version number: 1

First published: 30 December 2014

Prepared by: Patient Safety Domain, NHS England

Classification: Official

Contents

Provisional monthly publication of Never Events reported as occurring between 1 April 2014 and 30 November 2014

This report provides a provisional summary of Never Events that have occurred between 1 April and 30 November 2014.

Each monthly report updates the previous month's publication as incidents are locally investigated and more accurate information becomes available throughout the 2014/15 financial year.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. For more detail on Never Events, see:

www.england.nhs.uk/ourwork/patientsafety/never-events/

Reconciliation of Never Events reported through different routes

In April 2013, NHS England became responsible for the Never Events policy framework. Never Events data for 2013/14 to date have been collected from the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) by the NHS England Patient Safety Domain.

In prior years, although efforts were made at each year's end to identify any duplicates in the number of Never Events reported via both the NRLS and STEIS, an accurate assessment of overlap (and therefore the total number of Never Events reported to either or both systems) was difficult.

To avoid this, any possible Never Events reported via NRLS since April 2013 have been passed by NHS England to commissioners, who are asked to discuss with the relevant provider organisations and either confirm this is not a Never Event or to ensure the incident is reported as a Never Event on the STEIS system. This process means that (once this confirmation has been received) STEIS can be considered as the reliable and complete data source.

Additionally, the quality of reporting of Never Events made to the STEIS system is routinely reviewed. Where a Serious Incident is logged as a Never Event but does not appear to fit any definition of a Never Event on The *Never Events list 2013/14 update*, commissioners are asked to discuss with the provider organisation and either add extra detail to the STEIS system to confirm it is a Never Event or to remove its Never Event designation from the STEIS system.

The detail of this reconciliation process is shown in the Appendix.

IMPORTANT NOTES on the provisional nature of these data

To support learning from Never Events, NHS England is committed to early publication. However, because of the process of reconciliation described above, and because reports of apparent Never Events are made as soon as possible before local investigation is complete, all data are subject to change.

This provisional report is drawn from the STEIS system, and includes all Serious Incidents where the date of the incident was between 1 April 2014 and 30 November 2014 and where on 8 December 2014 they were designated by their reporters as Never Events.

Summary

At the time data for this report were extracted on 8 December 2014, 199 Serious Incidents on the STEIS system were designated by their reporters as Never Events with a reported incident date between 1 April 2014 and 30 November 2014. Of these 199 incidents:

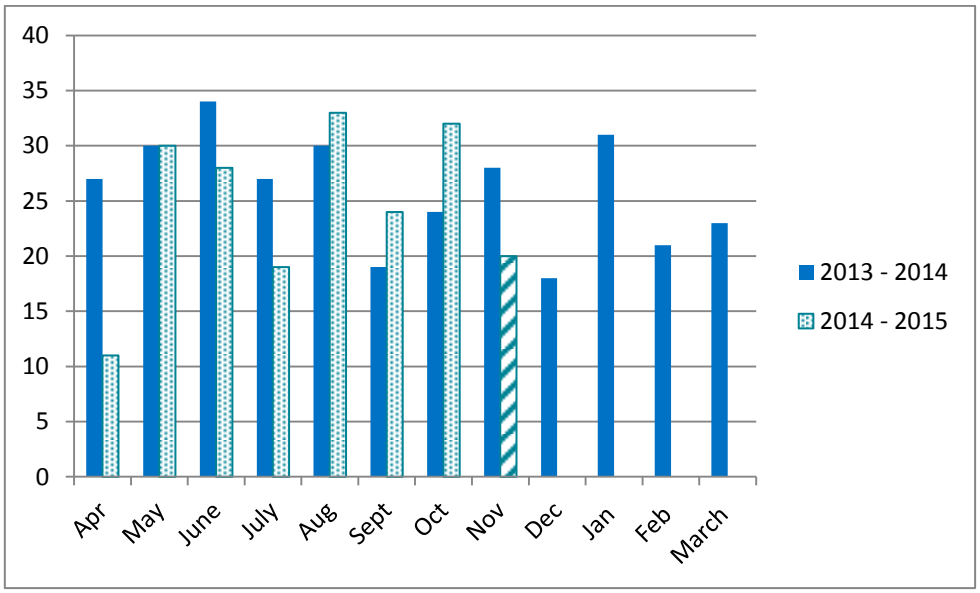
- There were 197 Serious Incidents that appeared to meet the definitions of a Never Event in The *Never Events list 2013/14 update* and the actual date of incident fell between 1 April 2014 and 30 November 2014. This number is subject to change as local investigation takes place.
- Two of the reported Serious Incidents appeared to meet the definitions of a Never Event but the actual dates of incidents were clearly prior to April 2014. These were both an apparent retained foreign object recently discovered when the patient underwent further surgery or x-ray examination.

More detail is provided in the tables below.

TABLE ONE: Never Events 1 April to 30 November 2014 by month of incident

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Month in which Never Event occurred	**Number**
April	11
May	30
June	28
July	19
August	33
September	24
October	32
November	20
Total	**197**
Note as described above, two additional reported incidents occurred prior to 1 April 2014	

Figure one: Never Events declared on STEIS (numbers per month from dataset for publication) since 1 April 2013*



*November 2014 data likely to be incomplete

TABLE TWO: Never Events 1 April to 30 November 2014 by type of incident

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type of Never Event	**Number**
Wrong site surgery	82
Retained foreign object post procedure	63
Wrong implant/ prosthesis	25
Misplaced naso or oro gastric tubes	7
Inappropriate administration of daily oral methotrexate	6
Maladministration of a potassium containing solution	4
Air embolism	3
Escape of a transferred prisoner	2
Maladministration of insulin	2
wrong route administration of chemotherapy	1
Wrong gas administered	1
Transfusion of ABO incompatible blood components	1
Total	**197**
Note as described above, two additional reported incidents occurred prior to 1 April 2014	

TABLE THREE: Never Events 1 April to 30 November 2014 by type of incident with additional detail

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* of Never Event	**Number**
Wrong site surgery	**82**
Wrong tooth removed	20
Wrong lesion removed	5
Wrong side chest drain	3
Wrong level spinal surgery	3
Wrong toe	2
Wrong site angioplasty	4
Wrong side spinal injection	2
Wrong eye	2
Wrong eye - Ranibizumab	2
Wrong side tonsillar cyst	1
Incorrect breast lump margins excised	1
Wrong patient	1
Pelvic kidney (congenital condition) apparently misidentified as ectopic pregnancy on ultrasound; kidney removed	1
Wrong side illiac artery	1
Sigmoidoscopy instead of cyctoscopy	1
Consented for liver biopsy instead of pancreas biopsy; liver biopsy carried out	1
Stent inserted to wrong side	1
Wrong scalp lesion removed	1
Surgery commenced but found unnecessary (relates to pre-operative investigation)	1
Wrong side femoral angiogram	1
Unnecessary procedure - specimens mixed up resulted in further surgery.	1
Wrong side of the head	1
Wrong area of breast removed	1
Laser treatment to wrong area	1
Wrong area of ear biopsied	1
Femoral line inserted on wrong patient	1
Wrong area of scalp excised	1
Wrong procedure undertaken	1
Wrong breast lump removed	1
Hysterectomy with conservation of ovaries intended but hysterectomy and oophorectomy carried out	1
Carpal tunnel procedure instead of DeQuervains	1
Wrong side ear grommets	1
Wrong eye - Cataract surgery	1
Wrong side hip injection	1
Endovenous laser treatment on wrong leg	1
Wrong side nephrostomy	1

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* of Never Event	**Number**
Wrong toe nails removed	1
Injection under imaging on wrong patient	1
A unilateral orchidectomy undertaken in error while attempting to repair a hydrocele	1
Wrong side ureteric stent	1
Wrong labial skin tag removed	1
Wrong skin lesion excised	1
Wrong lesion biopsied	1
Excision of wrong scar	1
Acute salpingitis apparently misdiagnosed as appendicitis; fallopian tube removed	1
Wrong toes	1
Wrong finger - middle finger instead of ring finger	1
Wrong finger joint incision (correct finger)	1
Retained foreign object post procedure	**63**
Vaginal swab	20
Surgical swab	6
Guide wire - chest drain	5
Throat pack	5
Ribbon gauze	2
Vaginal tampon	2
Part of a surgical needle	2
Bert bag	2
Trocar	1
Screw from retractor	1
Guide wire - NG tube	1
Guide wire - peritoneal catheter	1
Guide wire - femoral artery	1
Guide wire - PICC line stylet	1
Vaginal sponge	1
Hypodermic needle	1
Guide wire - CVC line	1
Implant guide pegs	1
Surgical needle	1
Dressing used during surgical procedure	1
Guide wire - jugular line	1
Not known	1
Vaginal pack /tampon	1
Guide wire - mid line	1
Part of instrument	1
Red tag from surgical swab bundle	1
Microvascular clamp	1
Wrong implant/ prosthesis	**25**
Lens	12
Hip prosthesis	7

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* of Never Event	**Number**
Knee prosthesis	5
Wrong size stent	1
Misplaced naso or oro gastric tubes	**7**
Misplaced nasogastric tube	7
Inappropriate administration of daily oral methotrexate	**6**
Inappropriate administration of daily oral methotrexate	6
Maladministration of a potassium containing solution	**4**
Maladministration of a potassium containing solution	4
Air embolism	**3**
Air embolism	3
Escape of a transferred prisoner	**2**
Escaped during unescorted ground leave	2
Maladministration of insulin	**2**
Insulin not given	2
Wrong route administration of chemotherapy	**1**
Wrong route administration of chemotherapy	1
Wrong gas administered	**1**
Medical air instead of oxygen	1
Transfusion of ABO incompatible blood components	**1**
Wrong patient	1
Total	**197**
Note as described above, two additional reported incidents occurred prior to 1 April 2014	

TABLE FOUR: Never Events 1 April – 30 November 2014 by healthcare provider

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Airedale NHS Foundation Trust	1				1		
Alder Hey Children's NHS Foundation Trust			1		1		
Ashford and St. Peters Hospitals NHS Foundation Trust	1	2		1	4		
Barking Havering & Redbridge University Hospitals NHS Trust				1	1		
Barlborough NHS Treatment Centre		1			1		
Barts Health NHS Trust	1			1	2		
Basildon and Thurrock University Hospitals NHS Foundation Trust		1	1		2		
Birmingham Community Healthcare NHS Trust			1		1		
BMI Beaumont Hospital	1				1		
BMI Chiltern			1		1		
Bolton NHS Foundation Trust		1	1		2		
Bradford Hospitals NHS Foundation Trust	1				1		
Brighton and Sussex University Hospitals NHS Trust	2		2		4		
Buckinghamshire Healthcare NHS Trust			1		1		
Burton Hospitals Foundation Trust	2				2		
Cambridge University Hospitals NHS Foundation Trust		2			2		
Central Manchester University Hospitals NHS Foundation Trust			1		1		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Circle Nottingham Treatment Centre			1		1		
Colchester Hospital University NHS Foundation Trust	2		1		3		
County Durham & Darlington NHS Foundation Trust	1	1			2		
Derby Hospitals NHS Foundation Trust	1		1	2	4		
East and North Hertfordshire NHS Trust			1		1		
East Lancashire Hospitals NHS Trust				1	1		
East London NHS Foundation Trust				1	1		
Euxton Hall Hospital		1			1		
Fulwood Hall Hospital		1			1		
Gateshead Health NHS Foundation Trust	1		1		2		
George Eliot Hospital NHS Trust			1	1	2		
Gloucestershire Hospitals NHS Foundation Trust			1		1		
Great Ormond Street Hospital for Children NHS Foundation Trust	1				1		
Great Western Hospitals NHS Foundation Trust			1		1		
Guy's & St Thomas' NHS Foundation Trust	2	1	1	1	5		
Herts & Essex Community Hospital			1		1		
Hull & East Yorkshire Hospitals NHS Trust	1				1		
Imperial College Healthcare NHS Trust	1			1	2		
Ipswich Hospital			1		1		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
James Paget University Hospitals NHS Foundation Trust				1	1		
Kettering General Hospital NHS Foundation Trust				1	1		
King's College Hospital NHS Foundation Trust	2	2	1		5		
Kingston Hospital NHS Foundation Trust			1		1		
Lancashire Teaching Hospitals NHS Foundation Trust		1	2		3		
Leeds Teaching Hospitals NHS Trust			3		3		
Leicestershire Partnership NHS Trust				1	1		
Lewisham and Greenwich NHS Trust	2				2		
Liverpool Community Health NHS Trust			1		1		
Liverpool Heart and Chest NHS Foundation Trust			1		1		
Maidstone and Tunbridge Wells NHS Trust		1	1		2		
Medway NHS Foundation Trust	1		1	1	3		
Mid Cheshire Hospitals NHS Foundation Trust				1	1		
Mid Essex Hospital Services NHS Trust			4		4		
Mid Staffs Foundation Trusts			1		1		
Mid Yorkshire Hospitals NHS Trust				1	1		
Milton Keynes General NHS Foundation Trust	1				1		
Moorfields Eye Hospital NHS Foundation Trust	1	2			3		
Norfolk & Norwich University Hospitals NHS Foundation Trust			1		1		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
North Bristol NHS Trust			2		2		
North Cumbria University Hospitals Trust	1		1		2		
North West London Hospitals NHS Trust				1	1		
Northampton General Hospital NHS Trust	1		1		2		
Northern Devon Healthcare NHS Trust			1		1		
Nottingham University Hospitals NHS Trust		2			2		
Nuffield Health Taunton Hospital		1			1		
Nuffield, Brentwood Hospital		1			1		
Oxford University Hospitals NHS Trust	1		1	1	3		
Peninsula Community Health			2		2		
Peterborough and Stamford NHS Foundation Trust	1		1		2		
Poole Hospital NHS Foundation Trust	1				1		
Queen Elizabeth Hospital - King's Lynn - NHS Foundation Trust	2		1	2	5		
Queen Victoria Hospital NHS Foundation Trust			1		1		
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust			1		1		
Royal Berkshire NHS Foundation Trust			1		1		
Royal Brompton & Harefield NHS Foundation Trust	2				2		
Royal Cornwall Hospitals NHS Trust	1				1		
Royal Free London NHS Foundation Trust			2		2		
Royal Liverpool & Broadgreen NHS Trust			2		2		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
Royal Surrey County Hospital NHS Foundation Trust			2		2		
Salford Royal NHS Foundation Trust			1		1		
Sheffield Teaching Hospitals NHS Foundation Trust	2				2		
Shepton Mallet Treatment Centre	1				1		
South Tees Hospitals NHS Foundation Trust		1			1		
South Warwickshire NHS Foundation Trust			1		1		
Southampton Treatment Centre			1		1		
Southport & Ormskirk Hospital NHS Trust				2	2		
Spire Hartswood Hosiptal			1		1		
Spire Methley Park Hospital	1				1		
Spire Sussex Hospital			1		1		
Spire Wellesley Hospital		1			1		
St George's Healthcare NHS Trust	2				2		1
Stockport NHS Foundation Trust	1				1		1
Surrey and Sussex Healthcare NHS Trust				1	1		
Tameside Hospital NHS Foundation Trust	1				1		
The Dudley Group NHS Foundation Trust	1				1		
The Hillingdon Hospital NHS Foundation Trust			1	1	2		
The Ipswich Hospital NHS Trust			1		1		
The Princess Alexandra Hospital NHS Trust	2				2		
The Priory Thornford Park Hospital				1	1		
The Rotherham NHS Foundation Trust	1				1		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	1		2		3		
The Royal National Orthopaedic Hospital NHS Trust			2		2		
The Royal Wolverhampton NHS Trust			1		1		
The Walton Centre NHS Foundation Trust			1		1		
United Lincolnshire Hospitals NHS Trust	1				1		
University College London Hospitals NHS Foundation Trust	1		2	1	4		
University Hospital of South Manchester NHS Foundation Trust			2		2		
University Hospital Southampton NHS Foundation Trust	1		1		2		
University Hospitals Birmingham NHS Foundation Trust			1		1		
University Hospitals Bristol NHS Foundation Trust			4		4		
University Hospitals Coventry and Warwickshire NHS Trust	1				1		
University Hospitals of Leicester NHS Trust	1				1		
University Hospitals of North Midlands NHS Trust	1				1		
Walsall Healthcare NHS Trust	1				1		
West Hertfordshire Hospitals NHS Trust	1	1			2		
West Middlesex University NHS Trust	1				1		

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED Provider Organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Other NE (types 4-25)	Sub-total SI reported as NE that can be matched to NE list type 1-25	Additional SI reported as NE that cannot be matched to NE list 1-25	Additional NEs detected since April 2014 but NE occurred at an earlier date
West Suffolk NHS Foundation Trust	1				1		
Weston Area Health NHS Trust			2		2		
Wirral University Teaching Hospital NHS Foundation Trust		1		1	2		
Worcestershire Acute Hospitals			1		1		
Wrightington, Wigan and Leigh NHS Foundation Trust	3				3		
Yorkshire Clinic (Ramsay Healthcare)	1				1		
Total	**63**	**25**	**82**	**27**	**197**	**0**	**2**

Appendix: technical process of reconciliation of NRLS and STEIS

The following steps are undertaken as incidents are reported and become available for review:

1. Ensuring all NRLS reports of Never Events are reported as Never Events via STEIS:

    a. Identifying possible or apparent Never Events in the NRLS:
        i. The NRLS is searched for all reports with the term ‘Never Event’ in the free text and reports where the field ‘Never Event’ has been reported as = Yes. These reports are reviewed by clinicians. Incidents that are clearly not Never Events are disregarded but all possible or apparent Never Events are flagged for reconciliation with STEIS.
        ii. All incidents reported to the NRLS with an outcome of death or severe harm are reviewed by clinicians, and regardless of whether or not the term ‘Never Event’ is used, all possible or apparent Never Events are flagged for reconciliation with STEIS.

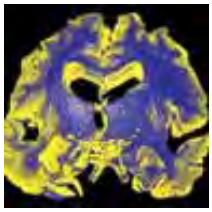
    b. Matching apparent and possible Never Events reported via NRLS with STEIS:
        i. Where the provider organisation, date of incident and detail of incident (e.g. type of retained object) can be matched with a Never Event reported on STEIS no action is taken.
        ii. Where the provider organisation, date of incident and detail of incident (e.g. type of retained object) CANNOT be matched with a Never Event reported on STEIS, commissioners are contacted and asked to contact the relevant provider organisations and either confirm this is not a Never Event or to ensure the incident is not flagged in the Never Event field on the STEIS system.

2. Ensuring the quality and completeness of STEIS flagging of Never Events:

    a. Whilst the designation of an incident as a Never Event is the remit of the commissioning organisation, STEIS is routinely reviewed by clinicians with specialist expertise and where an incident does not appear to meet the definitions in The *Never Events list 2013/14 update* commissioners are asked to either add extra detail to confirm the type of Never Event, or to take its Never Event designation off the STEIS system.

    b. Some Never Events may only be detected at a later date (particularly retained objects found during further surgery). Where reports to STEIS

clearly describe Never Events occurring prior to the date they are reported as occurring on STEIS, commissioners are asked to ensure incident date on STEIS reflects when the Never Event occurred, not when it was detected. For the purpose of this provisional publication of Never Events, where date of actual incident is clear from free text, it is used in analysis.



The treatment - dementia (URL=http://www.pulsetoday.co.uk/clinical/more-clinical-/neurology/the-treatment-dementia/20008605.article)

Dr Luke Solomons

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More than 500 GP practices have closed in last five years, 'stark' Government figures reveal

11 September 2014 | By Sofia Lind (URL=/sofia-lind/57.bio)

More than 500 GP practices have closed since 2009/10, the Government has admitted, in what GPC has described as a 'stark' indication of the crisis facing general practice.

Health minister Dr Dan Poulter revealed in Parliament that the number of practices closing has increased dramatically since 2010, when 79 practices closed, compared with 2014, which has already seen 78 practices closing up to 31 August.

Overall, 518 practices have closed in the period, including 126 in 2013 and 124 in 2012.

Dr Poulter provided the figures in response to a question from Edmonton MP Andy Love, who had asked about closures in England, London and in his constituency area of Enfield, London. Mr Love has also given his support to Pulse's Stop Practice Closures campaign. (URL=http://www.pulsetoday.co.uk/home/stop-practice-closures/)

The figures showed that in the same time period, 110 practices opened, meaning there was just one new opening to every five closures. This year to date, there have been nine new practice openings.

Related stories

Scores of practices teetering on the brink of closure (URL=http://www.pulsetoday.co.uk/home/stop-practice-closures/scores-of-practices-teetering-on-the-brink-of-closure/20007384.article#.VBBPXfldV2E)

Join the fight to protect your patients (URL=http://www.pulsetoday.co.uk/your-practice/join-the-fight-to-protect-your-patients/20007392.article)

Practices closures set to widen GP privatisation (URL=http://www.pulsetoday.co.uk/home/stop-practice-closures/practices-closures-set-to-widen-gp-privatisation/20007855.article)

Pulse has reported this year that LMC leaders had been approached by more than 100 practices who were considering closing due to reduction in funding and recruitment problems (URL=http://www.pulsetoday.co.uk/home/stop-practice-closures/scores-of-practices-teetering-on-the-brink-of-closure/20007384.article) , and as a result started the Stop Practice Closures campaign. (URL=http://www.pulsetoday.co.uk/home/stop-practice-closures/)

The new figures also seems at odds with figures provided by NHS England in response to a freedom of information request by Pulse, which revealed that 99 practices had closed in the past four years. (URL=http://www.pulsetoday.co.uk/news/practice-news/revealed-99-gp-practices-have-closed-since-2010/20004336.article)

Dr Poulter emphasised that these latest figures ‘also include practice mergers and takeovers and do not provide an accurate representation of activity or service provision’, adding: ‘In many cases, practices listed in these figures as having closed, will have in fact merged and will continue to see patients.’

An NHS England spokesperson reiterated the position, adding: ‘NHS England aims to ensure that all patients will be able to register with a GP.’

But GPC negotiator Dr Beth McCarron-Nash said: ‘It is stark. I think that general practice is in crisis and need urgent negotiated solutions and obviously we continue to lobby NHS England and the Department of Health to address the fundamental problems that GPs are facing.’

‘There has been no premises investment since 2004, there is constant change to the NHS, including the hand grenade that has been the Health and Social Care Act, a disinvestment in GP practice, a disinvestment in the contract and the fact that they have not had a national workforce strategy to actually solve the fact that over 25% of GPs are over the age of 50, and that along with the catastrophic changes to the NHS pensions scheme.’

‘I think all of this is a perfect storm for a GP to say “listen, I’ve had enough”, and the other thing I’ve missed off the list is the increasing levels of bureaucracy, such as the CQC etc.’

Please note: this article was changed at 11:56 on 11 September 2014 to reflect that there was one opening every five closures, not one every 21

Practice closures and openings 2009-14

	England		*NHS London area*		*Enfield Clinical Commissioning Group area*	
	Closed	*Opened*	*Closed*	*Opened*	*Closed*	*Opened*
2010	79	55	12	21	0	0
2011	111	19	21	6	0	1
2012	124	14	31	4	7	0
2013	126	13	39	5	2	0
2014 (to 31 August)	78	9	14	4	3	0

Source: *House of Commons Hansard*

Click here to find out more about our campaign (URL=http://www.pulsetoday.co.uk/SPIN2.aspx?navCode=584)

Please click here to sign our petition now! (URL=http://epetitions.direct.gov.uk/petitions/67648)

Readers' comments (37)

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Ambulance Quality Indicators Data 2014-15

This site contains the monthly Ambulance Quality Indicators (AQI) Statistical Notes, spreadsheets, and text files. The AQI comprise the Systems Indicators (AmbSYS), and the Clinical Outcomes (AmbCO) which are published three months after AmbSYS. Data are split by month, and by each of the eleven Ambulance Trusts in England.

Background information for the statistics below is on the AQI landing page, including:

- links to pages like this one but for 2011-12 to 2013-14;
- text files and time series spreadsheets with all data back to April 2011;
- the specification guidance used by data providers;
- a Quality Statement, including user engagement and revisions policy;
- contact details for these statistics.

AQI Statistical Notes

- October 2014 AmbSYS and July 2014 AmbCO (DOCX, 293KB)
- September 2014 AmbSYS and June 2014 AmbCO (DOCX, 339KB)
- August 2014 AmbSYS and May 2014 AmbCO (DOCX, 161KB)
- July 2014 AmbSYS and April 2014 AmbCO (DOCX, 276KB)
- June 2014 AmbSYS and March 2014 AmbCO (DOCX, 251KB)
- May 2014 AmbSYS and February 2014 AmbCO(DOCX, 277KB)
- April 2014 AmbSYS and January 2014 AmbCO (DOCX, 609KB)

Systems Indicators – spreadsheets

- AmbSYS Indicators October 2014 (XLSX, 41KB)
- AmbSYS Indicators September 2014 (XLSX, 41KB)
- AmbSYS Indicators August 2014 (XLSX, 39KB)(Revised 6 November 2014)
- AmbSYS Indicators July 2014 (XLSX, 39KB)(Revised 6 November 2014)
- AmbSYS Indicators June 2014 (XLSX, 38KB)(Revised 6 November 2014)
- AmbSYS Indicators May 2014 (XLSX, 84KB)(Revised 6 November 2014)
- AmbSYS Indicators April 2014 (XLSX, 83KB)(Revised 6 November 2014)

Systems Indicators – csv data

- AmbSYS April – October 2014 (CSV,19KB)

Clinical Outcomes – spreadsheets

- AmbCO July 2014 (XLS, 33KB)
- AmbCO June 2014 (XLS, 32KB)
- AmbCO May 2014 (XLS, 32KB)
- AmbCO April 2014 (XLS, 33KB)(Revised on 3 October 2014)

Clinical Outcomes – csv data

- AmbCO April – July 2014 (CSV, 8KB)

Pre-release Access List

This document lists people who have access to the statistics in the 24 hours before publication:

- AQI Pre-Release Access List 5th December 2014 (DOCX, 32KB)

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Ambulance Quality Indicators Data 2013-14

This publication covers the Ambulance System Indicators (AmbSYS) and Clinical Outcomes (AmbCO) measuring ambulance service quality in England.

The Clinical Outcomes data runs with a three-month time lag behind the Systems Indicators data. This time is required to resolve the outcomes of those patients transported by ambulance.

Revisions are published periodically (usually every six months) in line with NHS England Analytical service (Operations) team's revisions policy.

Further information for this collection, including guidance, can be found here.

AQI Statistical Report:

March 2014 AmbSYS. and December 2013 AmbCO. Report (DOCX, 196KB)

Systems Indicators – Excel Format

AmbSYS. Indicators March 2013-14 (XLS, 41KB) (Revised 6 November 2014)
AmbSYS. Indicators February 2013-14 (XLS, 41KB) (Revised 6 November 2014)
AmbSYS. Indicators January 2013-14 (XLS, 41KB) (Revised 6 November 2014)
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AmbSYS. Indicators May 2013-14 (XLS, 39KB) (Revised 6 November 2014)

AmbSYS. Indicators April 2013-14 (XLS, 39KB) (Revised 6 November 2014)

Systems Indicators – CSV Format

AmbSYS. Indicators April 2013-March 2014 (CSV, 32KB)(Revised 6 November 2014)

Clinical Outcomes – Excel Format

AmbCO. March 2013-14 (XLS, 35KB) (Revised 5 September 2014)

AmbCO. February 2013-14 (XLS, 35KB) (Revised 5 September 2014)

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Clinical Outcomes – CSV Format

AmbCO. April 2013-March 2014 (CSV, 36KB) (Revised 5 September 2014)

Pre-release Access List

AQI Pre-Release Access List 2nd May 2014 (DOCX, 17KB)

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Ambulance Quality Indicators Data 2012-13

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Further information for this collection, including guidance, can be found here.

Systems Indicators – Excel Format

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Further information for this collection, including guidance, can be found here.

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- Ambulance Systems Indicators December 2012-13 (CSV, 4KB) (Revised May 2013)
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- Ambulance Systems Indicators October 2012-13 (CSV, 4KB) (Revised May 2013)
- Ambulance Systems Indicators September 2012-13 (CSV, 4KB) (Revised May 2013)
- Ambulance Systems Indicators August 2012-13 (CSV, 4KB) (Revised May 2013)
- Ambulance Systems Indicators July 2012-13 (CSV, 4KB) (Revised May 2013)
- Ambulance Systems Indicators June 2012-13 (CSV, 4KB) (Revised May 2013)
- Ambulance Systems Indicators May 2012-13 (CSV, 3KB) (Revised May 2013)
- Ambulance Systems Indicators April 2012-13 (CSV, 3KB) (Revised May 2013)

Clinical Outcomes 2012-13 – Excel Format

- Ambulance Clinical Outcomes March 2012-13 (XLS, 70KB)
- Ambulance Clinical Outcomes February 2012-13 (XLS, 70KB) Revised August 2013
- Ambulance Clinical Outcomes January 2012-13 (XLS, 70KB) Revised August 2013
- Ambulance Clinical Outcomes December 2012-13 (XLS, 70KB) Revised August 2013
- Ambulance Clinical Outcomes November 2012-13 (XLS, 70KB) Revised August 2013
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19 December, 2014

Ambulance Quality Indicators: Quality statement, September 2014

Contents:

1. Introduction

This Statement, describing many aspects of quality, accompanies the Ambulance Quality Indicators (AQI) published monthly by NHS England at www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators. NHS England will update this Statement each summer.

1.1 Contact information

We welcome feedback on the AQI, and this Statement, to:

Ian Kay, Analytical Services (Operations), NHS England, 5E24 Quarry House, Leeds LS2 7UE; 0113 824 9411; i.kay@nhs.net.

2. Relevance

2.1 Purpose

The purposes of the AQI are for;

- Ambulance Trusts to manage the service they provide;
- NHS England to monitor the service, and respond to enquiries from the media and the public;
- Department of Health (DH) to brief ministers on performance and account to Parliament;
- Parliament, the media and the public to hold the public service organisations to account;
- Clinical Commissioning Groups to commission services.

The 26 March 2013 Handbook to the NHS Constitution[1] lists 13 bullets with government pledges on waiting times, and one bullet relates to two of the AQI:

- "all ambulance trusts to respond to 75 per cent of Category A calls within eight minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner."

[1] Handbook: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

2.2 Specification

NHS England creates a specification[2] for the data to be collected, based upon user requirements, and discussion with data providers. These include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data.

NAIG and NASCQG represent the eleven Ambulance Trusts in England who provide and use the data.

Operational changes can affect the specification. For example, in June 2012, Ambulance calls in Category A were split[3] between the new definitions of Red 1 and Red 2. Therefore, NHS England created a new data specification, informed by advice from NAIG, and labelled the statistics to explain the change.

2.3 Users

We receive many enquiries from NHS England staff, including the Operations Directorate, Chief Executive's Office, and Media Relations relaying questions from the media. We also receive many enquiries from DH including the Performance Insight Team (PIT), Urgent and Emergency Care Team, and relayed enquiries from Parliament. Our engagement plan is to continue to answer queries and discuss products with these staff, and to annually review our service to them.

Requests from the above contacts in 2014 included:

- several parliamentary questions on ambulance response times;
- comparing how response times vary with call volumes;
- comparing, for 999 and 111 telephone calls, the proportions of emergency ambulance journeys that result in patient transportation to A&E, to check each telephone triage system works as it should;
- using counts of calls presented to switchboard to allocate some 2014/15 operational resilience funding to Ambulance Trusts.

Less frequently, we receive requests from other users. In the first half of 2014 we had enquiries from Clinical Commissioning Groups, students, academic institutions, Monitor, other government Departments, commercial organisations and the public.

We have registered with the Health Statistics User Group and StatsUserNet forums in order to post and respond to any discussions there regarding the AQI.

The AQI website received 1111 unique page views during June 2014.

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[2] The specification for the data that Ambulance Trusts provide is in the AQI Guidance v1.31 at www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators.

[3] Red 1 calls are the most time critical, and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls are serious, but less immediately time critical, and cover conditions such as stroke and fits. www.gov.uk/government/news/changes-to-ambulance-response-time-categories

We have announced the monthly publications from 4 July 2014 onwards on twitter.com, using the @NHSEnglandStats account, which had 636 followers as at 2 September 2014.

2.4 Use of feedback

We encourage users to contact us with questions and feedback, and we are interested in how they use our data.

We improved the AQI commentary in January 2014, with the addition of more guidance, definitions, tables and graphs. We refined graphs in June 2014, following discussions with NHS England policy staff, and expanded the commentary in September 2014 using advice from the UK Statistics Authority.

During spring 2013, we considered collecting Clinical Outcomes (CO) for a particular month in the seventh month after that month had ended. However, we decided in July 2013 to continue to collect in the fourth month, following feedback from users. The Association of Ambulance Chief Executives (AACE) said:

- "as a measure of quality, data that is 6 months old is not helpful.
- although data might be more complete, by taking the pressure off the hospitals to provide the data, we would be giving out the message that the importance of the information has diminished.
- many ambulance services have worked very hard to build up relationships with hospitals, and the increased time period would be seen as a backwards step."

2.5 Other feedback received

The DH Urgent and Emergency Care Team told us:

- "Information from the Ambulance Quality Indicators (AQI) collection is used by the Department of Health to brief Ministers, answer Parliamentary Questions and provide responses to correspondence on the Category A response times, the number of emergency calls, the number of emergency responses and the number of emergency patient journeys, and how these have changed since the last year."

North West Ambulance Service NHS Trust told us:

- "The Ambulance Quality Indicators (AQI) provide a regulatory check as the central mandated return for ambulance services. The information provides a high level benchmark of ambulance services for comparison. The development of the measures and supporting guidance have enabled Trusts to provide a patient centred holistic view of ambulance service provision."

2.6 Statistical planning

The collection of ambulance quality indicators from the NHS is 'licensed' through a formal process operated by the Health and Social Care Information Centre that assesses the reasons why such information needs to be collated centrally and the burden on the NHS of supplying the information. Licenses require ministerial approval. In addition, fundamental reviews of existing data collections have been carried out in recent years.

Within NHS England, planning is typically carried out across analytical services as a whole rather than limited to statistical functions. This is done on an ongoing basis, in response to emerging demands for information and analysis. Those demands can originate from within the organisation, from other health organisations or from external sources such as public debate. Such requests for new information and analysis need to be prioritised against existing work. Wider prioritisation exercises are often carried out as part of the annual business planning process or as part of strategic reviews.

NHS England seeks users' views where any changes would have a material effect on existing statistical products.

3. Accuracy

The "Joint DH – NHS England Statement of Administrative Sources" at www.england.nhs.uk/statistics/code-compliance contains information on how we use the Administrative Sources for AQI.

The collection is intended to be a census of all activity, not a sample, so there should be no sampling error. However, as calls and responses are part of a stochastic process, the statistics are subject to random variation, both between Trusts and over time. There are also sources of non-sampling error.

3.1 Coverage error

The statistics do not include details of some emergency events, because the information has not been captured in administrative systems in time for it to be included in the publication.

This could be caused where time is required after emergency events for the details to be recorded in administrative systems. The timetable for the Systems Indicators (SI) data collection is quick, with Trusts only having about three weeks after a month ends to supply total numbers of calls, incidents and responses.

This is why we give Trusts an opportunity to revise data every six months, to pick up any late reporting that was not available when they first submitted data.

3.3 Processing error

Ambulance Trusts use two approved call prioritisation systems (the Medical Priority Dispatch System and NHS Pathways) to categorise category A (immediately life threatening) and other less serious incidents. These systems also generate the data required by the specification, so the burden upon Trusts of providing data is low.

Ambulance Trust telephone operators who answer the calls ask a series of questions to ascertain the nature of the emergency, following a pre-agreed path depending on the input to the bespoke software, which classifies the category of the emergency. Processing (non-sampling) errors could occur where operators in the ambulance control centres incorrectly input data into their administrative system. Measurement errors could occur from operators who mis-interpret a response to a question or have different interpretations to the same question, thus leading to a mis-categorisation.

To ensure this is reduced to a minimum, ambulance Trusts have their own internal training and monitoring of actual calls, and act upon any mis-classification.

For Clinical Outcomes, each Ambulance Trust has a different Patient Report Form to be completed by clinicians for each individual outcome; some use paper records, others wholly electronic, and the remainder use a mix of electronic and paper.

3.4 Validity

Ambulance Service Chief Executives are contractually responsible for ensuring that their data are submitted in accordance with the specification.

We provide Trusts with an Excel template that requires data suppliers to select their organisation and time period from drop-down lists, ensuring each Trust's data reach the NHS England Unify2 data collection system in an identical format.

It would be possible to include numeric validation checks on whether the figures supplied in the template, are within a certain acceptable range. However, because Trusts vary so much in activity, from 460,000 Category A calls in London to 7,000 in the Isle of Wight in 2013-14, the acceptable ranges would be too wide to be useful.

Instead, we use validation spreadsheets each month that highlight data that are not similar to previous data from the same Trust. We maintain several contact details for suppliers, and ask them to check the data, which leads to them either confirming the results or sending corrected data in good time for publication.

We maintain contact with data suppliers, and continue to request more information about their collection and quality assurance processes. We have instigated the first in what we intend to be a series of visits to Trusts to gain deeper insight into their collection and assurance processes.

Ambulance Trusts can be fined[4] for failing to meet the standards in the Handbook to the NHS Constitution, creating an incentive to ensure reported performance is maintained. Part of our confidence in the reliability of the data, is due to the fact that, in at least one month in the first half of 2014, every single trust reported that it had missed the 75% target for either Red 1 or Red 2. In addition, four trusts reported they had missed the Red 2 target for 2013-14 as a whole.

The Association of Ambulance Chief Executives (AACE) have told us they completed an informal internal audit in 2014. They found that trusts had a range of data quality measures in place, with a few examples of particularly good practice; no governance arrangements were found to be weak. They had no concerns over general misreporting although they did find that some AQI measures needed tighter definition in order to ensure consistent reporting. They plan to establish a small group of control managers and informatics staff to work on reaching a more consistent understanding in respect of those measures.

[4] "East Midlands Ambulance Service fined £3.5m for failing patient response target", www.itv.com/news/central/update/2013-05-22/east-midlands-ambulance-service-fined-3-5m-for-missing-patient-target

NASCQG organised a benchmarking day in 2014, where all Ambulance Trusts mapped and compared their CO data collection processes. NASCQG collated the information into a paper for the National Ambulance Services Medical Directors Group and for AACE. NASCQG are also developing a programme of peer-to-peer review, where Trusts visit each other to harmonise their data systems.

For non-Foundation Trusts (FT), the NHS Trust Development Authority is responsible for providing assurance that Trusts have effective arrangements in place that enable them to record data accurately.

For FTs, Monitor ensures they are well-governed. It is the responsibility of each FT's Board to put processes and structures in place to ensure its national data returns are accurate. If it came to light that data returns were not accurate, Monitor would consider whether the Trust is in breach of its licence, although Monitor does not have the mandate to audit FT performance data.

We will use the UK Statistics Authority *Quality Assurance and Audit Arrangements for Administrative Data* to further evaluate our current practices.

4. Timeliness

We publish Ambulance Systems Indicators (SI) for each complete month about five weeks after the month ends, at 9:30am on a pre-announced Friday. Our Timetable on the AQI website itself (see Introduction) shows publication dates as far forward as August 2015. Publication dates are also on the National Statistics publication hub[5], and in the NHS England 12 month statistical calendar[6].

We publish Clinical Outcomes (CO) data three months after SI data. This is because, for patients assisted by Ambulance Trusts, enough time must pass before assessing the condition of patients. Further time is then needed, for Ambulance Trusts to collect and process outcome information from hospitals, before passing it on to us.

Section 2.4 Use of feedback describes how the timeliness for CO data was decided.

5. Accessibility

The AQI are accompanied by a Statistical Note to help interpret the data. To meet Public Data Principles, all data items are available in comma separated variable (csv) format as well as in spreadsheets.

This statement, the Statistical Notes, and data files, are all available free of charge via the website at the top of this statement.

[5] National Statistics Publication Hub: www.gov.uk/government/statistics/announcements
[6] NHS England statistical calendar: www.england.nhs.uk/statistics/12-months-statistics-calendar

6. Coherence

6.1 KA34 collection

We first collected the AQI in April 2011. Some data items overlapped with the existing KA34 collection by the Health and Social Care Information Centre (HSCIC) that dated back to 2004. Other data items were new, to meet the requirement in the Department of Health NHS Outcomes Framework[7] for outcomes that matter most to people, and not just process targets. Conversely, the KA34 collection included some information on Category C calls, not included in the AQI.

Like the AQI, the KA34 collected data direct from Ambulance Trusts, but data from the two collections did not always match. Trusts had several months to provide KA34 data, unlike the AQI, where Trusts submit data to us about three weeks after the end of each month. Also, NHS England includes the revisions described in Section 7 below, which do not feature in the KA34 collection.

The 2013 HSCIC publication at www.hscic.gov.uk/catalogue/PUB11062 includes both KA34 and AQI data, so comparisons can be made for 2011-12 and 2012-13 where the two sources overlap. HSCIC discontinued the KA34 collection in March 2013.

6.2 Dashboard

Each month we email an updated Dashboard with the latest AQI data to the Ambulance Trusts, and the following organisations place it on their own websites:

North East	www.neas.nhs.uk/patient-information/performance-information.aspx
North West	www.nwas.nhs.uk/about-us/how-we-are-doing/delivering-quality/quality-indicators/quality-indicator-dashboard
Yorkshire	www.yas.nhs.uk/Publications/Ambulance_Quality_Indicat.html
East Midlands	www.emas.nhs.uk/about-us/ambulance-quality-indicators
West Midlands	www.wmas.nhs.uk/Pages/TrustPerformanceACQI.aspx
East of England	www.eastamb.nhs.uk/Performance/ambulance-quality-indicators.htm
London	www.londonambulance.nhs.uk/about_us/how_we_are_doing/clinical_quality_indicators/clinical_dashboard.aspx
South Central	www.southcentralambulance.nhs.uk/our-services/performance information/ambulanceclinicalqualityindicators.ashx
South West	www.swast.nhs.uk/What%20We%20Do/How-we-are-doing.htm
Association of Ambulance Chief Executives	http://aace.org.uk/national-performance/national-clinical-dashboards

[7] The NHS Outcomes Framework 2011/12 from the Department of Health: www.gov.uk/government/publications/nhs-outcomes-framework-2011-to-2012

The data in the Dashboard are identical to the AQI, but the Dashboard has an interactive map, and a facility for Trusts to embed their own commentary in Portable Document Format (PDF).

6.3 Other parts of the UK

We have contacted organisations that produce similar ambulance data in other countries of the UK, and who have agreed these brief descriptions of their data. The following links to websites for Wales, Scotland and Northern Ireland are also on the NHS England AQI website.

The Welsh Ambulance Services NHS Trust provides monthly data for Wales. Until July 2007, the data was collected quarterly on the KA34 Patient Transport Services return. The publication contains no Clinical Outcome (CO) data; it concentrates on the ambulance response to Category A calls within 8 minutes and other intervals, which are shown for smaller geographies than those in the AQI.
http://wales.gov.uk/statistics-and-research/ambulance-services/?lang=en

Data for Scotland are published directly by the Scottish Ambulance Service. They include monthly Systems Indicators for areas of Scotland, and CO data for strokes and Return of Spontaneous Circulation. They are available in extensive Quality Improvement Indicators (QII) documents.
www.scottishambulance.com/TheService/BoardPapers.aspx

The Northern Ireland Ambulance Service (NIAS) provides data on a monthly basis to the Department of Health, Social Services and Public Safety using the KA34 information return. The publication contains similar System Indicators to England, along with other statistics on Emergency Care Departments. These are detailed monthly and broken down by Local Commissioning Group (LCG) to help report against the Ministerial target on ambulance response times.
www.dhsspsni.gov.uk/index/stats_research/hospital-stats/emergency_care-3/emergency-care-stats.htm

The definition of Category A, as immediately life-threatening calls, is the same in England[8], Wales[9], Scotland[10], and Northern Ireland[11], but clock start definitions differ, and England also splits Category A into Red 1 and Red 2.

Category A emergency response clock start definitions

England	Red 1	When the call starts	
	Red 2	Earliest of:	chief complaint information is obtained; chief complaint (or Pathways initial DX code) information is obtained; first vehicle assigned; 60 seconds after Call Connect.

[8] www.gov.uk/government/news/changes-to-ambulance-response-time-categories
[9] Page 1, http://wales.gov.uk/docs/statistics/2013/130529-ambulance-services-quality-report-en.pdf
[10] Page 7, www.scottishambulance.com/UserFiles/file/TheService/Annual%20report/SAS_Annual%20Report%202013_web%20-%20final%20interactive.pdf
[11] Page 13, www.dhsspsni.gov.uk/nihs-emergency-care-2013-2014.pdf

Wales	When the location of the incident is established
Scotland	When the chief complaint is established
Northern Ireland	When these have been ascertained: caller's telephone number, exact location of incident, and the nature of the chief complaint

7. Revisions

7.1 Revisions Policy and practice

The AQI use the Unify revisions policy[12], which applies to all data collected by NHS England via the bespoke software of the Unify2 data collection system. This policy states that NHS England normally publishes revisions on a six-monthly basis, but changes this schedule when necessary.

Where an Ambulance Quality Indicators (AQI) publication contains revisions, we describe them in the Statistical Note accompanying that publication. For example, page 7 of the AQI Statistical Note on 5 September 2014[13] stated which Trusts were affected by revisions to Clinical Outcomes (CO). Graphs showed how all eight CO indicators were affected at national level by revisions, and all revisions to individual months of more than one percentage point were listed.

7.2 Revisions schedule

When collecting AQI data for September or March, we request revisions from Trusts for all the previous months in that financial year. So, for example, during October 2014, when we collect the Systems Indicators (SI) for September 2014, we will also collect revisions to the SI data already published for April to August 2014 inclusive. We will then publish such revisions on 7 November 2014.

Because three extra months are needed before Ambulance Trusts can provide CO data, we collect revisions to these at a different time. So, for example, during July 2013, when we collected CO data for March 2013, we also collected revisions to the CO data already published for April 2012 to February 2013 inclusive, and published those revisions on 2 August 2013.

7.3 Change to revisions schedule

In May 2014, data suppliers informed us about the Myocardial Ischaemia National Audit Project (MINAP). This Project led to revisions to ST-elevation myocardial infarction (STEMI) CO data. The timetable for the Project meant that revised data from hospitals on the outcomes of such patients would reach Trusts too late for our planned publication of revisions on 8 August 2014.

Therefore, we discussed the situation, via a facilitator in NASCQG, and agreed to accept the revisions during August rather than July. This meant that revisions were available to users at the earliest opportunity, on 5 September 2014, rather than the

[12] Unify revisions policy: www.england.nhs.uk/statistics/code-compliance/#Unifypolicy
[13] AQI Statistical Report with April 2014 CO data at www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2014-15

next six-monthly update in the schedule, 6 February 2015. We explained the change in our 8 August 2014 Statistical Note.

8. Privacy of individuals

For this publication, Ambulance Trusts purely provide us with counts each month for the appropriate categories, such as “All Red 1 calls resulting in an emergency response within 8 minutes”. We do not receive any identifying information such as names, addresses, dates, or demographics; so the privacy of individuals is protected.

News

Winter pressures daily situation reports for 8 to 14 December 2014

19 December 2014 - 09:30

NHS England has today published the latest statistical information relating to hospital situation reports for the period 8 to 7 December 2014.

The data are available here.

Categories: Home

Tags:

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19 December, 2014

News

Delayed Transfers of Care: monthly situation reports, November 2014

19 December 2014 - 09:30

Today NHS England published the latest statistical information relating to Acute and Non-Acute Delayed Transfers of Care for November 2014. This information is gathered from providers within NHS Trusts, NHS Foundation Trusts, and Independent Sector Organisations.

The data includes:

- number of patients delayed on the last Thursday of the month
- number of total delayed days during the month

Data on delayed transfers of care is split by:

- Local Authority that is responsible for each patient delayed
- Agency responsible for delay (NHS, Social Services or both)
- Type of Care that the patient receives (acute or non-acute)
- Reason for delay

Latest delayed transfer of care data is available here.

Categories: Delayed Transfers of Care

Tags: delayed discharges • delayed transfers of care

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Annual Report

East Midlands Ambulance Service NHS Trust

A review of our year

2013/2014

Annual Report

2013/2014

Foreword

Welcome to the East Midlands Ambulance Service NHS Trust Annual Report for the period 1 April 2013 to 31 March 2014.

The Annual Report 2013/14 acknowledges the significant challenges we have faced this year to deliver essential emergency medical care at a time when we are tasked with driving down operating costs and improving efficiency and productivity.

As well as setting out our aims and objectives for the year ahead, the report also celebrates our greatest achievements and highlights the incredible commitment and professionalism of our staff, the support given by generous volunteers and the invaluable involvement of patients and their representatives.

If you would like to learn more about East Midlands Ambulance Service NHS Trust, please visit us at www.emas.nhs.uk

Chairman's report

Welcome to our annual report for 2013/14. I'm very pleased to be presenting it to you as the Interim Chairman for the trust, and I hope you find it an interesting and informative read.

This year must be acknowledged as a challenging one for the Trust. We saw several changes at Board level, including the departure of Phil Milligan as Chief Executive and Jon Towler as Chairman, but we also faced some significant challenges in respect of our performance, quality and governance.

Despite the tireless efforts of our staff day in, day out, we did not achieve our performance standards on a consistent basis throughout the year. As a result, we were rightly tasked by Healthwatch and the Care Quality Commission to improve the quality of our services and achieve our response times.

As part of our trajectory to improve things, we were asked by NHS England to attend a Risk Summit in October to examine the challenges we face and identify the obstacles that prevent us from delivering our key objectives. The Risk Summit membership included the Trust Development Authority, the Care Quality Commission, Healthwatch, our Commissioners and Health Education England.

To help us move forward, we developed *Better Patient Care*, our quality improvement programme which is enabling us to do things differently. Since its publication in December 2013, we have delivered on many of the plans it contained and our performance standards are now showing steady signs of improvement.

Despite the challenges we have faced in the last year, EMAS staff have responded to 729,682 emergency calls during 2013/14, providing essential emergency medical attention to those in desperate need - which highlights the extraordinary dedication of our staff every day, both on the front line and those who provide support to our work.

Clearly, we need to do much more to improve our organisation, and the inspection of the Care Quality Commission (CQC) in January 2014 highlighted those areas such as vehicle availability and support to staff where more needs to be done.

However, it was very pleasing to attend a follow up Risk Summit in February 2014 and receive recognition from those who were at the original Risk Summit, for the improvements we have made so far. It is only right that I pay tribute to the hard work and commitment of our dedicated staff who continually demonstrate not only their commitment to their work but regularly go beyond what is expected of them. I also want to pay tribute to my fellow Non-Executive Directors for their commitment to the organisation and support to me.

At EMAS, we are all united by a common purpose - to provide the best possible care for our patients. With a new leadership team in place, led by Sue Noyes as Chief Executive, I am confident that with the support of everyone in the Trust, we will continue to achieve the turnaround we need. We are all committed to delivering Better Patient Care – thank you for your support to help us do that.

Pauline Tagg Chairman (Interim)

Chief Executive's report

Welcome to our Annual Report for 2013/2014. This report is for our patients, the public, our stakeholders, and our staff. It is our opportunity to share with you all what we have been doing over the last year; where we need to make improvements, and to outline what our priorities are for the coming year to deliver the service you deserve.

I joined EMAS in October 2013 at a particularly challenging time for our service, and an obvious indicator of this was our performance, particularly in the time we took to get to our patients. This factor; and the need to make improvements across a range of issues led to the introduction of a quality improvement programme – *Better Patient Care* in December 2013.

The plan was designed to put us on a credible trajectory that would lead to significant improvements in patient care; in staff morale; in our leadership stability; and in the relationships and reputation we have with our commissioners and other stakeholders whom we work with. I am pleased to say that we have seen improvements in our response times as well as other areas of our service. We still have a lot of work to do though – the inspection report from the Care Quality Commission following their visit to in January 2014 confirmed that there is more room for improvement over the longer term. We know we have issues to address in terms of vehicle availability, training and support to staff, all of which will improve morale. I was pleased to see the CQC did highlight that improvements had been made since their last inspection in responses to less urgent calls, infection control, our complaints handling and timeliness of responses, reduction in staff sickness and the monitoring of equipment.

However we know we have much to do and are not complacent about the task .What I can say is we are committed to putting the pride back into our organisation and delivering changes which will make sure our service is focused on better patient care, and on supporting our staff.

Whenever I am out and about on my station visits, I always ask my front line staff, 'What is the best thing about the job?' and they invariably say it's the interaction they have with the patient that makes it all worthwhile. It's for that reason that I launched our Listening into action staff engagement programme in early 2014. This is to help us in my time here in the organisation to harness the best staff ideas, big or small, across EMAS or locally and to make the necessary changes happen. It is also helping us to work in a more supportive and respectful way with each other.

We've also listened to our partners in the last few months as we have been forming our service plans. One very important development for us will be the opportunities which the recent review of urgent and emergency care by Sir Bruce Keogh will provide. We have worked closely with our commissioning colleagues to develop plans for the future and to make sure our patients get the right care in the right place; first time. This will be the bedrock on which we build for the future.

I would like to end by saying I am very proud of the progress we have made at EMAS over the last few months and of my colleagues who work tirelessly to provide the best possible care and treatment to our patients. I would like to congratulate everyone, staff and volunteers for providing outstanding care to hundreds of thousands of patients across the East Midlands and to send out a strong and positive message to everyone who has an interest in the work of our organisation.

> *"We are a healthcare provider. We provide healthcare on the move and in the community. Better Patient Care is helping us to re-establish ourselves in that role and for our partners and the public to see us as an organisation which can be relied upon when we are needed by them. (extract from Better Patient Care).*

Thank you all for your support to put the pride back in EMAS.

Sue Noyes Chief Executive

A profile of East Midlands Ambulance Service NHS Trust

East Midlands Ambulance Service NHS Trust (EMAS) provides emergency and urgent care, patient transport, call handling and clinical assessment services for 4.8 million people in an area covering approximately 6,425 square miles across the six counties of Derbyshire, Nottinghamshire, Lincolnshire, Northamptonshire, Leicestershire and Rutland. We also provide our services in North and North East Lincolnshire.

We employ more than 2,800 staff across more than 70 locations, including two Emergency Operations Centres at Nottingham and Lincoln. Our largest staff group is made up of our accident and emergency 999 crews and we operate a fleet of around 700 vehicles, including emergency ambulances, fast response cars, specialised vehicles and patient transport vehicles. Our overall annual expenditure budget this year was £145,399k.

Every day we receive around 2,000 calls from members of the public who have rung 999 – this is the equivalent of receiving an emergency call every 43 seconds.

Accident and Emergency Service

As well as a resident population of just over 4.8m people, we have to meet the demands placed on us by visitors who fall ill or suffer an injury. With four large cities, major arterial roads, an international airport, a lengthy coastline and several country parks, this extra activity is significant, particularly during the busier summer months. Aside from the challenges posed by our geographical boundaries and the infrastructure of the region, EMAS has to respond to the rising number of 999 calls made by the public.

As support for our conventional ambulances, we receive valuable assistance from a large number of Community First Responder schemes which provide emergency cover mainly in the more rural areas we serve. We also benefit from the invaluable presence of three separate air ambulances which permanently operate across the region which are operated by registered charities. In addition, we have a team of doctors who provide both a primary response role to life-threatening calls and clinical support for crews at serious clinical incidents such as road traffic collisions.

We also operate a Hazardous Area Response Team which is made up of more than 40 personnel specially trained in dealing with Chemical, Biological, Radioactive and Nuclear incidents and Urban Search and Rescue techniques.

We continually strive to further improve patient care by ensuring that patients consistently receive the right response first time and on time. Our approach also means that more patients will be treated in the community, and fewer people will go to A&E unnecessarily.

Patient Transport Service

We provide Non-emergency Patient Transport Service (PTS) in the North and North East Lincolnshire area. This service is available for patients who need to attend either a hospital or clinic for routine outpatient appointments or day care sessions; it provides much-needed support to patients and their carers as part of the overall health-care package.

Call handling and clinical assessment

Our Clinical Assessment and Advice Service dealt with 25,896 calls during the year. This allows the Trust to provide patients with an alternative care pathway leading to fewer admissions to A&E departments. We are committed to further improving the speed and quality of our call handling and work in a more integrated way with partners to ensure consistent clinical advice for patients who need urgent care.

The EMAS Trust Board

The EMAS Trust Board comprises of 13 members:

- Chairman
- Chief Executive
- 6 Executive Directors
- 5 Non-Executive Directors (one vacancy)

The Board's role is to:

- agree a common set of objectives that set the high-level direction of the Trust
- determine whether it can robustly achieve its objectives based on risk analysis
- implement controls and establish governance systems enabling it to monitor and achieve its objectives
- provide assurance and understand what information it needs.

The Trust Board's main functions encompass:

- Formulating policy and foresight (in relation to the external environment) stating purpose, vision, values, culture and climate.
- Thinking strategically to consider the Trust's positioning within the health community, alongside setting corporate direction, reviewing and deciding key resources and implementation processes.
- Supervising management (overall patterns, not operational detail), monitoring budgetary control, reviewing key results and ensuring organisational capability.
- Exercising accountability to stakeholders and ensuring directorial audits.

Executive Directors are responsible for managing EMAS' affairs on a day-to-day basis under approved Board policy and statutory requirements. In accordance with good governance practice, the Board of Directors includes a balance of independent Non-Executive Directors with skills and expertise in the public and private business sectors which complement those of our Executive Directors. No Director on the Board has declared any interests which conflict with their responsibilities to the Trust.

The Trust Board and management team operate within an assurance framework based on the 'Combined Code of Corporate Governance' articulated through its Governance Strategy. The Trust's Scheme of Delegation identifies the types of decisions reserved to the Board and those which may be taken by management. The Board takes assurance for the performance management of delivery of its objectives from the Audit, Quality and Governance, Workforce and Finance and Performance Committees. The Committees obtain assurance from regular reports from management and external bodies and through information provided through the Trust's performance management system.

On-going self-assessments to monitor the performance of our Board and key committees are carried out as part of our review process.

The following tables identify the number of attendances made by each Board member at our key meetings. The Finance and Performance Committee and Workforce Committee were not established until 16 December 2013 and therefore have not been included in this analysis.

Board meetings

Executive Directors	Possible attendances	Actual attendances
P Milligan	2	2
J Sargeant	8	8
D Farrelly	7	6
K Glover	7	6
J Gray	1	1
M Gough	3	2
S Noyes	5	5
A Schofield	8	7
A Spice	2	0
S Dykes*	1	0
T Mills	6	6
R Henderson	5	4
M Bull**	1	1
N Cook	1	1

* Attended as Acting Medical Director

** Attended as Acting Director of Finance

Non-Executive Directors	Possible attendances	Actual attendances
J Towler	3	3
G Austin	7	7
P Tagg	8	8
G Newton	8	8
S Dawkins	8	7
D Toberty	8	7

Audit Committee meetings

Non-Executive Directors	Possible attendances	Actual attendances
G Austin	5	5

S Dawkins	6	6
D Toberty (Chair)	6	6
G Newton	6	6

Quality and Governance meetings

Executive Directors	Possible Attendances	Actual Attendances
J Gray (Lead Executive until July 2013)	2	1
K Glover (Lead Executive n July 2013)	8	7
J Sargeant	8	3
D Farrelly	5	5
A Schofield	8	5
M Gough	3	1
T Mills	5	4
R Henderson	4	1
S Dykes*	1	0
S Cascarino	1	1

* Attended as Acting Medical Director

Non-Executive Directors	Possible attendances	Actual attendances
P Tagg (Chair until December 2013)	5	4
J Towler	4	4
S Dawkins (Chair from January 2014)	8	8
G Newton	8	8

The operating environment

The financial environment

As with 2013/14, we fully expect 2014/15 to present a significant financial challenge as we strive to reduce our operating scale while improving efficiency and productivity. The greatest challenge, however, will be to embed delivery of national performance standards within the funds available. This will provide mitigation against a number of key financial risks and allow us to continue building our reputation as a strong brand in the delivery of emergency and urgent care.

The financial plan reflects the challenges we face during the next 12 months and proposed methods of mitigating them. It is designed to deliver:

- 1.5% revenue surplus
- National performance standards regionally
- Cost improvement programme savings of £ 5.8m
- Continuity of services risk rating 4
- Achievement of statutory financial duties while an NHS Trust
- Risk assessment framework

We received £3.4 million of non-recurrent transformational funding to enable us to achieve our response time targets without impacting on quality. However, we were unable to achieve all three key response time targets and this led to fines of £4.9 million being imposed. In response to the lack of performance improvement, we received an unplanned investment of £4.9 million from our Commissioners in December 2013 which offset the impact of the fines.

A proportion of EMAS' income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between EMAS and NHS Erewash Clinical Commissioning Group (our lead commissioners) through the Commissioning for Quality and Innovation payment framework. The CQUINs relate to 4 quality domains; Safety, Effectiveness, Patient Experience and Innovation. Through use of the Commissioning for Quality and Innovation (CQUIN) framework, the total value of our CQUIN indicators was £3.3million.

Service improvement

This is key to EMAS' future development and our quality Improvement Plan 'Better Patient Care' provides a detailed account of all the initiatives we have either already taken or will be introduced to ensure that the organisation fulfils its responsibilities. The key themes in the plan (for delivery in 2014/2015) are as follows:

- To build on achievements to date and ensure that we are able to sustain strong performance and respond to patients in timely and appropriate way.
- To develop a culture where EMAS staff feel valued, motivated and empowered to contribute to and be involved in the decisions that affect them and our patients.
- To develop competent, capable and supportive leaders and managers at every level who are committed to the development of the organisation, their teams and their own continuing professional development.
- To improve clinical effectiveness in order to facilitate the appropriate clinical management for patients.
- To ensure that the Trust has in place robust systems to capture, monitor and learn from information relating to patient safety and experience, using this to create a culture of continuous improvement.
- To ensure that sufficient resources are available to the Trust to deliver high quality services to patients.

- To maintain and transform the EMAS estates to support staff well-being and our ability to respond to the needs of patients.

- To further improve Internal and external communication and engagement

The full Better Patient Care document is available on our website www.emas.nhs.uk

Examples of the measures taken to date are:

- Review of 999 activity data and introduction of demand-sensitive rotas (more staff are in the right place at the right time)

- Reduced the number of ambulance vehicles sent to 999 calls by greater emphasis on Clinical Assessment who provide a 'hear and treat service' (undertaken over the phone and directly with patients/callers).

- Introduction of a consultant paramedic and General Practitioner in the Emergency Operations Control room to provide clinical leadership at key times

- Better categorisation of the calls as they are received, i.e. whether life-threatening or urgent, so that resources can be allocated more appropriately

- Improvements in ambulance response cycle times, including faster turnaround by ambulance staff at hospitals

- Worked in partnership with the NHS 111 service to ensure ambulances are only requested for appropriate emergency calls.

- Carried out a recruitment drive which, as at 1 April 2014, saw 110 more front-line staff in post compared to the same time last year

Integrated business plan

This was developed during the year under review (in alignment with our Better Patient Care improvement plan) and had three phases:

Phase 1

This contained a quality improvement plan made up of eight work streams focussing on delivering organisational recovery. The plan supported achievement of performance standards by the end of March 2014 and laid the foundations for sustained change

Phase 2 Transition (Consolidation & Longer Term Planning)

Building on phase 1, this will ensure we maintain performance levels and make a transition that achieves performance in a sustainable way. Through this phase, initiatives such as Listening into Action and the People Capability Framework will come to fruition. Further incremental improvements will be made at the same time as developing plans to introduce transformational change.

Phase 3 Transformation

This phase commits us to delivering transformational change to achieve the strategic aims and objectives of the organisation. This will include delivering more with less, moving into new business areas and securing EMAS' position as a community based provider of urgent and emergency healthcare across the East Midlands.

Equality Delivery

Equality and diversity is embedded within the Trust's business portfolio to ensure we meet our legal and regulatory requirements as well as contract and commissioning requirements and specifications. By

implementing the ‘NHS Equality Delivery System Two’ we will look at objectives that generate workforce capability and confidence around equalities through better awareness, ownership and involvement. This will not only increase the diversity of our workforce, but also deliver services that effectively respond to and meet the needs of the diverse communities that we serve. We aim to embed equalities within all our staff engagement initiatives, especially in areas that support the development of special interest groups. We also pledge to identify and engage with national and regional equalities initiatives that nurture talent and support career development particularly from under-represented staff. We will also identify innovative and creative ways to improve collection and use of equalities data to improve our equality performance.

Foundation Trust status

In light of the overriding need to achieve improved performance and tackle the other underlying issues that were preventing EMAS and its staff from progressing in the way required (and as rapidly as possible) in late 2013, the EMAS Board decided to place our application for FT status on hold with the intention of reviewing circumstances in 2014.

Our achievements at a glance

During 2013/14, we have continued to make significant progress on a broad range of initiatives. The following information provides a snapshot of key developments within each of our directorates.

Operations Directorate

Operational performance

The national targets that ambulance services are required to achieve are: Red 1 and Red 2 emergencies – a response within 8 minutes for 75% of all calls and Red 1 and Red 2 emergencies – arrival of a patient conveying vehicle within 19 minutes for 95% of all calls.

During the early months of the year under review, our performance continued to fall short of these targets. The position showed little change as we moved into the winter months (when we inevitably face the additional challenges of poor weather and increases in general illness). However, following the introduction of measures laid down in Better Patient Care, we were pleased to see signs of recovery in February and; for the month of March 2014, were only 10 seconds away from hitting the Red 1 and Red 2 response standard. Also, we hit the 95% standard for both months.

Although this was a pleasing outcome demonstrating that the measures we had taken to improve were delivering the planned results, the uplift was not high enough to affect our full-year figures which showed that we hit 71.26% of Red 1 and 71.46% of Red 2 calls within 8 minutes and (standard: 75%) and 93.82% of calls against the 19 minute standard (standard: 95%). Our call pick-up time performance was 94.3% of calls answered within 5 seconds (target 95%). In total, we received 786,744 calls. Of these, 25,896 were provided with over the phone clinical assessment. 185,767 were treated at the scene and 444,758 were treated and then conveyed to a treatment centre. This represents a conveyance rate of 68.2%.

As we moved into a new reporting year and further changes in Better Patient Care started to come into effect, we remain confident that our results for 2014/2015 will show a marked improvement.

EMAS-wide developments

While our divisions have the freedom to make localised changes, some issues affect all divisions and are therefore managed on an EMAS-wide basis. Key developments during 2013/14 were:

Restructure

As an integral part of the Trust's previous Being the Best agenda, the Operations Directorate was restructured to support and enhance the quality of care, with clinical leadership embedded through the roles of consultant paramedics, locality quality managers and clinical team mentors. The restructure was completed during the year and is in the process of receiving a reflection review.

Resource Management Centre

The Resource Management Centre (RMC) was launched in March 2012 and now plays an essential role in coordinating and recording frontline Accident and Emergency and Emergency Operations Centre (Control) staff resources (such as rota management, annual leave, absence and sickness and any other abstractions). By utilising the RMC instead of managing resources on a divisional basis, we have a comprehensive picture of the resources available across the Trust. This enables us to staffing and vehicle resources for particular times of day and in specific areas. This has removed previous inconsistencies and significantly improved the way we match resources to predicted patient demand. This is resulting in better care for our patients and improved working arrangements for frontline staff.

A review of the department was held in September 2013 to ensure it was still fit for purpose. While it was clear that the overall strategy remained relevant, some changes were recommended to align the RMC's workforce to the three operational divisions. All rotas were re-aligned to once again provide full support for the operational divisions as part of the staff contact element of the RMC. Work continues to implement access to

electronic rostering from home, and the project plan is being developed by the ICT team for operational roll out in April 2014.

Emergency Operations Centre and clinical assessment

The Emergency Operations Centre (EOC) will continue to provide high-quality patient care as an Advance Medical Priority Dispatch System (AMPDS) Centre of Excellence facility. The EOC now has enhanced systems to support dedicated clinical advice to patients through Hear and Treat and Hear and Refer systems as well as operational staff clinical support through integrated mobile communication systems.

The further transformation of our EOC facility will be achieved by a number of specific and parallel work streams that include:

- Establishment of meaningful links with field operations staff to create a broader understanding between disciplines
- Introduction of additional dispatch functions to address urgent journeys and incident command capabilities
- Enhancement of command and control systems to optimise computer-aided dispatch decision support
- A review and reconfiguration of our Nottingham and Lincoln EOC Control Rooms
- Enhancement of the Clinical Assessment team processes and systems to maximise on its capability and productivity with a focus on recruitment, retention and specialist functions
- Evaluating and defining a future strategy for the Trust's mobile data and automatic vehicle location systems to support integrated electronic patient reporting and data-capture technologies
- Review of the contractual and practical constraints of the current computer-aided dispatch systems and test them for 'fit for purpose' functionality and future capability

Hazardous Area Response Team

Throughout the year, our Hazardous Area Response Team (HART) provided invaluable support to patients in areas or environments that require staff with specialist skills, techniques or equipment. The team has formed excellent working relationships with colleagues from the police, fire and rescue services across the region, providing treatment to patients in the inner cordon or 'hot zone' of incidents, saving lives that may otherwise have been be lost. The longer-term medical implications for patients rescued from hazardous environments have been reduced due to early clinical assessment, triage and treatment and the overall health service response to dealing with hazardous incidents is now managed more effectively than ever before.

Emergency preparedness

The Emergency Preparedness team has continued to work closely with partner agencies in the preparation and review of plans to support the new Local Health Resilient Partnerships. During the year, we have participated in a number of single and multi-agency exercises to test plans including Exercise Georgiana which simulated a large-scale train accident. A number of large live exercises took place during year with resourcing from divisions, HART and Special Operations Response team. The East Midlands Airport exercise in November 2013 confirmed the robust and resilient plans and working arrangements we have in place to deal with any emergency that should arise.

In December, we played an active role in dealing with the east coast tidal surge and resultant flooding. Our Emergency Preparedness team has also received accreditation to deliver training for incident 'loggists' within the Trust. Loggists perform an important role in recording all decisions taken in the course of managing any large scale or untoward event and ensuring that the reasons why the action was taken are referenced.

During the year, the Emergency Preparedness team has worked closely with a range of external agencies and has received significant support from within EMAS to help meet its obligations for maintaining resilience against known and potential risks. The team has supported and worked with the Local Resilience Forums to

ensure joined-up multi-agency planning and response enabling us to meet our obligations under the Civil Contingencies Act. Our Major Incident Plan is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance.

Looking ahead to 2014/15, we will be participating in the delivery of training for incident commanders in the National Joint Emergency Services Interoperability Programme. We are continuing to develop our business continuity policies and processes to ensure alignment with ISO 22301 which has resulted in a successful business continuity audit by peers.

Special Operations Response Team

Our Special Operations Response Team (SORT) provides invaluable support to patients in areas or environments that require staff to use specialist equipment for decontaminating patients or setting up mass casualty clearing centres at major incidents. The team has formed excellent working relationships with colleagues from our HART and fire and rescue services across the region by working closely with them during the year. A number of the SORT team have also been trained to respond to large-scale firearms incidents alongside the HART and a similarly-trained firearms response team from Nottingham Fire and Rescue Service.

Events team

The Event team has continued to support operational delivery by providing an ambulance presence at a range of major sporting venues such as football grounds, race courses, rugby clubs and cricket clubs. The team also attends other public events with high visitor numbers across the region. During the year, the team has enjoyed an excellent track record of successful clinical interventions, demonstrating the benefit of having professional first aid cover available at large-scale public events. Looking ahead to 2014/15, the Events team will build upon their great work as contracts have been agreed with all our major customers for an ambulance presence at their events.

Fleet

During the year we have introduced a number of new measures to improve efficiencies and reduce cost, with great success. These include the introduction of a year-round cold weather tyre programme which has had significant safety and cost-saving benefits for us, not least in wet weather, which was agreed in 2011/12. In conjunction with the ICT team, we took over the repair of tough book docking stations that are fitted in DCA vehicles in a bid to reduce costs and down time. And, following an audit by the Freight transport Association, we have achieved accreditation to their van excellence programme that recognises high operational standards in fleet workshops

We also began some innovative work in fitting expandable patient surfaces to all vehicles with Stryker stretchers – we were the first Trust outside the USA to do so. This provides all 120 vehicles with the capability to convey a bariatric patient up to a safe working load of 318g (700lbs).

During the year we also introduced a salary sacrifice car-leasing scheme for Trust colleagues that provides a cost-effective, sustainable vehicle option to them for a monthly lease charge. Uptake has been very positive with nearly 70 members of staff taking part to date.

In February 2014, we rolled out the fitting of tracking devices to all conventional and have undertaken an upgrade to our fleet management computer system. This provides us with greater functionality and allows us to measure and control costs more efficiently than before, leading to improved overall fleet efficiency.

Throughout 2013/14 we consistently delivered the required level of vehicle availability to support operational requirements. This was measured daily and reported to the Trust board on a monthly basis.

Other vehicle projects that began in 2013 include:

- A ground-breaking mobile treatment centre that will have significant benefits in reducing conveyance to hospital rates
- Delivery of the final three bariatric support vehicles (support vehicles with a range of equipment to deal with patients who present manual handling issues)
- Two improved-concept A&E vehicles to base our 2014 build on. These are lighter and more robust

following staff feedback on the previous year's model

- A modern 4x4 vehicle for the Peak District based on a Volkswagen Amarok that has patient carrying capability. This was generously funded by a charity donation

In November 2013 the Fleet department were allocated responsibility for managing the Medical Device Engineering section of the Trust. At that time we took over the Radio Frequency Identification tagging of equipment and made huge progress in a short time frame. This provides us with information about which vehicle is carrying what equipment, which is essential for ensuring equipment is serviced regularly, safe and available. This also provides compliance towards the CQC outcome 11 Safety, Availability and Suitability of Equipment.

Clinical Services and Nursing and Quality Directorates

Our Clinical Services Directorate and Nursing and Quality Directorate operate as two independent functions. However, they have shared responsibilities in many areas and therefore operate in close liaison with one another.

The achievements during 2013/14 of both are detailed separately below.

Clinical Services Directorate

Clinical Governance, Clinical audit and quality improvements

In 2013/14 Clinical Governance continued to develop, including improvements in medicines management. We contracted an expert pharmacy adviser from South Central Ambulance Service. We developed new drug bag and drug roll systems for the provision of medication for use by frontline clinical staff. We have continued to monitor closely the use of controlled drug opiate analgesia through the audit programme and have updated our procedures.

Part of ensuring Clinical Governance, is through Clinical Audit. This provides the means by which the Trust ensures quality clinical care, by making individuals accountable for setting, maintaining and monitoring standards. It is focussed around the three domains of quality - clinical effectiveness, patient safety and patient experience.

Through clinical performance indicators, both national and local, our clinical care can be assessed and monitored as improvement plans are put into place. The Clinical Audit department works closely with clinicians in order to ensure quality clinical care is embedded into the care we give to our patients.

Research and development

2013/14 has seen a continuing increase in research activity and quality at EMAS. Our success as a research team was reflected in the progress of our own programme of research, the number and range of studies we have undertaken, our contribution to external studies and the number of new studies in development. We have also achieved success in contributing to landmark and internationally excellent publications in peer reviewed journals together with presentations to national and international conferences. Another important indicator of success is the increasing involvement of staff from executive to front-line in research.

EMAS is one of the highest recruiting ambulance services to National Institute for Health Research (NIHR) portfolio studies. Our research takes place at various levels from masters and doctoral studies to regional, national and multinational studies with a range of healthcare and academic partners in the UK, Australia and the United States. We use a variety of research methods from observational to qualitative and experimental studies. This range of research is important if we are to develop individuals to become future researchers and

EMAS to develop a research culture organisationally, where research drives innovation and improvements in care for our patients.

Clinical audit and involving practitioners in quality improvements

We launched a number of initiatives over the past year to increase staff involvement and capacity for research. This includes recruiting research paramedic champions, who are funded to support research studies. There is a new scheme to support staff who wish to pursue clinical academic careers. In this programme, funded by East Midlands Health Innovation and Education Cluster, we are working with our local universities (Lincoln, Sheffield Hallam and Northampton) to help paramedics and other ambulance clinicians to embark on higher degrees involving research such as masters or doctoral programmes. Ultimately this will support the development of consultant paramedics and future clinical academic leaders in paramedic science. Two of our research staff have already embarked on PhD programmes.

Working with our partners to improve patient experience

April 2013 represented a milestone for the NHS as it heralded the start of a new way of planning and commissioning local health services. The primary care trusts were replaced by GP-led clinical commissioning groups (CCGs), and the strategic health authorities were discontinued. Public health became part of a Public Health England and the local authorities, and local authorities also became the hosts for the local Health and Wellbeing Boards, which help to ensure local health and social care needs are being met.

In the East Midlands, there are 11 Clinical Commissioning Groups who work in local health communities across the region in partnership with our Trust and other health providers to address the emergency and urgent care needs across the five counties we are responsible for. By working closely with these partners, and other stakeholders such as patient groups, we strive to continually improve the services we provide. An important element to partnership working is ensuring appropriate EMAS representation on local Urgent Care and various integrated care programme boards, as well as the Major Trauma Network and the Regional Clinical Senate.

We continue to play an integral role in developing new pathways; the numerous falls services across the region are an example of this. 2013/14 also saw the bedding in of the new pathways for major trauma, stroke and heart attacks, where we transported appropriately identified patients direct to specialist centres of excellence to provide the best patient care as quickly as possible.

As part of the Better Patient Care programme, we have introduced many initiatives to improve the clinical care we provide. The Clinical Directorate is working closely with other divisions to provide a strong clinical focus on many aspects of this programme.

Clinical leadership

During the year we saw the introduction of new structures to support clinical leadership. This included three consultant paramedics, one for each division, but who will work closely with the Clinical Services and Quality Directorate including the Medical and Nursing Director and deputy directors. There will also be six new locality quality managers and a number of clinical team mentors. All these clinicians are now helping us to achieve our aim of delivering high-quality care with the patient at the heart of all we do.

Nursing and Compliance Directorate

Infection Prevention and Control team

In 2013/14, the Infection Prevention and Control (IPC) team continued to maintain a high profile, working collaboratively with operational colleagues to build on and sustain the successes of the previous year. The team worked closely with operational managers to carry out joint audit and inspections designed to enhance the managers' IPC knowledge and inspection capability to assess compliance with all aspects of the Hygiene

Code, Risk and Safety Standards and Safeguarding. Audits and inspections continue to be undertaken by both specialist teams and operational managers to assess compliance and provide assurances to the Board. The results from the IPC inspections continue to demonstrate a high level of compliance with IPC policy over the year and corrective action for any non-compliant areas is taken until full assurances are received.

This year has seen improvement in compliance with the deep clean targets. While the North Division has experienced periods of non-compliance, this has improved during the year.

IPC continues to play a vital role in supporting frontline services by ensuring accurate and timely information on communicable diseases is disseminated to frontline staff; working with logistics to introduce and evaluate equipment and consumables, continually driving improvements in practice and by promoting a zero tolerance approach to poor compliance with IPC standards. The team has been involved in developing the IPC specification for premises as part of the Estates Strategy.

The Operational Infection Prevention and Control group (a sub group to the Strategic IPC group) is key to sharing IPC information and gaining meaningful feedback from operational managers and continues to be well supported. The Link Champions IPC Group has been reformed into a virtual group using educational opportunities and newsletters as a means of communicating essential IPC messages.

Close working with other health partners and the Health Protection Agency has continued by building strong links with health economy IPC Groups in each county, Health Protection Agency attendance at EMAS Strategic Infection Prevention and Control Group meetings and the regular provision of outbreak information across the Trust. The Trust has also worked collaboratively with the NHS Trust Development Authority to ensure compliance with national standards, developing action plans in response to feedback following site visits.

During 2013/14, peer review was undertaken by the Yorkshire Ambulance Service (YAS) IPC team with very positive findings. Following review of evidence, site visits and interviews with staff it was the opinion of the YAS team that EMAS can demonstrate compliance with the Hygiene Code.

Looking ahead, our priorities for 2014/15 are:

- To sustain the improvements in deep clean compliance ensuring consistent achievement in all areas throughout the year
- To continue to work closely with Estates and operational managers to ensure that our premises meet the required standards of cleanliness and are maintained to a good standard
- To continue to work with frontline staff and managers to ensure high levels of IPC knowledge and continued adherence to practice standards

Patient and staff safety

Health and safety aims to ensure that our staff, patients, their relatives or members of the public are not harmed as a result of our activities. During the year, we have continued to deliver our Risk Management Audit Programme which ensures we meet compliance standards and strengthen both staff and patient safety by identifying areas of risk, applying mitigations and introducing harm-reduction strategies. The programme includes observed practice, premise inspections and vehicle audits across the key areas of infection prevention and control, patient safety and staff safety.

During 2013/14 data relating to slips, trips and falls was analysed and a strategy to reduce these types of incidents was developed and implemented. The number of slips, trips and falls will be monitored in 2014/15 to assess the impact of this strategy.

We have continued to develop our Essential Education programme to ensure all staff have targeted health and safety training. During 2013/14, we focussed on incident investigation training, display screen equipment assessment and reducing slips, trips and falls.

In October 2013, we expanded the incident telephone reporting line to be available 24 hours per day, 7 days per week and continued to promote this facility to staff. In early 2013, we also purchased an integrated online incident reporting system which allows staff to report and process incidents electronically. This was rolled out to all EMAS managers during 2013/2014 and staff will be able to report incidents online from early 2014/15. Both the online reporting system and the telephone reporting line will make it easier to report incidents and allow us to carry out investigations in a more effective, timely way. We have seen a significant increase in the numbers of incidents reported in the low- and no-harm category during 2013/14 which is a sign of a maturing safety culture.

In 2013/14 we also reviewed a number of national reports including those written by Professor Don Berwick and Sir Bruce Keogh and have considered the implications for EMAS, using the learning from these to inform our patient safety action plan and work plan.

Looking ahead, our priorities for 2014/15 are:

- To continue to encourage incident reporting, particularly in the low- and no-harm category so we can identify and mitigate risk and reduce harm

  To continue to develop and implement strategies to reduce harm by responding to incident reporting themes and trends
- To deliver training on the impact of human factors on safety in healthcare as part of the Essential Education programme

Learning from our Strategic Learning Review Group

To build on our solid track record, it is essential that we continue to implement changes in response to learning. Learning is captured through our Divisional Learning Review Groups and disseminated to managers and staff through the Strategic Learning Review Group. Some examples of changes made during the year include:

- Revised packaging of safety razors resulting in a reduction in staff inoculation injuries
- Introduction of sporicidal wipes to provide appropriate decontamination in cases of known or suspected contamination with spores (such as Clostridium difficile)
- Development of an Escalation Standing Operational Procedure (SOP) with associated staff communications to provide staff with guidance regarding how to escalate concerns during live incidents
- A framework has been developed for Clinical Support Desk staff to follow which includes red/amber/green safeguarding referral flowcharts which streamlines the process leading to improved timeliness of onward referrals and appropriate escalation
- Warning stickers placed on the seats of Vauxhall Movanos warning staff of a finger entrapment hazard
- Introduction of ECG electrodes suitable for sensitive skin as standard
- Revision of the Safe Carriage of Staff and Patients SOP to clarify minimum requirements for securing staff and patients, options available for children and babies and action to be taken if an appropriate securing device is not available or cannot be used for clinical reasons

- Audit of securing devices to ensure all vehicles have appropriate capability and provision of additional devices to enable replacement if broken or soiled
- Introduction of hypoglycaemia patient-held record/information booklet and automatic referral to specialist diabetes service
- Analysis of patient experience feedback by call category and division to identify local themes and actions required to facilitate improvement
- Case studies from incidents, complaints or Patient Advice and Liaison Service (PALS) are now regularly included in the Clinical Update bulletins
- Revision and reissue of end-of-life care guidelines to frontline staff
- Revised procedure for dealing with second and subsequent calls approved by Clinical Governance Group to reduce repetition of questioning
- Incident reporting and management system configured to enable automatic alerts to the relevant manager in the case of attitude-related complaints and PALS so that repeated incidents can be identified and appropriate action can be taken
- Introduction of 'recruiting for attitude' processes to ensure that equal importance is given to attitude and technical/clinical ability to improve patient experience
- Improved bariatric capability

Learning is influenced through serious incidents, claims and patient experience reviews which are collated through Divisional and Strategic Learning Review Groups. Our Organisational Learning Team uses these channels to formulate a training needs analysis, develops and then delivers learning packages, using real-life examples, to make the education relevant to frontline staff.

Looking ahead, our priorities for 2014/15 are:

- To continue to evaluate the impact of changes to ensure that the anticipated benefits are realised
- To improve how we communicate with frontline staff by developing new communication channels and modes of delivery
- To improve the way in which we triangulate learning from a wider range of sources to enable priority improvement actions to be identified and implemented

Patient experience

We continually strive to create a patient-focused organisation that is responsive to patient need and to ensure lessons are learned and disseminated across the organisation. Throughout the year, we have continued to use innovative methods to capture patient experience. We have also used an electronic Facebook-style system to run a second campaign to capture staff ideas and experiences. We then developed an action plan to ensure staff suggestions were given due consideration and, where appropriate, put into action.

Patient stories were also submitted to the Board on a regular basis. These accounts, from patients, their carers or relatives, ensured that personal experiences were heard and noted. These personal stories have been integral to our understanding of patient experience and as a result, we have implemented some real improvements to our service provision.

We continue to survey our A&E and PTS patients on a regular basis to capture invaluable feedback. We regularly review the questions we ask to simplify the process and make our surveys more accessible and appealing to patients.

Throughout the year we have worked hard to meet the challenging timeframes we set ourselves in early 2012 for timely response to formal complaints and PALS, and we have seen continued improvement in performance. In addition, the quality of our investigations has continued to improve and, as a direct result, the number of second letters received from complainants requesting additional information has significantly reduced.

During 2013/14, we developed an action plan in response to the review of complaint handling in the NHS carried out by Professor Tricia Hart and Ann Clwyd, MP. This review was aimed at improving the experience of complainants and ensuring that learning and changes result from patient feedback.

Our priorities for 2014/15 are:

- To introduce more innovative methods of capturing patient feedback in collaboration with patient groups, such as mystery shopper placements or face-to-face interviews
- To develop methods to obtain patient feedback via frontline staff
- To work with the other ambulance services to facilitate benchmarking of patient experience information

Safeguarding children and adults at risk

The referral rate for children and adults continues to increase during 2013/14 as a result of our focus on safeguarding. This has been achieved through a comprehensive safeguarding awareness campaign, education and on-going audit of practice and referrals.

During 2013/2014, key achievements of the Safeguarding team include:

- Continued to develop alternative referral pathways for care concern issues and utilised Multi-Agency Safeguarding Hubs (MASH) which were introduced in the region to streamline referrals and ensure appropriate agencies are informed
- Introduced a new IT system, SystmOne, to ensure trends and early identification of complex cases, supporting effective and timely information sharing
- Further developed the role of Dignity Champions, integrating themes from the dementia agenda.
- Developed supportive tools to strengthen documentation of the mental capacity assessment
- Launched a mental health education campaign for all staff with a focus on self-harm and suicide
- Achieved consistent engagement across the divisions in community projects and forums in relation to learning disability, mental health and safeguarding
- Piloted the use of a memory screening assessment to facilitate early identification of dementia

During 2013/14, a peer review was carried out by the North West Ambulance Service (NWAS) Safeguarding team with very positive findings. Following review of evidence, site visits and interviews with staff, the opinion of the NWAS team was that EMAS not only meets the essential criteria for safeguarding, but, in some areas, excel. They cited the progress made against the Prevent agenda and the robust arrangements for safeguarding supervision as examples that they would incorporate into their own practice.

Looking ahead, our priorities for 2014/15 are:

- To continue to develop the role of the Dignity Champions

- To remain responsive to emerging plans to make adult safeguarding a statutory responsibility
- To continue to work in partnership with other agencies to ensure appropriate and timely sharing of information and ensuring that lessons learned from Serious Case Reviews or Domestic Homicide Reviews are put into practice

Governance

During 2013/14, the Governance team proposed revisions to our corporate governance arrangements which were accepted by the Trust Board and have now been implemented. The revisions strengthened the Board and committee arrangements by increasing the frequency of key meetings, introducing a Workforce Committee and establishing reporting links for the key governance groups to ensure the committees receive the information and assurance they require.

The team worked with the Board to revise the Board Assurance Framework to reflect the risks associated with the delivery of the initiatives set out in the Trust's annual plan. Risk management arrangements were also enhanced throughout the organisation with the provision of further guidance for staff and a standard risk register template.

The Governance team has monitored the implementation of the actions from the last Care Quality Commission (CQC) inspection in January 2014 and has overseen the on-going self-assessment process against CQC standards to ensure that we are meeting these requirements or taking appropriate action where necessary.

Looking ahead, our priorities for 2014/15 are:

- To ensure on-going compliance with all CQC standards
- To further embed risk management arrangements across EMAS by providing support and advice to managers and quality assuring local risk registers
- To further strengthen corporate governance arrangements by ensuring the Trust Board has the capacity and capability to undertake its role through filling vacancies and progressing the Board Development Programme

Workforce Directorate

This year saw our continued focus on achieving the goals of our Workforce Strategy, *Driving Quality, Delivering Change 2012-2016.* This set out what we will do to ensure a highly-skilled, motivated and engaged workforce to meet the health needs of the local population.

The strategy also details our cultural aims to ensure our organisational environment is focused on patient safety, driven by quality and value and demonstrates a commitment to learning and development with a high level of employee engagement and empowerment. We want to create an environment where innovation and entrepreneurialism is encouraged and where equality of opportunity is embedded in everything we do.

In 2013/2014, a number of supporting strategies were also developed to complement the Workforce Strategy and support the development and wellbeing of our staff. An exciting and progressive Learning and Development Strategy was approved by the Trust Board in July 2013. The vision of this strategy is: *To create a culture of competence and organisational learning through developing and empowering staff to be able to deliver safe, effective, compassionate and professional care.* This is supported by a set of common aims and key principles, which are:

- That patient care and experience remain central to workforce at entry level and through career development. In particular, in recruitment, education planning, design and delivery

- To recognise the value of formal and informal learning opportunities to support staff to achieve and maximise their potential in every day practice, contribute to service delivery and organisational learning and development

- Ensure high-quality education for all staff that is accredited, meets national standards and facilitates seamless progression and career development

- Ensure flexible and responsive education to meet service requirements utilising blended teaching and learning methods within a defined and flexible career framework

- For staff to take responsibility for continuing professional development in line with registration requirements

- Collaboration and partnerships with other education providers to ensure accredited education at levels aligned to the Qualifications and Credit Framework and national Ambulance Education Strategy

In addition, we developed the newly approved health and wellbeing strategy for 2013/2017. This will ensure a

comprehensive prevention-focussed approach to health improvement and employee wellbeing to ensure a healthy workplace, improved staff engagement, and enhanced individual and organisational performance. This, ultimately, leads to improved patient experience and quality of care.

Our Being the Best transformational change programme required significant workforce redesign to deliver capacity and capability at every level during the year. The Workforce Directorate played an integral role in developing the necessary support for its implementation to ensure the service model and operational management restructure supported delivery of strategic aims and objectives.

Alongside these programmes, we developed our Quality Improvement Plan in December 2013. By working in partnership with external stakeholders, we will reset the role, culture and effectiveness of our organisation. The plan was designed to put EMAS on a credible trajectory that will, within a short time frame, markedly improve patient care. Again, the Workforce Directorate has a key role to play in facilitating the delivery of this plan, such as supporting targets in relation to attendance management, appraisal, essential education and workforce planning. The Directorate will also strive to ensure we recruit the best people for the right jobs, create and maintain a culture that sustains all staff in their work, and develop our leaders to listen and act in the best interests of patients and staff.

To consolidate our activities in this area, we established a Workforce Committee as a sub-group of the Trust Board. Its purpose is to:

- Agree strategies that will foster the attraction, development, engagement, wellbeing, retention and deployment of a high quality workforce including performance appraisals and ensure essential standards of quality and safety are maintained.
- Drive workforce change through legislative and best practice human resource management to support achievement of Trust objectives within a robust governance framework.
- Monitor implementation of workforce strategies.
- Monitor performance against key workforce metrics.
- Monitor workforce planning arrangements providing assurance to the Trust Board

Since its establishment, the Workforce Committee has supported a number of initiatives including:

- ECA and Technician Career Progression programmes 2014/2015
- Commissioned an internal review to assess the effectiveness of the current measures of staff safety to ensure effectiveness. This is due to report back to the Workforce Committee in July 2014.

The Workforce Committee has four subgroups:

- Workforce Resourcing and Governance Group
- OD-Education Delivery Group
- Workforce Equality and Wellbeing Group
- Trust Partnership Forum

The key achievements of the Workforce Directorate during 2013/14 include:

Workforce planning to ensure capacity and capability

To achieve our objective of a proactive patient-centred approach to workforce planning, we have focussed on improving the systems, processes and assurance mechanisms to support robust capacity and capability planning.

We are working in partnership with experts from the Local Education and Training Council, and governance arrangements have also been improved to:

- ensure multi-disciplinary internal and external engagement in developing our workforce plan
- gain assurance using the NTDA Workforce Planning checklist
- ensure a reporting line through to the Workforce Committee which is a sub-group of the EMAS Board

We have strengthened our workforce plans to ensure our focus on capacity and capability to support transformation to the new service model and achievement of the quality-improvement programme. This has included commissioning a follow up to the independent external review of resourcing levels initially conducted in 2012/2013 to take place in early 2014. This will provide assurance that we have the right number of resources with the right skill mix required to meet operational demand, ensure business continuity and meet the regional and national standards.

During 2013/2014, in line with our Workforce Plan, we recruited and trained 176 Emergency Care Assistants; 46 paramedics; recruited 38 staff for EOC across both Emergency Medical Despatch and Clinical Assessment Team roles; and 76 other staff in support functions. This included an increase in overall frontline staffing by 155 new roles, as well as keeping up with natural turnover.

During 2013/2014 we experienced a higher turnover rate (7%) of frontline staff than in previous years (4%), therefore the recruitment plan for 2014/2015 reflects this higher rate to maintain funded establishment and skill mix.

In addition to increasing frontline staff numbers, we implemented the operational management restructure aiming to:

- Embed clinical leadership at every level, ensuring quality is our first priority
- Ensure the fewest number of managerial layers, to streamline communications and decision making.
- Ensure clear accountability for the delivery of key performance indicators, where each individual knows what they are accountable for
- Adopt a model of devolved responsibility in service line management
- Support an environment of health and wellbeing

Through this process we have secured 106 whole time equivalent first line managers against a target of 114 in post, with the 20 middle manager posts being fully recruited to within a year. Additional interim arrangements at senior management level were also secured for Quarter 4 of 2013/2014 to increase and strengthen leadership capacity on a county basis.

During the year, we continued to support the national apprenticeship programme by the recruitment of apprentices into a range of support and operational support positions. Since 1 April 2013, nine apprentices began work in Fleet, Workforce Directorate, Corporate Affairs and the Performance Management Information

Team. Of the 13 apprentices that completed their schemes in 2013/2014, five went on to successfully secure roles within EMAS and one in the wider NHS.

Through our recruitment campaigns we have ensured a values-based approach focussed on attitudes, behaviours and ability. While assessment of ability has remained an integral component of the recruitment process, it is now widely recognised that employees' values, attitudes and behaviours have a significant impact on the quality of care and patient experience. This has been highlighted through the year in a number of high-profile publications, not least, the recommendations made by Robert Francis QC in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and the Government response. To better support values-based recruitment, we have employed a number of strategies during the year including education and training for recruiting manager, values-based interview techniques, questions to explore attitudinal and behavioural factors, use of psychometric instruments, assessment centres and patient and stakeholder involvement.

In addition, in the latter part of 2013/2014 we finalised the development of a new corporate induction programme for launch from 1 April 2014. As part of this new induction programme, new staff will complete a corporate induction online prior to joining EMAS, rather than face to face on their first day of employment. In accordance with the objectives of the Learning and Development Strategy this will provide new starters with a comprehensive and professional resource prior to joining the Trust. The online induction also outlines the expectations of the individual within the role they have been employed to do, raises awareness of codes of conduct and expected standards of behaviour and practice, and provides essential corporate information.

Employment relations

One of the goals of the Workforce Directorate is to deliver best practice in human resource management to drive cultural change and encourage discretionary behaviour. Throughout the year we have remained focussed on supporting workforce transformation and redesign. A number of issues were successfully concluded including:

- Implementation of the rota changes in line with the Process Evolution recommendations
- A review regarding a range of Agenda for Change and job evaluation issues (such as overtime arrangements and bank holiday working) providing consistency across EMAS in the application, standardisation and viability of staffing issues
- Contribution to regional and national working groups in order to ensure the views and needs of EMAS as an ambulance service is accounted for
- Further development in case management policies and procedures to enable learning and ensure that fair and equitable processes are in place for our staff
- Introduction of a paperless timesheet to enable a more efficient service for our staff
- Implementation of a web-based travel claim system to enable better tracking and efficient payments
- Successful relationships built in partnership with our trade unions to improve communications and employee relations

In addition, during the latter part of 2012/2013 and the early part of 2013/2014 the team successfully led the implementation of the Pensions Auto Enrolment in line with national regulatory requirements. This included communication and engagement with staff, the pensions regulator, NHS Pensions and trade union colleagues to ensure EMAS complied with its implementation date of 1 July 2013, and establishment of an alternative scheme to meet the auto-enrolment obligations.

Leadership and management development

One of the key priorities for the Workforce Team this year has been to focus on strengthening leadership

capability across the Trust in line with the agreed objectives of the Learning and Development Strategy. This remains a priority through the subsequently established Quality Improvement Plan (QIP) which has committed to ensure we develop competent, capable and supportive leaders and managers at every level from board to frontline, who are committed to the development of the organisation, their teams and their own continuing professional development.

Since agreement of the QIP in early December 2013 we have successfully developed our People Capability Framework that defines the competencies, attitudes and behaviours for staff and managers at every level, supporting leadership and management development. The framework also supports cultural development and underpins:

- workforce planning
- values-based recruitment
- education and training
- appraisals
- talent management
- succession planning

At the heart of the People Capability Framework lie the principles and values set out in the NHS Constitution and our own values, ensuring a clear line of sight between values and capabilities to support leadership and management development in practice. During Quarter 4 we are carrying out assessments in order to understand our leadership capability gaps, develop leadership and management education plans from Board to frontline, and to design, source and implement leadership development interventions from April 2014 to strengthen and improve leadership skills supporting the delivery of safe, high-quality, sustainable services. This will help us to deal with daily operational challenges, plan for change and reflect, learn from and evaluate outcomes. Developing leadership capability is a crucial element in making sure we are more equipped to care for our patients, support our staff, ensure a common purpose and strategic direction, and bring about sustained cultural change.

While work to develop the framework was in progress, we continued to invest in and develop our leaders and managers to support cultural development, improve leadership capability at all levels, support organisational development and meet our plans to achieve Foundation Trust status. This included a range of activities including accredited programmes such as CMI Coaching and Mentoring and Recruitment and Selection; bespoke team and management development programmes including managing attendance and undertaking appraisal and development planning; a formal Board Development Programme and staff access to a range of management tools and diagnostics.

In response to feedback from staff, we also developed and implemented a bespoke Supportive Management Behaviour programme. The programme focused on recognising and valuing staff, improving management behaviour, teamwork and interpersonal relations, motivating, empowering and supporting staff. The programme began in 2012/2013 and continued throughout 2013/2014.

In addition, through our subscription to the East Midlands Leadership Academy, managers at every level accessed the broad range of programmes available which included:

- Top Leaders programme
- Board Development programme
- Leadership masterclasses
- Coaching and mentoring
- Mary Seacole programme – Leading Care 1 – First Line Management
- Leading Across Boundaries – the clinical leadership programme.
- OD Skills Development programme

Clinical leadership and clinical education, training and development

Delivering excellence in education, training and development remained the priority for the Education Team during 2013/2014, and this was reflected in the successful development of the new Learning and Development Strategy, which was approved in July 2013. The strategy supports the continued development of:

- Proactive patient-centred workforce planning
- Values-based recruitment focussed on attitudes, behaviours and ability
- Professional corporate and local inductions for new staff
- Initial education and training programmes for clinical staff that are accredited and meet the national standards and codes of conduct
- Essential education programmes to ensure standards of quality and safety are maintained.
- Clinical programmes and updates to support CPD, and widening participation
- Leadership and management development at all levels supporting organisational development.
- Meaningful appraisal and clinical supervision programmes
- Preceptorship, mentorship and coaching
- Talent management, succession planning and career progression

With much activity at a national level driving significant change in education for the ambulance workforce to ensure standardisation of education and training, fair access to funding, and enhancing the threshold of entry to the profession, the Learning and Development Strategy seeks to ensure development of models of education and career progression routes that align with national strategy and deliver the workforce requirements to meet the needs of the Trust and its stakeholders.

During 2013/2014, alongside our workforce plan, the Education Team supported the on-going education and development of staff. We implemented the annual Essential Education programme supporting essential standards of quality and safety, statutory and mandatory requirements and clinical updates. The programme included:

- Attitudes and behaviours
- Self-harm/suicide (including mental health)
- Equality and diversity
- Slips, trips and falls (staff and patients)
- Maternity/obstetrics
- Assessment of spinal injuries (C Spine) including the new traction splint
- Infection prevention and control
- Conflict resolution training
- Equipment updates
- Workstation set up
- Moving and handling updates
- Resuscitation update (including equipment use). This was supplemented and supported by a resource pack providing staff with additional information on other subjects and signposting to further rereading to support ongoing development
- Continued delivery of the rolling programmes for clinical staff resulted in an additional 47 staff complete the Pre-Hospital Assessment and Disposition Education programme and 19 staff become accredited mentors to support newly-qualified paramedics in practice

The Directorate also provided a range of continuous professional development opportunities. These included e-learning resources, internal classroom-based workshops, access to National Vocational Qualifications and external higher education modules. These mechanisms were used to support continuing professional

development and clinical leadership. Examples include: customer services, skills for life (maths and English), anatomy and physiology, mentorship, academic writing, clinical assessment and decision making, and top-up education for clinical staff to do diploma and degree-level education.

During 2013/2014 the Education Team maintained approval from accrediting bodies (including the HCPC, IHCD/EdExcel and CMI) to deliver education and training, demonstrating the high quality of education provision, the professional standards maintained by the EMAS Education faculty and their professional teaching qualifications.

In addition, the team secured additional approval and accreditation from OFQUAL, the national regulator of qualifications, exams and assessments. Working with FutureQual, an accredited awarding organisation, we demonstrated that the Education Team are competent to deliver a range of education and training and have the relevant quality assurance systems in place through a robust accreditation process. This concluded with an External Quality Assurance Approval site visit on 8 Jan 2014 which confirmed that the team comply with General Conditions of Recognition as issued by The Office of Qualifications and Examinations Regulation (Ofqual).

The report from the accrediting body stated: *This is a well-organised well-established centre with a team that are supportive and keen to ensure everything is in place to offer qualification through FUTURES Awards*. It is testament to our Education Team that we continue to be accredited to provide both current and prospective first aid clients with independent assurance that the training they receive is relevant, suitable and delivered to a standard that would be associated with an NHS ambulance service.

In addition, it is excellent news that EMAS was the first UK ambulance service to be accredited to deliver Level 3 Award in Education and Training Module, Level 4 Certificate in Education and Training and the Level 5 Diploma in Education and Training.

In the Quarter 4 of 2013/2014, the Education Team have focussed on supporting the key priorities of the Learning and Development Strategy for implementation in 2014/2015 including:

- Appraisals: Updating and further developing the web-based appraisal system, supporting performance development review and clinical supervision and enabling managers to conduct meaningful staff appraisals. The tool is being developed to ensure inclusion of the People Capability Framework and to enable consistent application of pay progression arrangements from April 2014

- Career progression: Emergency Care Assistant and Paramedic Education models are being refreshed to enable accredited learning across the education pathway and provide a progression route for clinical staff

Staff engagement

One of the workforce goals and objectives detailed in the Workforce Strategy, *Driving Quality Delivering Change 2012–2016,* is to *'promote an engaged workforce and deliver our Staff Engagement Strategy'*. To achieve this and build upon our existing objectives, we are focussed on engaging our staff and establishing the Trust as 'a great place to work'.

During 2013/2014 we have engaged with staff through a range of approaches including:

- Listening events for staff and managers
- Surveys and pulse checks
- Team briefs
- Trust Board quality visits

We also held our first annual Awards event, a direct result of feedback and suggestions from staff. This was a major occasion, the first of its kind for EMAS, enabling us to better recognise and celebrate the achievements of our staff, either through their actions or their length of service to the Trust. The event was held in April 2013

and was attended by more than 360 people, including stakeholders, clinical commissioning groups, sponsors, media representatives and staff.

The feedback received from staff and guests alike was overwhelmingly positive, all agreeing that the event had generated a feeling community spirit and togetherness. All those nominated in categories were recognised for exemplifying our values including integrity, competence, respect, and teamwork in their working lives. An exception to this was an award for going beyond the call of duty. Presentations were also made to our frontline and non-frontline staff for 20 years' long service. Following the success of the event, this will now be a regular fixture in the EMAS calendar.

Staff survey

The annual Staff Opinion Survey was conducted by the Picker Institute on our behalf. Picker also administered the survey for five other ambulance Trusts enabling us to have some comparative data ahead of the Department of Health report which detailed our results against all other ambulance Trusts and other parts of the NHS.

Our response rate for 2013 was 29.8%. The average response rate for the five other ambulance Trusts was 41.3%. In comparison with those five other trusts, our results were:

- Significantly better than average on 30 questions
- Significantly worse than average on 9 questions
- Not significantly different than the average on 52 questions

Compared to last year's Staff Survey results, we had significantly improved in several areas. Those areas that showed the greatest improvement in the scores were:

- No training in how to handle violence to staff/patients/service users
- No training in how to deliver a good patient/service user experience
- In last 3 months, have come to work despite not feeling well enough to perform duties
- In last month, saw errors/near misses/incidents that could hurt patients

These are the areas that have most significantly deteriorated:

- Percentage of staff suffering work-related stress in last 12 months
- Support from immediate managers
- Percentage of staff able to contribute towards improvements at work
- Work pressure felt by staff

In the latter part of 2013/2014 we pledged our commitment to turn Listening into Action to support staff engagement and cultural change. Our mission is to create and develop a culture that is open, supportive, empowers staff and maintains patient interest at its heart. This is combined with increased visibility and access to Board members and more opportunities for colleagues to have concerns addressed and their ideas valued and developed.

To achieve our objectives, we need to fundamentally shift how we lead and work. This can be done by putting staff – who we recognise as having the most operational knowledge and experience – at the heart of change. Listening into Action will provide the vehicle through which we aim to:

- Engage all the right people to deliver better outcomes for our patients, our staff and our Trust
- Align ideas, effort and expertise behind the patient experience, safety and quality of care

- Radically improve how engaged and valued people feel
- Build the confidence of managers and leaders to lead through engagement
- Give teams permission to get on and make positive changes happen together

We implemented the first phase of this long-term programme in January 2014, establishing a sponsor group and a network of Listening into Action innovators. Staff conversations are now being scheduled for March to coordinate feedback from staff, together with staff survey and listening events feedback to ensure an integrated and comprehensive approach to staff engagement.

From April 2014 we are launching quarterly engagement surveys combined with the introduction of the Friends and Family Test. As part of our QIP, we will also carry out a barometer assessment of our cultural health in 2014/2015.

Staff health and wellbeing

We placed significant focus on supporting the wellbeing of our staff and improving attendance levels during 2013/2014 and this remains a high priority. During 2013 we successfully developed our new Health and Wellbeing Strategy for 2013/2017 to ensure a comprehensive prevention-focussed approach to health improvement and employee wellbeing to ensure a healthy workplace, improved staff engagement and enhanced individual and organisational performance resulting in improved patient experience and quality of care.

Key objectives of the Health and Wellbeing Strategy are to:

- Deliver improvement in employee health, wellbeing and attendance at work through health promotion and prevention approaches within a comprehensive health and wellbeing service Improve levels of attendance and productivity in line with sickness absence targets and reduce the annual cost of sickness absence
- Reduce incidence of musculoskeletal injury and absence through prevention and early intervention strategies
- Reduce incidence of work-related stress and mental ill-health through prevention and early intervention strategies including the development of individual care pathways to support staff following traumatic incidents
- Involve staff and other stakeholders in the development of health and wellbeing initiatives to drive cultural change, improve staff engagement and levels of individual responsibility
- Improve leadership and management capability to provide effective support for staff concerning matters of health and wellbeing
- Meet the NHS Constitution commitment to '*provide support and opportunities for staff to maintain their health, wellbeing and safety'*

Good progress has been made and a number of positive initiatives came to fruition, including:

- Continued provision of our Occupational Health (OH) and Employee Assistance programme focussed on taking proactive and preventative measures to support staff wellbeing
- A range of education and training programmes to support management capability were available for staff and managers
- The introduction of a Physiotherapy Information Line providing staff with day one (of onset of symptoms) triage and advice directly from our OH providers
- Day one referrals (of staff reporting absence from work due to sickness) to a trained practitioner who can assess the condition and advise on the appropriate course of remedial treatment

Following these measures being introduced, we have achieved a downward trend in sickness absence rates when compared with previous years. Our overall absence rate in 2012/2013 was 6.30%. In 2013/2014, our target for sickness absence was 5.3% (1% below the previous year outturn) and we achieved 5.8%.

Our focus on health and wellbeing remains a key priority for 2014/2015 when we will implement the objectives of the Health and Wellbeing Strategy, introduce early intervention and rehabilitation programmes for staff with long-term conditions (muscularskeletal and mental health) and carry out a range of health promotion events across all divisions.

Corporate Governance

Compliments and formal complaints

During the year, we received more than 500 expressions of appreciation from patients or members of the public. Where the staff involved in any particular incident can be identified, a copy of the letter of thanks is sent to the person involved and a copy placed on their personal file.

The following table provides information on the receipt and handling of complaints:

Number relating to A&E	174
% rate in relation to journeys provided	0.028% (631,612 journeys)
Number relating to PTS	3
% rate in relation to journeys provided	0.0025% (119,847 PTS journeys)
Number acknowledged within three working days*	175/177 (98.9%)
Number receiving a formal response in 20 working days*	125/172 (72.6%)
Number of complaints proved to be justified	23 justified (74 Partially Justified 70 Not Justified 5 Not Applicable)
Number referred to the Parliamentary and Health Service Ombudsman (PHSO) for Independent Review	6 (Of which 3 were not upheld)

Where a complaint against the Trust is deemed to be substantiated the EMAS will ensure that the reasonable, fair and proportional remedy is provided to the complainants. This is in line with the principles for Remedy guidance published by the Parliamentary and Healthcare Ombudsman. The Trust utilizes various remedies which include an apology, explanation, remedial action and where appropriate financial compensation.

Corporate Affairs

This team is located in the Chief Executive's Directorate and helps to develop our services by promoting dialogue with patients and the public, staff, health community colleagues, the media and other stakeholders.

Communications

The ambulance service is very much in the public eye and is therefore the focus of considerable media attention, the team fielding approximately 1,600 media enquiries per annum from the 85+ news outlets located in EMAS' area. In addition, the team is proactive in issuing press releases, helping to bring recognition to the good work done by our staff in the service of the community.

We place great emphasis on delivering good internal communication. The weekly Chief Executive's Bulletin continues to be very popular and the monthly Chief Executive video conference provides all staff with the opportunity to be updated on EMAS business and to have their questions responded to directly by the Chief Executive. Our staff website is run by the communication team and is increasingly becoming the best route for staff to keep in touch with the latest news. We also have dedicated communications campaigns on key issues for staff (e.g. dignity in care, patient safety, infection prevention and control, safeguarding vulnerable people). All staff are given the opportunity to sign up to Communications Direct (whereby they receive email updates on their home PC) and this has also proven to be popular with just over 1,000 staff registered as subscribers.

On the external communications and engagement front, our stakeholder newsletter *EMAS Aspect* was issued monthly electronically to over 700 named individuals and the address list continues to grow. Our website had just under 500,000 visitors over the year. We also started to make much better use of social media options such as Twitter (we now have over 6,000 followers) and You Tube.

In response to suggestions from staff that EMAS do more to recognise their achievements, the team played a key role in staging a formal Awards Ceremony in April 2013. Over 300 personnel attended the event and the feedback received was that staff really appreciated being recognised. The event clearly helped to improve morale and is now to be a permanent fixture in EMAS' calendar.

In 2013, the team was approached by two production companies inviting us to pitch for programmes that were to be broadcast on national TV. We were delighted to be successful in both our bids which led to EMAS featuring in two series, both of which attracted viewing figures well over the 1.5 million mark – 999 What's Your Emergency (Channel 4) and Student Paramedics (BBC 2). The programmes stimulated a significant amount of posts on social media sites all of which praised the great work of our staff.

In response to the ever increasing demand on 999 services, the team took the initiative of launching a major public education campaign '#99wise' aimed at educating the public about the correct use of the emergency

number and how alternative care pathways could be utilised. Two key elements of the campaign were the running of daily messages on a local commercial radio station (over a four month period) and having large posters affixed to all front line ambulances promoting the #999wise scheme. Several other UK ambulance services expressed an interest in running a similar campaign in their areas and the team are hopeful that the work they spearheaded will attain a national focus.

To support the public and staff consultation process associated with our Better Patient Care change programme, the team supported various communications including the production of a consultation document, a dedicated web page, Twitter and Facebook pages.

Community relations

This team continued to work closely with a wide range of stakeholders including the Heathwatch groups across our patch. Formed in April 2013, these groups have shown a keen interest in EMAS' activities most notably in relation to our performance achievements. Whilst recognising that the speed of arrival to 999 calls is important, the team have been eager to encourage Healthwatch members to assess our performance across a wider base and to give due consideration to, for example, patient outcomes.

EMAS is conscious of the need to develop better relationships with external audiences and to achieve this, the team the team has attended 160 stakeholder and public events during the year. These are used to educate and inform interested parties and members of the public about issues such as how the service is managed, how we respond to emergency calls and what people can do to help us provide the best service possible, for example, by following the guidance in the #999wise campaign. As part of their remit, the team encourages people attending events to learn emergency life-saving skills and during the year, 415 people were trained.

The team continued to keep our FT members up-to-date with developments through the publication of a magazine and are now looking at alternative ways of communicating with this large group (as part of our cost efficiency programme) by use of electronic systems.

Community First Responders (CFR)

Responsibility for the managements of our CFR schemes transferred to the department in April 2013. Shortly after, we introduced a new three-year Community Response Strategy, *Treating Communities Promptly and Safely*. The aim of this strategy is to achieve increased levels of satisfaction and improved clinical outcomes

for patients in emergency situations across the East Midlands. This strategy embeds the principles of the Francis Review, the NHS Volunteer Responder's Governance Framework and the EMAS Volunteer Policy (v5.0). This framework and policy has been approved by the National Director of Operations Group and is considered as best practice for volunteers within NHS ambulance services. Since its launch, a significant amount of progress has been made on developing the number of schemes (and volunteers) that operate in our area. By being local, CFRs can provide emergency medical care to patients whilst an ambulance is en route to the incident and this makes a real difference in the number of lives saved.

To help support the work of our CFR groups and develop them further, in November 2013 a CFR conference was held. The event allowed attendees to take part in discussions on, for example, how communications could be improved and a range of actions were taken after the conference in response to the ideas put forward. In recognition of the high level of commitment of certain groups, we purchased 10 fast response vehicles in EMAS livery for members to use (rather than their own cars). This initiative was welcomed by members of the groups concerned and the increased pride led to volunteers making themselves available to respond to calls for more hours than was previously the case.

The work carried out to promote CFRs has led to 147 new volunteers being recruited during the year and the setting up of 11 new schemes in areas where that was previously no cover. As at 31 March 2014, we operated 259 schemes and had 1,288 volunteers. In association with developing CFR schemes, the team were also very active in promoting the placement of Community Public Access Defibrillators across our area. During the year, 311 machines were introduced.

Equality

EMAS is required to publish information annually to demonstrate compliance with the Public Sector Equality Duty. In addition, the Equality Act requires that specific and measurable equality objectives are prepared and published. This information is on EMAS' website 'Meeting the Requirements of the Public Sector Equality Duty'. This is the main avenue through which we publish information to demonstrate a commitment to and progress on equality matters. This information ranges from workforce data through to patient experience survey results and was locally acknowledged as a model of good practice. The information is updated regularly in line with developments and to reflect annual requirements.

Our Essential Education programme has been designed with input from our Equality Manager to embed equality and diversity in our core learning. The Essential Education programme includes face-to-face training and observed practice, and ensures that all staff are educated in key areas appropriate to their role – such as clinical skills, infection prevention and control, safeguarding and patient safety.

Through a broad range of internal and external stakeholder events and forums, we continued to develop our equality objectives by working in partnership with stakeholders including other local Trusts; local community groups; stakeholders representing protected characteristics; local authority networks and Local Involvement Networks.

Our Stonewall Health Champions work resulted in a dedicated action plan to support Lesbian, Gay and Bisexual members of staff and the public and the second Emergency Services Joint Gay staff network for Nottinghamshire involving The Police, Fire and Rescue and EMAS. This development has been strongly supported by Trade Union colleagues from GMB and UNISON and included collaborative working and EMAS' attendance at the Nottinghamshire and Leicestershire Gay Pride Festivals.

The Directorate enhanced EMAS' profile by attending Leicester MELA, one of the biggest South Asian Festivals in the UK and several staff provided interviews for community focussed radio stations to raise awareness of health and wellbeing during periods of fasting or religious observance.

We have also introduced a Diversity Inclusion Group with staff from across the organisation, Equality Delivery System Implementation Group and continue to support our Chaplaincy Group, Staff Network and specialist Bullying & Harassment Advisors. During 2013/2014 we will further develop our Equality Action Plan and Equality and Diversity Strategy to ensure the principles of equality and diversity are understood and embedded in everything we do.

The following table provides details of our gender distribution as at 31 March 2014:

Role	Male	Female
Directors	8	4
Other Senior Managers	0	0
Employees	2,003	1,531

Finance and ICT Directorate

Finance team

This year has seen the Finance team undergo a thorough review in recognition of the significant changes we have made in the management and structure of the Trust since July 2012 when the Director of Finance and Performance was appointed.

This review resulted in a major departmental restructure designed to strengthen the core of the function and ensure it was fully aligned to the needs of the Trust. Once a period of formal consultation and the selection process has finished, the new structure came into effect during the latter half of the year and will continue to be developed and refined as the Trust itself evolves.

As part of the restructure three Divisional Finance Managers were appointed to provide dedicated support to the Senior Operational Managers. In addition, the introduction of a Project Accounting Team has created capacity to provide resilience to support the delivery of the Trust's Cost Improvement Plan, provide short- and medium-term planning including the Foundation Trust application process as well as provide support to the Divisional Finance Managers.

The core Financial Services and Business Support function has been expanded to cover all aspects of management and annual accounting processes and has been strengthened by the recruitment of suitably experienced and qualified members of staff.

The Finance team have played an integral role during in supporting the Trust's strategic objectives and organisational development initiatives, including developing, implementing and monitoring the delivery of Cost Improvement Plans, providing support to the 'Being the Best' initiative and Foundation Trust application process.

During the year, the objectives of the Cost Improvement Plans programme were set. They were:

- To align with national policy to save £20billion by 2015 (5% per year) by making continuous efficiency improvements to maintain patient-focused, high-quality, safe care
- To deliver financial improvement to support EMAS towards becoming a Foundation Trust

The Cost Improvement Plan programme is the key enabler to achieving these objectives, with the focus on:

- Strengthening the Cost Improvement Plan governance structure
- Strengthening the Cost Improvement Plan planning, monitoring and reporting processes
- Planning and delivering the 2013/2014 Cost Improvement Plan target
- Planning the 2014/2015 and 2015/2016 Cost Improvement Plan targets
- Delivering the required actions in 2013/2014 for the 2014/2015 schemes to be effective
- Setting up a rolling two-year process to include developing greater capability and capacity within EMAS to generate, plan and deliver Cost Improvement Plans

Robust governance arrangements have continued to be developed to ensure that these were aligned with the Cost Improvement Plan process. The aim of the governance process was to ensure that staff aren't burdened by excessive bureaucracy while being able to easily communicate progress and exceptions that require action.

The development and integration of a structured, focused programme of staff engagement helped the Cost Improvement Plan programme to gain support to ensure the programme is successful. This included putting in place core processes to give the Board confidence that individual Cost Improvement Plans would be delivered on time and to a high standard with exceptions highlighted. A key aspect of the governance arrangements was the development of a structured plan and process to provide the Board with assurances that benefits were fully understood, monitored and on track for realisation. Furthermore, a central reporting system has enabled the Board to keep up to date with risks, issues and progress throughout the lifecycle of the Cost Improvement Plan programme.

The department has provided significant input into the Trust's estate reconfiguration project providing support to all aspects of the potential merging/disposal of existing sites and the investment in new premises located to increase our performance and service to patients.

The purpose of the Finance and Performance Committee is to:

- Monitors both the operational and financial performance of the Trust and considers performance against the Trust's objectives as set out in the Integrated Business Plan and the Annual Plan
- Oversee the Trust's arrangements in relation to cash forecasting, investing surplus cash and banking
- Formulate and monitor the capital programme in line with the Trust's business strategy and also oversees the estates function
- Ensure the quality of data used within the organisation is suitable for decision making and reporting

2013/14 Achievements

- Contribution towards the Trust reaching its agreed financial target at 31 March 2014
- Development of its review and challenge to Senior Officers of the Trust regarding financial and operational performance

The Finance team continued to offer support to the Audit Committee and monitor progress against implementation of audit recommendations. The team also worked closely with our internal and external auditors to further strengthen financial control and probity.

Looking ahead, our key priorities for 2014/2015 are:

- Support the Better Patient Care initiative
- Further embed and develop the new Finance Directorate structure
- Proactively support delivery of the 2014/2015 Cost Improvement Plan programme
- Support the Foundation Trust application process

- Support evaluation of outsourcing options

Information Communication and Technology

The Information, Communication and Technology (ICT) service continued to make substantial progress with improvements to our ICT infrastructure. This has included refreshing legacy hardware while improving the resilience and recoverability of the key systems. One key aspect of this improvement work supported completion of the first phase of the trusts IT Business Continuity project which has seen our 'core 999 CAD' IT system migrated to new highly-resilient, highly-available segregated IT servers.

In June 2013, six weeks before the first phase of improvement works completed, the Trust suffered a significant ICT outage which impacted all systems. While the effect caused widespread disruption, critical functions performed impeccably with well-practiced manual processes and the incident further emphasised the need to continue investing in resilient IT systems to better protect service provision. Further work will continue in 2014/15 to fully optimise and enhance the continuity arrangements for all critical systems.

The ICT service launched a roll-out of Microsoft Office 2013 to support the introduction of a new Business Intelligence system and also continued to extend the use of video conferencing facilities using Microsoft Lync to approximately 300 staff. This aimed to improve communication between remote staff, reduce time spent on travel and associated costs.

During the year the internal management systems were upgraded to help improve the quality and effectiveness of service provision to end users while automating a range of activities to free costly skilled resource to be better utilised elsewhere. One example of this is a Self-Service Portal which has enhanced and streamlined the process for users, reducing chance of error and driving further efficiency within ICT systems and processes.

The ICT service also supported the introduction of a range of Trust information systems within areas such as Risk and Safety, Fleet, Safeguarding, Human Resources, and Business Intelligence.

In December 2013, ICT worked in collaboration with a diverse range of internal and external stakeholders on a significant piece of work to fully redevelop our ICT strategy to drive increased efficiencies, improve the management of information, support greater innovation and deliver improved IT governance arrangements.

Performance Management Information Team (formally the Business Intelligence Unit)

The Business Intelligence Unit was restructured during the year and became the Performance Management Intelligence Team in September 2013. This was to allow other specialist analysts to merge to extend the team's technical capabilities and provide greater resilience within the information provision.

Between April and September, a new Microsoft business intelligence system was procured, developed and introduced. Latest versions of software such as Excel and SharePoint 2013 are used to provide users with not only the most effective and up-to-date technology, but also enabled a user-friendly, intuitive information portal to be launched. The launch was supported by a series of end-user workshops which not only allowed an introduction and demonstration of the system capabilities, but also provided feedback and ideas for future development.

The Business Intelligence system (IRIS) was then re-launched with a more user-friendly layout and clear structure, including a report library and improved efficiencies. The Performance Management Intelligence Team continue to transfer current reports to the new Business Intelligence system which place more emphasis on live and automatically refreshed reports and dashboards running from a data warehouse.

Moving forward, it will be a continuation of developing the current elements of the Business Intelligence system and the priority will be to link resource (staff rota) data with computer-aided dispatch and start to create more linked reports that allow triangulation between resource, activity and performance.

Identifying and prioritising the areas of Business Intelligence provision that need further development will shape activity for 2014/15, as there are rich data provisions to consider. This will allow us to use a single system and report on overall performance against a number of metrics from organisational down to individual level, ensuring a consistent single vision.

Information Governance

We are continually working on improving our Information Governance as we respond to an ever-increasing number of requests for information under both the Data Protection and Freedom of Information Acts. Information sharing has increased dramatically following the publication of The Information Governance Review, also known as Caldicott 2.

To support effective, efficient information sharing with key stakeholders, a number of protocols and agreements have been developed. Following the annual assessment of the Information Governance Toolkit by our internal audit, we achieved a score of 94% which is graded as satisfactory.

Summary of other personal data-related incidents in 2013/2014

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	2
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure disposal - hardware	0
G	Non-secure disposal - paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access / disclosure	0
K	Other	0

The results of our annual information governance awareness survey with staff also demonstrated that staff have improved awareness of their responsibilities and recognise that the annual mandatory training they receive is relevant to their role.

Charitable funds

During 2013/14, we continued to receive donations from members of the public who have made use of our services either in an emergency or to attend an outpatient appointment or visit a day care unit. Our online and text-giving facilities have made it easier for members of the public to donate funds to support our work. The Charitable Funds Committee is made up of Non-Executive and Executive Directors and other EMAS representatives, and the committee has responsibility for managing the fund. The day-to-day administration is carried out by our finance department and funds are subject to an internal and external audit.

The majority of donors asked for the funds to be used for the benefit of patients and/or staff, while a small number made specific requests about how they would like us to use the money. During the year, our Charitable Funds Committee approved the purchase of new medical equipment and improved recreational facilities for our staff. The committee also approved the purchase of a 4x4 carrying ambulance to be used across the High Peaks and Derbyshire Dales, which complied with the terms of the restricted legacy at the cost of £129,000. The committee also took steps to encourage staff to put forward suggestions on innovative projects which could be supported from our charitable funds.

The Treasury agreed that the International Accounting Standard 27, Consolidation and Separate Financial Statements, should apply in full including the consolidation of NHS Charities from 1 April 2013. International Accounting Standard 27 requires consolidation of a group of entities under the control of a parent where there exists 'the power to govern the financial and operational policies of an entity so as to obtain benefits'. Control was presumed to exist where a parent owned directly or indirectly more than half of the voting power of an entity; including where a body acts as a corporate trustee. The Board of the Trust acts as a corporate trustee to the East Midlands Ambulance Service NHS Trust Charitable Fund and thus the provisions on this standard apply. However, the Trust in 2013/2014 decided not to consolidate the Accounts of the Trust and those of the charitable funds on the grounds of materiality. Under the terms of the International Financial Reporting Standards this is acceptable accounting treatment which has been agreed with our external auditors.

Sustainability performance

We are committed to embedding good environmental practices into the way we deliver and support the delivery of emergency and allied healthcare services. We will continue to deliver our environmental objectives in line with the NHS and Public Health England sustainability strategy (2014 to 2020). Specifically, these objectives will always be aligned to our corporate objective of improving the healthcare services our patients receive.

Our 2013/14 carbon footprint was 25,263 tonnes of CO_2 (Carbon), which implies that we emitted approximately 34.6 Kg of carbon for every emergency call we received or 56.8 Kg of carbon for every healthcare resource we deployed. We have reduced our carbon footprint by 23.3% over the last 3 years which can be attributed to: investment in new ambulances; estate maintenance and improvement programme; the continuing rollout of video conferencing facilities; better business and operational models; and our quality improvement programme.

In response to rising energy and utility prices and as part of our commitment to reduce the carbon footprint of our estate, we introduced systems that improved the way we monitor and manage the environmental performance of our buildings. During the year under review, we installed 52 smart electricity meters and 4 gas meter data-loggers and regularly monitored the energy used at each of our premises. These improvements have significantly reduced the number of estimated energy invoices we receive. One of the benefits of monitoring the environmental performance of our buildings is that we successfully reduced our energy and utility spend by £211,830 during the 2013/14 financial year.

We have developed a sustainability development management plan (SDMP) that will serve as the framework on which we will continue to improve our sustainability performance. Sustainability performance will be measured by our environmental footprint and level of preparedness to extreme weather conditions and external environmental risks. We will put in place systems that help us to be compliant with relevant environmental legislations as well as embed good environmental practices into the way we deliver and support the delivery of emergency and allied healthcare services to the people in the East Midlands region.

Remuneration Report

Executive Directors

Name	Role	Date appointed	Date left
P Milligan	Chief Executive	1.12.2011	2.8.2013
S Noyes	Interim Chief Executive	15.10.2013	
J Sargeant[1]	Director of Finance and Performance	11.7.2012	
M Bull	Interim Director of Finance	4.8.13	13.10.13
D Farrelly	Director of Workforce and Strategy	1.7.2006	
K Glover	Director of Nursing	14.9.2009	
Dr J Gray	Director of Clinical Services	1.11.2010	30.06.2013
Dr S Dykes	Director of Clinical Services	1.7.2013	1.10.2013
Dr T Mills	Director of Clinical Services	2.10.2013	
A Spice	Commercial Director	3.1.2012	9.9.2013
S Cascarino	Chief Operating Officer (Interim)	8.1.2013	24.5.2013
M Gough	Chief Operating Officer	26.5.2013	22.1.2014
R Henderson	Director of Operations	5.11.2013	
A Schofield	Director of Corporate Affairs	3.12.2012	

Notes

[1] J Sargeant served as Interim Chief Executive for the period 3.8.2013 to 14.10.2013.

Directors' salaries are agreed by the Remuneration Committee (with reference to similar posts in the NHS). Directors are employed on a permanent contract which may be terminated by retirement, resignation or, in the event of unsatisfactory performance, by dismissal. The notice period for all Director contracts is three months. In the event of a contract being terminated, EMAS meets all statutory and standard NHS termination payments which are dependent on the individual's age and length of service in the NHS.

All Executive Directors are Trustees of the EMAS Charitable Fund.

Non-Executive Directors

All Non-Executive Directors are members of the Remuneration and Nominations Committee. All Non-Executive Directors are Trustees of the EMAS Charitable Fund. Non-Executive Directors serving during 2013/2014:

Name	Date appointed	Date left	External interests
J Towler	1.7.2011	7.11.2013	None
P Tagg[1]	11.10.2011		None
G Austin	1.7.2006		None
S Dawkins	11.10.2011		None
G Newton	11.10.2011		None
D Toberty	7.11.2011		None

Notes

[1] P Tagg was appointed as Interim Trust Chairman from 10.11.2013.

Some of the Board's responsibilities are delegated to committees, chaired by Non-Executive Directors.

During 2013/2014 the Trust undertook a full review of its committee structure which was amended from 17 December 2013.

The following table details the Trust Board committees in place during 2013/2014 and their Non-Executive membership. It should be noted that this is not an exhaustive list of all committee members with the exception of the Audit Committee which only consists of Non-Executive Directors.

Committee	Membership information	
	1 April 2013 to 16 December 2013	17 December 2013 to 31 March 2014
Remuneration and nominations	All serving Non-Executive Directors	All serving Non-Executive Directors
Audit	D Toberty (Chair) G Austin S Dawkins G Newton	D Toberty (Chair) S Dawkins G Newton

Quality and governance	P Tagg (Chair) S Dawkins G Newton J Towler (Ceased 7.11.2013)	S Dawkins (Chair) G Newton
Investments	G Austin (Chair) S Dawkins D Toberty J Towler (ceased 7.11.2013)	Duties incorporated into the Finance and Performance Committee
Finance and performance	Committee commenced 17 December 2013	G Austin (Chair) D Toberty
Workforce	Committee commenced 17 December 2013	G Newton (Chair) G Newton
Charitable fund	J Towler (Chair) G Newton P Tagg	P Tagg (Chair) S Dawkins D Toberty

All Directors have confirmed that, as far as they are aware, there is no relevant audit information of which EMAS auditors are unaware and that they have taken all the steps necessary as a Director to make themselves aware of any relevant audit information and to establish that EMAS auditors are aware of that information.

The following remuneration report for the year ended 31 March 2014 has been audited. This consists of the tables of senior managers' salaries and allowances and pension benefits, and the accompanying narrative.

Senior managers' remuneration

This remuneration report is for the year ending 31 March 2014. Executive Directors remuneration is paid in accordance with the Department of Health Pay Framework for Very Senior Managers (VSM) in strategic and Special Health Authorities, primary care and ambulance trusts. Our Remuneration and Nominations Committee has delegated responsibility for setting remuneration for the Chief Executive and all Executive Directors in accordance with the VSM Framework.

The Trust operates in accordance with the VSM Pay Framework Performance-Related Pay Awards Scheme and Department of Health annual updates concerning its application. In addition, we apply our policy of annual performance development reviews in order to assess individual performance. The Remuneration Committee is authorised to monitor and evaluate individual performance in accordance with the provisions of the VSM Pay Framework and the requirements of the Department of Health.

EMAS operates in accordance with the VSM Pay Framework Performance-Related Pay Awards Scheme and Department of Health updates concerning its application. We did not award any annual uplifts or performance bonus payments to senior managers during 2013/14.

Remuneration Report to year ending 31 March 2014

Salaries and Allowances			31 March 2014						31 March 2013					
			Salary Bands of £5,000 £'000	Expense payments (taxable) total nearest £100 £'00	Performance pay and bonuses Bands of £5,000 £'000	Long Term performance pay and bonuses Bands of £5,000 £'000	All pension related benefits Bands of £2,500 £'000	Total Bands of £5,000 £'000	Salary Bands of £5,000 £'000	Expense payments (taxable) total nearest £100 £'00	Performance pay and bonuses Bands of £5,000 £'000	Long Term performance pay and bonuses Bands of £5,000 £'000	All pension related benefits Bands of £2,500 £'000	Total Bands of £5,000 £'000
Phil Milligan	Ceased 2 August 2013	Chief Executive Director	120 - 125	0	0	0	0	120 - 125	140 - 145	0	0	0	0	140 - 145
Sue Noyes[1]	Commenced 15 October 2013	Interim Chief Executive Director	65 - 70	37	0	0	0	65 - 70	N/A	N/A	N/A	N/A	N/A	N/A
David Farrelly	Ceased 28 February 2014	Director of Workforce	105 - 110	0	0	0	0	105 - 110	100 - 105	0	0	0	0	100 - 105
Kerry Gulliver	Ceased 31 July 2012	Director of Workforce (Acting)	N/A	N/A	N/A	N/A	N/A	N/A	20 - 25	10	0	0	0	20 - 25
Nick Cook[6]	Commenced 1 March 2014	Interim Director of Workforce	20 - 25	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jon Sargeant[2]		Director of Finance & Performance	115 - 120	0	0	0	0	115 - 120	85 - 90	0	0	0	0	85 - 90
Ian Turnbull	Ceased 11 July 2012	Acting Director of Finance & Performance	N/A	N/A	N/A	N/A	N/A	N/A	25 - 30	8	0	0	0	25 - 30
Martin Bull[5]	Commenced 4 August 2013 Ceased 13 October 2013	Interim Director of Finance	25 - 30	0	0	0	0	25 - 30	N/A	N/A	N/A	N/A	N/A	N/A
Karen Glover		Director of Nursing	95 - 100	49	0	0	0	100 - 105	90 - 95	49	0	0	0	90 - 95
Sheila Cascarino[3]	Ceased	Chief Operating Officer	45 - 50	0	0	0	0	45 - 50	70 - 75	0	0	0	0	70 - 75
Mark Gough	Commenced 26 May 2013 Ceased 22 January 2014	Chief Operating Officer	75 - 80	0	0	0	0	75 - 80	N/A	N/A	N/A	N/A	N/A	N/A
Richard Henderson	Commenced 5 November 2013	Director of Operations	50 - 55	20	0	0	0	50 - 55	N/A	N/A	N/A	N/A	N/A	N/A
Peter Ripley	Ceased 6 January 2013	Director of Operations	N/A	N/A	N/A	N/A	N/A	N/A	65 - 70	38	0	0	0	65 - 70
James Gray	Ceased 30 June 2013	Director of Clinical Services	30 - 35	0	0	0	0	30 - 35	130 - 135	0	0	0	0	130 - 135
Steven Dykes	Commenced 1 July 2013 Ceased 1 October 2013	Director of Clinical Services	20 - 25	0	0	0	0	20 - 25	N/A	N/A	N/A	N/A	N/A	N/A
Trevor Mills	Commenced 2 October 2013	Director of Clinical Services	60 - 65	0	0	0	0	60 - 65	N/A	N/A	N/A	N/A	N/A	N/A
Andrew Spice	Ceased 9 September 2013	Commercial Director	55 - 60	0	0	0	0	55 - 60	85 - 90	0	0	0	0	85 - 90
Alan Schofield	Commenced 3 June 2013	Director of Corporate Affairs	65 - 70	0	0	0	0	65 - 70	N/A	N/A	N/A	N/A	N/A	N/A
Jon Towler	Ceased 7 November 2013	Chairman	20 - 25	0	0	0	0	20 - 25	35 -40	0	0	0	0	35 -40
Pauline Tagg[4]		Interim Chairman	10 - 15	0	0	0	0	10 - 15	5 - 10	0	0	0	0	5 - 10
Gary Austin		Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 - 10	0	0	0	0	5 - 10
Stuart Dawkins		Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 - 10	0	0	0	0	5 - 10
Gillian Newton		Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 - 10	0	0	0	0	5 - 10
Dermot Toberty		Non-Executive Director	5 - 10	0	0	0	0	5 - 10	5 - 10	0	0	0	0	5 - 10

[1] Sue Noyes appointed as Interim Chief Executive until 15 July 2014.
[2] Jon Sargeant carried out the duties as Interim Chief Executive 3 August 2013 to 14 October 2013.
[3] The Trust obtained the services of Sheila Cascarino from Odgers Interim.
[4] Pauline Tagg was an Non-Executive Director and commenced as Interim Chairman on 10 November 2013 until 10 May 2014.
[5] The Trust obtained the services of Martin Bull from Martim Bull Limited.
[6] The Trust obtained the services of Nick Cook from Garenby Sanderson

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2013/2014 was £142,500 (2012/2013 £142,500) This was 4.64 times (2012/2013 4.55 times) the median remuneration of the workforce, which was £30,717 (2012/2013 £31,316).
This represents no signigicant change .

In 2013/2014 and 2012/2013 no employees received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension Benefits

Pension Benefits			Real Increase in Pension at Age 60 Bands of £2,500 £'000	Real Increase in Pension Lump Sum at Age 60 Bands of £2,500 £'000	Total Accrued Pension at Age 60 at 31 March 2014 Bands of £5,000 £'000	Lump Sum at Age 60 Related to Accrued Pension at 31 March 2014 Bands of £5,000 £'000	Cash Equivalent Transfer Value at 31March 2014 £'000	Cash Equivalent Transfer Value at' 31 March 2013 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Employer's Contribution to Stakeholder Pension £00
Phil Milligan	Ceased 2 August 2013	Chief Executive Director	0.0 - (2.5)	0.0 - (2.5)	55 - 60	165 - 170	0	1,144	(1,169)	0
Sue Noyes[1]	Commenced 15 October 2013	Interim Chief Executive Director	2.5 - 5.0	7.5 - 10.0	30 - 35	95 - 100	589	N/A	59	0
David Farrelly	Ceased 28 February 2014	Director of Workforce	0.0 - 2.5	2.5 - 5.0	25 - 30	80 - 85	455	418	25	0
Kerry Gulliver	Ceased 31 July 2012	Director of Workforce (Acting)	N/A	N/A	N/A	N/A	N/A	198	N/A	0
Nick Cook[6]	Commenced 1 March 2014	Interim Director of Workforce	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Jon Sargeant[2]		Director of Finance & Performance	0.0 - 2.5	0.0 - 2.5	30 - 35	100 - 105	589	557	19	0
Ian Turnbull	1 April 2011 to 11 July 2012	Acting Director of Finance & Performance	N/A	N/A	N/A	N/A	N/A	91	N/A	0
Martin Bull	Commenced 4 August 2013 Ceased 13 October 2013	Interim Director of Finance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Karen Glover		Director of Nursing	2.5 - 5.0	7.5 - 10.0	25 - 30	80 - 85	423	359	56	0
Mark Gough	Commenced 26 May 2013 Ceased 22 January 2014	Chief Operating Officer	20.0 - 22.5	62.5 - 65.0	30 - 35	90 - 95	571	N/A	378	0
Richard Henderson	Commenced 5 November 2013	Director of Operations	5.0 - 7.5	20.0 - 22.5	15 - 20	50 - 55	212	N/A	85	0
Peter Ripley	Ceased 6 January 2013	Director of Operations	N/A	N/A	N/A	N/A	N/A	709	N/A	0
James Gray	Ceased 30 June 2013 Commenced 1 July 2013	Director of Clinical Services						N/A		0
Steven Dykes	Ceased 1 October 2013	Director of Clinical Services	2.5 - 5.0	12.5 - 15.0	15 - 20	50 - 55	211	N/A	54	0
Trevor Mills	Commenced 2 October 2013	Director of Clinical Services	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Andrew Spice	Ceased 9 September 2013	Commercial Director	0.0 - 2.5	N/A	0 - 5	N/A	31	19	5	0
Alan Schofield	Commenced 3 June 2013	Director of Corporate Affairs	0.0 - 2.5	N/A	0 - 5	N/A	18	N/A	11	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members

Signed:

Sue Noyes

5 June 2014

Exit packages

Exit Packages agreed in 2013-2014

Exit package cost band (including any special payment element)	2013-2014 *Number of compulsory redundancies Number	2013-2014 *Number of other departures agreed Number	2013-2014 Total number of exit packages by cost band Number	2012-2013 *Number of compulsory redundancies Number	2012-2013 *Number of other departures agreed Number	2012-2013 Total number of exit packages by cost band Number
Less than £10,000	0	0	0	2	11	13
£10,000-£25,000	0	0	0	5	17	22
£25,001-£50,000	0	0	0	7	15	22
£50,001-£100,000	0	0	0	7	1	8
£100,001 - £150,000	0	0	0	2	2	4
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**0**	**0**	**0**	23	46	69
Total resource cost (£000s)	**0**	**0**	**0**	1,075,456	1,195,302	2,270,758

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for

Exit packages - Other Departures analysis

	2013-2014 Agreements Number	2013-2014 Total value of agreements £000s	2012-2013 Agreements Number	2012-2013 Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	45	1,082
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	1	113
Non-contractual payments requiring HMT approval	0	0	0	0
Total	0	0	46	1,195

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Operating and Financial Review

During the period to 31 March 2014, the Trust achieved the following financial duties:

Description of target	Target	Actual result
Adjusted surplus	£1,500k	£61k (excluding impairments effect)
3.5% return on capital	3.5%	3.5%
Compliance with capital resource limit	£6,361k	£5,236k

The financial position for 2013/2014 shows a retained surplus of £391k for the year. This figure is inclusive of net impairment write backs to buildings of £384k in recognition of the revaluation exercise carried out by the District Valuer on 31 March 2014. The adjusted surplus reported is within the parameters agreed with the NTDA.

Revaluation gains on buildings of £935k are shown in the accounts. An increase in value arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure. In this case it is credited to expenditure to the extent of the decrease previously charged there. This has created an impairment reversal of £384k in the accounts to the benefit of the Trust.

From 1 April 2013, primary care trusts ceased to exist with the commissioning function being transferred over to clinical commissioning groups. This change can be seen in the analysis of Trust income contained within note five of the full audited accounts.

The 2013/2014 results have been achieved with a 3.9% cost improvement plans equating to around £5.8 million. Cost improvement plans totalling £5 million have been drawn up for 2014/2015. This compares with delivery in the current year which is broadly in line with the level in the previous year.

Levels of cost improvement plans in the four subsequent financial years range between 4.0% and 4.5% as the Trust will move into a more conventional operational environment.

The Trust's main contract income is provided on a Payment by Results basis. Payment by Results is a system for the payment of NHS providers within the NHS in England, and is a way of paying providers a standard national price or tariff for each individual episode of treatment they supply.

Payments to the ambulance sector is underpinned by the principle of mandated national categories with local prices. The Trust's 2013/2014 A&E contract has been structured to reflect this.

The following income has been received from our commissioners against national categories:

	2013/2014 £'000	2012/2013 £'000

Calls	4,686	4,512
Hear and Treat	545	397
See and Treat	40,574	38,890
See, Treat and Convey	81,829	82,245

Local tariffs are applicable to the above.

During 2013/2014, we spent the majority of our available capital, as measured by the Capital Resource Limit (82%). A significant proportion of the Capital Programme is allocated to the purchase of ICT equipment (£1.5m) and improvements to the estate (£0.7 million).

Our performance regarding our compliance with the Better Payment Practice Code is set out within the Summarised Financial Statements. External audit services are provided by KPMG and our expenditure on external audit services for the year was £88k. In 2013/2014 KPMG received £25k in respect of Other Auditors' Remuneration.

All other non-financial performance indicators are covered elsewhere in the Annual Report.

The Accounts have been prepared in accordance with the guidance outlined in the 2013/2014 NHS Manual for Accounts and have been produced under International Financial Reporting Standards. The accounting policies have been approved by the Audit Committee.

EMAS operates income-generation activities covering vehicle maintenance training and operational cover for public events, such as football matches. These are not significant areas of income (approximately 0.9% of total income) and all are priced to cover the costs of providing the service plus a contribution to the fixed costs of the organisation.

EMAS does not make any professional indemnity insurance payments for its Directors or Officers.

The Trust confirms that it had not entered into any off payroll arrangements costing in excess of £58,220 per annum that were in place at 31 January 2012 nor had entered into new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months.

Pension Liabilities (see Note 10.6 in the full audited accounts) and Annual Governance Statement are contained in the full set of audited accounts available free of charge from the Finance Department at East Midlands Ambulance Service NHS Trust, Trust Headquarters, 1 Horizon Place, Mellors Way, Nottingham Business Park, Nottingham, NG8 6PY(or call 0115 844 5000). Copies of the Annual Report are available from the same address.

The Trust recognises the need to ensure the highest standards of probity and actively seeks to reduce the risk of fraud to NHS resources by creating an anti-fraud culture where fraud will not be tolerated. The Trust utilises the services of a specialised Local Counter Fraud Service responsible for investigating fraud within EMAS and has received specialist legal training and accreditation in countering fraud.

FOREWORD TO THE ACCOUNTS

EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

These accounts for the year ended 31 March 2014 have been prepared by the East Midlands Ambulance Service NHS Trust under section 232 schedule 15 of the National Health Service Act 2008 in the form which the Secretary of State has, with the approval of the Treasury, directed.

2013 - 2014 Annual Accounts of East Midlands Ambulance Service NHS Trust

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Susan Noyes.....Chief Executive

Date 5 June 2014

2013 - 2014 Annual Accounts of East Midlands Ambulance Service NHS Trust

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

5 June 2014 Date..... Susan Noyes .....Chief Executive

5 June 2014 Date..... Ian Reader .....Finance Director

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

We have audited the financial statements of East Midlands Ambulance Service NHS Trust for the year ended 31 March 2014 on pages 1 to 48. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Board of Directors of East Midlands Ambulance Service NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page ii, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2014 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements;

- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust's responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements

for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Basis of qualified conclusion

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in April 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2014.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness we identified that:

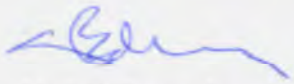
- The Trust had received £3.4 million of non-recurrent transformational funding to enable it to make improvements which would allow it to achieve its response time targets in 2013-14 without impacting on quality.
- The funding was invested but the Trust failed to achieve all three of its key response time targets in 2013-14 and as a result incurred fines of £4.9 million
- In response to the lack of performance improvement the Trust has received a further unplanned investment of £4.9 million from Commissioning bodies in December 2013 aimed at improving performance which offset the impact of the fines
- Whilst action was taken in January 2014 to improve performance, this was not sufficient and the Trust did not meet is response time targets in 2013-14. Results during the first two months of 2014/15 show improvement with response time targets being met.

Qualified conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all material respects, East Midlands Ambulance Service NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Certificate

We certify that we have completed the audit of the accounts of East Midlands Ambulance Service NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.



Neil Bellamy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St Nicholas House,
Park Row,
Nottingham
NG1 6FQ

5 June 2014

East Midlands Ambulance Service NHS Trust

Organisation Code: RX9

Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

In order to meet my responsibilities as Accountable Officer I have processes in place to ensure good working arrangements with partner organisations including the Trust Development Authority, NHS England and commissioners.

The governance framework of the organisation

The Board has established the following committees to support it in its role:

- a Quality and Governance Committee which monitors the effectiveness of the Trust's assurance framework, oversees compliance with legislative requirements, best practice in governance and regulatory standards and ensures that a greater awareness of clinical quality is fostered throughout the Trust;
- an Audit Committee which is responsible for reviewing the Trust's governance, risk management and internal control systems and also monitors the integrity of the Trust's financial statements and financial reporting mechanisms;
- a Workforce Committee which agrees and monitors the implementation of strategies relating to workforce issues and monitors performance against key workforce metrics
- a Finance and Performance Committee which considers performance against the Trust's objectives as set out in the Integrated Business Plan and the Annual Plan, monitors operational and financial performance, oversees the capital programme and monitors arrangements for cash forecasting, investing and banking.
- a Remuneration and Nominations Committee which has responsibility for setting the remuneration of the Chief Executive and Executive Directors and any groups not included within the Agenda for Change Pay Framework.

In addition the Better Patient Care Programme Board reports to the Trust Board. This is the programme board for the Trust's improvement programme. The improvement programme was developed following the Risk Summit held by NHS England in October 2013 to address a number of areas of concern, including failure to meet performance targets, Serious Incidents, response to complaints, compliance with Care Quality Commission (CQC) standards and governance arrangements. The Trust also has a Charitable Funds Committee which monitors and administers the East Midlands Ambulance Service Charitable Fund.

In November 2013 the Trust Board reviewed its corporate governance arrangements in an assessment of its own performance and effectiveness. It strengthened these arrangements further by increasing the frequency of Board meetings and Quality and Governance Committee meetings to monthly. Additional committees were also introduced to improve governance. This included the Workforce Committee and the Finance and Performance Committee which were both established in December 2013. Prior to this the Finance and Performance Committee had been referred to as the Investments Committee and was responsible for overseeing the Trust's arrangements in relation to cash forecasting and investment and monitored the capital programme

Minimum requirements are set for attendance at meetings against which performance is monitored.

The main issues considered by Board committees and highlighted to the Board during the year were:

- concerns regarding the Electronic Patient Report Form system, including usage rates and the appropriateness of the system and scanning and storage of forms
- the need for capital spending to be scheduled throughout the year
- compliance against the CQC standards, particularly in relation to the tracking of medical devices, servicing of vehicles and gas pipelines, ordering and storage of controlled drugs, sustaining performance against deep clean targets and recruitment checks undertaken by third party providers
- agreement for the funding of Hepatitis B vaccinations for Community First Responders
- an Information Technology Outage which had impacted on the Trust over a sustained period
- receipt of a Rule 43 letter from the Coroner in Lincolnshire relating to a delayed response to a call
- availability of bronze level commanders in the event of multiple major incidents
- the process for ensuring that Computer Aided Dispatch system markers on high risk properties were up to date and appropriate
- delays in the implementation of the Fleet Services computer system
- the implications of the Keogh Review: Transforming Urgent and Emergency Care (November 2013) upon Paramedic turnover rates and workforce planning
- The national education strategy and the implications of Paramedic Evidence Based Education Project on education and training and workforce planning
- concerns that operational risk registers were not always updated promptly
- concerns regarding achievement of annual trajectories for essential education, appraisals and quality audits in some areas
- an increase in the number of Serious Incidents reported by the Trust
- the external review of the system for reporting Serious Incidents
- concerns regarding the need for an enhanced programme management resource.

The Trust has arrangements in place for ensuring quality governance which include:
- the Quality and Governance Committee
- an annual Quality Account
- an annual Clinical Audit programme which is overseen by the Clinical Governance Group
- identification, investigation and learning from Never Events and Serious Incidents.

The Trust has arrangements in place to ensure the discharge of statutory functions. Responsibility for functions is clearly allocated to individual Executive Directors. Regular reports are presented to the Board and appropriate committees to provide assurance that statutory requirements are met and compliance ensured for individual functions. The Scheme of Delegation identifies responsibility for specific statutory roles and details delegated authority to undertake the functions.

The Trust is compliant with the HM Treasury and Cabinet Office Corporate Governance Code as set out below.

Leadership – The Trust is headed by a Board with collective responsibility for the long-term success of the organisation. The division of responsibilities between executive functions and the running of the Board are set out in the Trust's Standing Orders and Scheme of Delegation. There have been some changes to the membership of the Board during 2013/14. Phil Milligan resigned as Chief Executive in August 2013 and Jon Towler resigned as Chairman in November 2013. The Trust currently has an Interim Chief Executive and an Interim Chairman. There have been changes to some Executive Director posts during the year and the Trust currently has some roles filled on an interim basis. EMAS is in the process of appointing to these posts. Pauline Tagg took on the role of Interim Chairman in November 2013. As a result of this change there has been one Non-Executive Director vacancy since that time. There have been no other changes to Non-Executive Director positions during the year.

Effectiveness – Directors received an induction on joining the Board. This is supplemented with a Board Development Programme to enable Board members to keep their skills and knowledge up to date. Individual Directors, the Chief Executive and the Chairman undertake annual performance appraisals. The Board has been working with an experienced independent National Health Service Chief Executive to provide Board members with support and advice as part of the Board Development Programme.

Accountability – The Board recognises its responsibility for determining the nature and extent of the significant risks involved in achieving the Trust's strategic objectives. The Board ensures the Trust has sound risk management arrangements and internal control principles and has sought assurance that

these arrangements were operating effectively through its committees and the reports it receives during the year.

Sustainability – The Trust has a five year Integrated Business Plan which takes a long-term view of the vision of the Trust. Board members were involved in the development of the plan and the document was approved by the Trust Board. The Board receives regular reports from the Chief Executive which include information on national initiatives and general horizon scanning. These reports inform the work of the Board in developing its long-term plans.

Risk assessment

The Trust has a Risk Management Policy which is reviewed and approved annually by the Board. There is a systematic process for the identification of risk throughout the organisation through local or divisional risk registers and a Board Assurance Framework. The risk registers and Board Assurance Framework are reviewed regularly to ensure risks are managed effectively in accordance with the Risk Management Policy. Towards the end of the year it was identified that divisional risks registers were not being updated as frequently as required. Revised arrangements have been put in place to resolve this issue and ensure that risk registers are monitored regularly to identify and manage all risks which could impact on the achievement of the Trust's objectives.

Risks are scored for impact and likelihood using a risk evaluation model. The significance of a risk to the achievement of the Trust's strategic objectives determines whether a risk is managed locally or escalated for inclusion in the Board Assurance Framework. The Trust's strategic-level risks are contained in the Board Assurance Framework which details the risk and any mitigation through the application of controls, together with evidence that demonstrates the application of those controls.

The main risks identified during 2013/14 were:

- operational performance;
- financial performance and contractual issues;
- clinical quality
- staff development and engagement; and
- governance and relationships.

A number of these challenges are likely to continue into 2014/15. The Better Patient Care Programme is designed to manage these risks.

Risk management is further embedded within the Trust through service management responsibilities. Equality impact assessments are carried out against core business policies, and risk assessments and quality impact assessments are completed on proposed business activities and changes. Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has registered compliance with the NHS Equality Delivery System from January 2012.

The public and patients are involved in identifying risk and for bringing this to the attention of the Trust in a variety of ways including patient satisfaction surveys, complaints, litigation claims and Patient Advice and Liaison (PALS) concerns.

In January 2014 the CQC carried out an annual inspection of the Trust against the Essential Standards of Quality and Safety.

The CQC examined the following outcomes:

- Care and welfare of people who use services (outcome 4)
- Cleanliness and infection control (outcome 8)
- Safety, availability and suitability of equipment (outcome 11)
- Staffing (outcome 13)
- Supporting workers (outcome 14).
- Complaints (outcome 17).

The CQC concluded that the Trust had met standards for outcomes 8 and 17 but needed to take action in relation to the other outcomes examined. The main areas of concern identified are as follows:

- response standards were not being met;
- lack of staff resources;
- coverage of shifts;
- availability of vehicles;
- equipment availability and checks;
- lack of performance appraisals in some areas;
- low staff morale; and
- lack of time for management duties.

The Trust was aware of the issues identified and had been working to address these prior to the inspection through the Better Patient Care Programme.

The Trust's internal auditors have provided a significant assurance opinion for 2013/14, although they recognised that it had been a difficult year for the Trust with significant risk to the achievement of the agreed strategic objectives. The auditors also noted that the Trust's performance had been subject to external scrutiny and there had been a high level of turnover in Executive Directors. The significant assurance opinion means that there is a generally sound system of internal control within the Trust, designed to meet its objectives, and that controls are generally being applied consistently. No high risk issues were identified by the internal auditors during 2013/14, although limited assurance opinions were provided on the following reviews:

- Medicines Management
- Self-Certification
- Ambulance Response Times, Performance Management
- Medical Devices
- Electronic Patient Report Form Post Implementation

The internal auditors also noted that progress in implementing actions from internal audit had been slower than expected in some cases.

During 2013/14 there was one lapse of data security. As part of a daily work plan Patient Identifiable Data was sent via a text message to an independent ambulance service working for the Trust. The data was however sent to the incorrect mobile number. There was only one instance of this occurring and the incident was not sufficiently significant to report to the Information Commissioner.

The Trust received three reports to prevent future death (previously Rule 43 letters) from the Coroner in 2013/14. One report related to delayed response to a call, one to guidance for Paramedics in maternity cases and the third report to essential equipment to be taken to calls by solo responders.

The Trust has sound information governance policies and processes in place to prevent data security breaches and to address any issues which arise. This was demonstrated through achieving an assessment score of 94% - satisfactory, against the national Information Governance Toolkit in 2013/14, an increase of 3% on 2012/13.

The risk and control framework

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

As Accountable Officer I have responsibility for the overall direction of the risk management systems and processes within the Trust. The Director of Nursing and Compliance was the identified lead for risk and quality during 2013/14 and had responsibility for the management and development of the infrastructure on which the processes are based.

The Trust provides statutory and mandatory training and guidance to ensure that risk management is integrated into all policies and procedures which:

- raises awareness of incident reporting and near misses;
- ensures compliance with professional registration requirements;
- provides a consistent approach to the management of risk; and
- develops systems and processes which have the capacity to manage and mitigate risk.

Good practice and lessons learnt were widely shared during the year through mechanisms such as the Strategic and Divisional Learning Review Groups, the Operational Governance Group, Clinical Governance Group, Workforce Governance Group and various publications produced by the Trust.

The Board Assurance Framework is the key tool used by the Trust to provide assurance that risk and control mechanisms are in place and operating effectively. Through regular monitoring of the Board Assurance Framework and the operational risk registers, which underpin the risk management process, the Executive Team and the Trust Board ensure that current risks are managed appropriately and there are suitable arrangements for preventing and deterring risk.

The risk management arrangements are supported by a system of management control throughout the organisation which governs how the organisation operates. This includes the existence of clear policies and procedures to guide staff in their everyday work, a scheme of delegation which explains which groups and individuals have specific decision-making and financial authority, arrangements for the supervision and appraisal of staff and a system of audits and reviews of the Trust's processes to ensure compliance with legislation and internal requirements, particularly in relation to patient safety and effectiveness. These measures ensure that the organisation's statutory obligations and requirements from external regulators including the CQC are complied with and risks are effectively managed including the prevention and deterrence of those risks.

The Trust's quality impact assessment and equality impact assessment processes ensure that risks which could arise from changes to services, new initiatives or proposals for efficiency savings are identified early, prevented and deterred as appropriate and managed effectively.

The Trust has an annual Counter Fraud work programme in place and the result of the reviews undertaken are monitored by the Trust's Audit Committee.

The Board receives the Board Assurance Framework regularly and discusses the principle risks and the controls in place. The Board also receives integrated performance reports which provide data in respect of financial, clinical and national targets and objectives. Any areas of risk are highlighted through the use of a red, amber and green (RAG) rating system.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of risk management and the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Workforce Committee, the Finance and Performance Committee and the Quality and Governance Committee. Plans to address weaknesses and ensure continuous improvement of the system are in place.

Executive Directors within the Trust, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed and managed appropriately. This is reinforced by assurance from the Board Assurance Framework.

My review is also informed by meetings of the Executive Team and the Board and the work of the Board's committees.

My review is also informed by the annual audit plan and the outcomes of audits, clinical audit reports and performance monitoring.

The Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The priorities identified for 2014/15 were consulted on through the Local Involvement Networks and the Health Overview and Scrutiny Committees to ensure that the Trust prioritised those areas of interest to the public. The Trust Board reviews the Quality Account prior to publication and seeks assurance from the Executive Directors regarding the accuracy of the document. The Trust Board approves the Quality Account prior to publication.

A Quality Strategy was approved by the Trust Board in July 2012 and this document sets out the key documents, the key strategic priorities, the key Board assurances, and the key metrics in place to underpin the strategy. An update on the Quality Account Priorities is presented at regular intervals to the Trust Board. The Trust Board also receives an Integrated Board Report at each meeting which includes the key performance indicators identified in the Quality Strategy.

Significant Issues

There are no significant issues to report.

Accountable Officer : Sue Noyes
Organisation : East Midlands Ambulance Service

Signature:

Date 5 June 2014

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	2013-2014 £000s	2012-2013 £000s
Gross employee benefits	10.1	**(107,382)**	(112,275)
Other operating costs	8	**(40,486)**	(41,208)
Revenue from patient care activities	5	**146,022**	149,815
Other operating revenue	6	**4,109**	5,226
Operating surplus		**2,263**	1,558
Investment revenue	12	**24**	24
Other gains	13	**2**	6
Finance costs	14	**(65)**	(62)
Surplus for the financial year		**2,224**	1,526
Public dividend capital dividends payable		**(1,833)**	(1,854)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**391**	(328)

Other Comprehensive Income

	2013-2014 £000s	2012-2013 £000s
Impairments and reversals taken to the Revaluation Reserve	**(25)**	(362)
Net gain on revaluation of property, plant & equipment	**676**	90
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Other gain /(loss) (explain in footnote below)	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Other Pension Remeasurements	**0**	
Reclassification Adjustments		
On disposal of available for sale financial assets	**0**	0
Total Comprehensive Income for the year*	**1,042**	(600)

Financial performance for the year

Retained surplus/(deficit) for the year	**391**	(328)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	0
Impairments (excluding IFRIC 12 impairments)	**(384)**	358
Adjustments in respect of donated gov't grant asset reserve elimination	**54**	0
Adjustment re Absorption accounting	**0**	0
Adjusted retained surplus	**61**	30

The notes on pages 5 to 48 form part of this account.

Statement of Financial Position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15	**62,093**	60,582
Intangible assets	16	**42**	15
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**0**	0
Total non-current assets		**62,135**	60,597
Current assets:			
Inventories	21	**2,112**	1,822
Trade and other receivables	22.1	**6,370**	8,603
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**6,013**	6,094
Total current assets		**14,495**	16,519
Non-current assets held for sale	27	**0**	0
Total current assets		**14,495**	16,519
Total assets		**76,630**	77,116
Current liabilities			
Trade and other payables	28	**(12,602)**	(13,249)
Other liabilities	29	**0**	0
Provisions	35	**(687)**	(1,155)
Borrowings	30	**(17)**	(17)
Other financial liabilities	31	**0**	0
Working capital loan from Department	30	**0**	0
Capital loan from Department	30	**0**	0
Total current liabilities		**(13,306)**	(14,421)
Net current assets		**1,189**	2,098
Non-current assets plus/less net current assets/liabilities		**63,324**	62,695
Non-current liabilities			
Trade and other payables	28	**0**	0
Other Liabilities	31	**0**	0
Provisions	35	**(599)**	(997)
Borrowings	31	**(18)**	(33)
Other financial liabilities	30	**0**	0
Working capital loan from Department	30	**0**	0
Capital loan from Department	30	**0**	0
Total non-current liabilities		**(617)**	(1,030)
Total Assets Employed:		**62,707**	61,665
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**62,228**	62,228
Retained earnings		**(8,135)**	(8,551)
Revaluation reserve		**8,614**	7,988
Other reserves		**0**	0
Total Taxpayers' Equity:		**62,707**	61,665

The notes on pages 5 to 48 form part of this account.

The financial statements on pages 1 to 48 were approved by the Board on 5 June 2014 and signed on its behalf by

Chief Executive: Date: 5 June 2014

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	**62,228**	**(8,551)**	**7,988**	**0**	**61,665**
Changes in taxpayers' equity for 2013-2014					
Retained surplus/(deficit) for the year		391			**391**
Net gain / (loss) on revaluation of property, plant, equipment			676		**676**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial assets			0		**0**
Impairments and reversals			(25)		**(25)**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		25	(25)	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs		0			**0**
Transfers under Modified Absorption Accounting - Other Bodies		0			**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption		0	0		**0**
On Disposal of Available for Sale financial Assets			0		**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New PDC Received - Cash	0				**0**
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	0				**0**
PDC Repaid In Year	0				**0**
PDC Written Off	0				**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension				0	**0**
Other Pensions Remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**0**	**416**	**626**	**0**	**1,042**
Transfers between reserves in respect of modified absorption - PCTs & SHAs		0	0	0	**0**
Transfers between reserves in respect of modified absorption - Other Bodies		0	0	0	**0**
Balance at 31 March 2014	**62,228**	**(8,135)**	**8,614**	**0**	**62,707**

Balance at 1 April 2012	**62,228**	**(8,299)**	**8,336**	**0**	**62,265**
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained surplus/(deficit) for the year		(328)			(328)
Net gain / (loss) on revaluation of property, plant, equipment			90		90
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			(362)		(362)
Movements in other reserves				0	0
Transfers between reserves		76	(76)	0	0
Release of reserves to Statement of Comprehensive Income			0		0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
Transfers between Revaluation Reserve & Retained Earnings Reserve in respect of assets transferred under absorption		0	0		0
On Disposal of Available for Sale financial Assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	0				0
PDC Repaid In Year	0				0
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension				0	0
Net recognised revenue/(expense) for the year	**0**	**(252)**	**(348)**	**0**	**(600)**
Balance at 31 March 2013	**62,228**	**(8,551)**	**7,988**	**0**	**61,665**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31 March 2014

	NOTE	**2013-2014 £000s**	2012-2013 £000s
Cash Flows from Operating Activities			
Operating Surplus		**2,263**	1,558
Depreciation and Amortisation		**4,733**	4,734
Impairments and Reversals		**(384)**	358
Other Gains/(Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(65)**	(62)
Dividend (Paid)		**(1,792)**	(1,894)
Release of PFI/deferred credit		**0**	0
(Increase) in Inventories		**(290)**	(514)
Decrease/(Increase) in Trade and Other Receivables		**2,192**	(999)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**(201)**	(1,307)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(768)**	(1,842)
(Decrease)/Increase in Provisions		**(98)**	1,003
Net Cash Inflow from Operating Activities		**5,590**	1,035
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**24**	24
(Payments) for Property, Plant and Equipment		**(5,673)**	(6,922)
(Payments) for Intangible Assets		**(42)**	0
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**35**	322
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash (Outflow) from Investing Activities		**(5,656)**	(6,576)
NET CASH (OUTFLOW) BEFORE FINANCING		**(66)**	(5,541)
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		**0**	0
Public Dividend Capital Repaid		**0**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support Loans		**0**	0
Other Loans Received		**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**0**	0
Loans repaid to DH - Revenue Support Loans		**0**	0
Other Loans Repaid		**0**	0
Cash transferred to NHS Foundation Trusts		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(15)**	(17)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash (Outflow) from Financing Activities		**(15)**	(17)
NET (DECREASE) IN CASH AND CASH EQUIVALENTS		**(81)**	(5,558)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**6,094**	11,652
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**6,013**	6,094

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013-2014 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNI.

1.4 Charitable Funds

For 2013-2014, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements*, restated prior period accounts are presented where the adoption of the new policy has a material impact.

1.5 Pooled Budgets

The Trust has not entered into any pooled budget arrangements.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.6.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year
Non Current Assets. Values as disclosed in notes 15 and 16.
Asset lives, with the exception of buildings are set out in notes 15 and 16 with maximum lives being set by reference to the type of asset and it's expected useful life in normal use. Building lives are based on the recommendations received from the District Valuer. Land and buildings have been revalued as at 31 March 2014 and have not been subject to indexation in the year. The results of this are disclosed in note 15.

Provisions. Values as disclosed in note 35.
These have been estimated based on the best information available at the time of the compilation of the accounts.
Estimates of employee's legal claims are made including the advice received from the National Health Service (NHS) Litigation Authority to the size and likely outcome of each individual claim. The Trust's maximum liability regarding each claim is limited to £10k.
The employee frozen leave provision is computed with reference to each individual employee entitled to these payments and computed at their latest pay scales. No further employees will become eligible for these payments.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. This is from Clinical Commissioning Groups which are Government funded commissioners of NHS health and patient care. Revenue is recognised in the period in which services are provided.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8 Employee Benefits

Short-term employee benefits

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Notes to the Accounts - 1. Accounting Policies (Continued)

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

The Trust has revalued its land and buildings as at 31 March 2014 utilising the modern equivalent asset basis with the exception of specialised buildings.

Transport Equipment, Fixtures and Medical Equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it

Notes to the Accounts - 1. Accounting Policies (Continued)

- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants
The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Notes to the Accounts - 1. Accounting Policies (Continued)

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Notes to the Accounts - 1. Accounting Policies (Continued)

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms 2.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Notes to the Accounts - 1. Accounting Policies (Continued)

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial Assets are initially recognised at fair value.

For the Trust's financial instruments fair value equates to cost.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

Notes to the Accounts - 1. Accounting Policies (Continued)

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*; and

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.30 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trust's not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

From 2013/2014, the Trust does not consolidate the results of the East Midlands Ambulance Service Charitable Funds over which it considers it has the power to exercise control in accordance with IAS27 requirements on the basis that the values involved are immaterial.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.33 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.34 Joint ventures

Material entities over which the Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for by proportional consolidation.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.35 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.36 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.37 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013/2014. The application of the Standards as revised would not have a material impact on the accounts for 2013/2014, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled budget

The Trust has not entered into any pooled budget arrangements.

3. Operating segments

The Trust has identified two operating segments with reference to the type of operations being undertaken and the proportion of income generated.

	Health - Accident and Emergency		Health - Patient Transport Service		Total	
	2013-2014 £000s	2012-2013 £000s	**2013-2014 £000s**	2012-2013 £000s	**2013-2014 £000s**	2012-2013 £000s
Income	**147,354**	146,166	**2,777**	8,875	**150,131**	155,041
Surplus/(Deficit)						
Total Direct and Indirect Expenditure	**(147,099)**	(146,715)	**(2,641)**	(8,654)	**(149,740)**	(155,369)
Surplus/(deficit) before interest	**255**	(549)	**136**	221	**391**	(328)

The basis of the segmental analysis is the service line reports considered by the Trust Board.
The service line report is based on revenue income and expenditure. The latter includes direct costs, depreciation for vehicles, financing costs of vehicles and an apportionment of other support function costs.
The sum of the segments equates to the Statement of Comprehensive Income for the year ended 31 March 2014.
No service line reporting of assets or liabilities is undertaken and thus no details have been disclosed.
All cashflows to segments are derived from operating activities.
The above segmental analysis reflects the Trust losing the majority of its Patient Transport Service contracts from the 1st July 2012.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes	**2013-2014 £000s**	2012-2013 £000s
Income	**0**	0
Full cost	**0**	0
Surplus/(deficit)	**0**	0

5. Revenue from patient care activities

	2013-2014 £000s	2012-2013 £000s
NHS Trusts	**445**	691
NHS England	**0**	0
Clinical Commissioning Groups	**145,069**	0
Primary Care Trusts		147,698
Strategic Health Authorities		0
NHS Foundation Trusts	**43**	104
Department of Health	**14**	748
NHS Other (including Public Health England and Prop Co)	**0**	0
Non-NHS:		
Local Authorities	**0**	0
Private patients	**0**	0
Overseas patients (non-reciprocal)	**0**	0
Injury costs recovery	**0**	0
Other	**451**	574
Total Revenue from patient care activities	**146,022**	149,815

6. Other operating revenue

	2013-2014 £000s	2012-2013 £000s
Recoveries in respect of employee benefits	**294**	298
Patient transport services	**0**	0
Education, training and research	**846**	1,541
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of donations for capital acquisitions - NHS Charity	**0**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**8**	12
Income generation	**1,285**	1,190
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**0**	4
Other revenue	**1,676**	2,181
Total Other Operating Revenue	**4,109**	5,226
Total operating revenue	**150,131**	155,041

7. Revenue

	2013-2014 £000	2012-2013 £000
From rendering of services	**150,131**	155,041
From sale of goods	**0**	0

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

8. Operating expenses

	2013-2014 £000s	2012-2013 £000s
Services from other NHS Trusts	**0**	0
Services from CCGs/NHS England	**0**	
Services from other NHS bodies	**0**	0
Services from NHS Foundation Trusts	**0**	0
Services from Primary Care Trusts		0
Total Services from NHS bodies*	**0**	0
Purchase of healthcare from non-NHS bodies	**0**	0
Trust Chair and Non-executive Directors	**64**	74
Supplies and services - clinical	**3,434**	2,825
Supplies and services - general	**1,123**	1,255
Consultancy services	**1,049**	1,136
Establishment	**4,670**	4,251
Transport	**17,595**	18,763
Premises	**4,534**	4,090
Hospitality	**68**	
Insurance	**582**	
Legal Fees	**674**	
Impairments and Reversals of Receivables	**155**	5
Inventories write down	**111**	0
Depreciation	**4,718**	4,718
Amortisation	**15**	16
Impairments and reversals of property, plant and equipment	**(384)**	358
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Impairments and reversals of investment properties		0
Audit fees	**88**	91
Other auditor's remuneration:		8
Quality Governance Review	**25**	0
Internal Audit:		
Audit & Risk Assessment	**57**	48
Counter Fraud	**29**	19
Clinical negligence	**227**	411
Research and development (excluding staff costs)	**0**	0
Education and Training	**666**	502
Change in Discount Rate	**0**	0
Other	**986**	2,638
Total Operating expenses (excluding employee benefits)	**40,486**	41,208
Employee Benefits		
Employee benefits excluding Board members	**106,208**	111,254
Board members	**1,174**	1,021
Total Employee Benefits	**107,382**	112,275
Total Operating Expenses	**147,868**	153,483

*Services from NHS bodies does not include expenditure which falls into a category below

9 Operating Leases

The Trust's significant leases are in respect of vehicles for the provision of Accident and Emergency and Non-Urgent Patient Transport Services.
There are no provisions for the charging of contingency rentals or escalation costs.
The Trust is required at all times to keep the vehicles insured, taxed and with valid MOT certificates where necessary and fully maintained to ensure a fully roadworthy condition.
Should the lease agreements be subject to an early termination by the Trust, penalty clauses in the lease agreements would result in the outstanding balance of the lease payments to become immediately due.
At the natural termination of the lease agreements the Trust is required to return the vehicles in a similar condition to that supplied.
The Trust has no automatic right to purchase the vehicles or renew at the end of the lease period.

9.1 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2013-2014 Total £000s	2012-2013 £000s
Payments recognised as an expense					
Minimum lease payments				**4,134**	4,814
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**4,134**	4,814
Payable:					
No later than one year	0	443	3,263	**3,706**	3,583
Between one and five years	0	1,772	5,311	**7,083**	9,338
After five years	0	356	0	**356**	313
Total	**0**	**2,571**	**8,574**	**11,145**	13,234
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

The Trust receives small amounts of income from its aerial sites.

	2013-2014 £000	2012-2013 £000s
Recognised as revenue		
Rental revenue	0	4
Contingent rents	0	0
Total	**0**	4
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	0

10 Employee benefits and staff numbers

10.1 Employee benefits

	2013-14		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**90,322**	88,322	2,000
Social security costs	**6,638**	6,638	0
Employer Contributions to NHS BSA - Pensions Division	**10,859**	10,859	0
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**107,819**	**105,819**	**2,000**
Employee costs capitalised	**437**	187	250
Gross Employee Benefits excluding capitalised costs	**107,382**	**105,632**	**1,750**

Employee Benefits - Gross Expenditure 2012-2013	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	92,501	90,965	1,536
Social security costs	7,018	7,018	0
Employer Contributions to NHS BSA - Pensions Division	10,822	10,822	0
Other pension costs	0	0	0
Termination benefits	1,934	1,934	0
TOTAL - including capitalised costs	112,275	110,739	1,536
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	112,275	110,739	1,536

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

10.2 Staff Numbers

	2013-2014			2012-2013
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**1**	1	0	1
Ambulance staff	**2,077**	2,077	0	2,149
Administration and estates	**651**	599	52	639
Healthcare assistants and other support staff	**0**	0	0	0
Nursing, midwifery and health visiting staff	**28**	28	0	28
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**0**	0	0	0
Social Care Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**2,757**	**2,705**	**52**	2,817
Of the above - staff engaged on capital projects	**0**	0	0	0

10.3 Staff Sickness absence and ill health retirements

	2013-2014 Number	2012-2013 Number
Total Days Lost	34,089	41,466
Total Staff Years	2,679	2,905
Average working Days Lost	12.72	14.27

	2013-2014 Number	2012-2013 Number
Number of persons retired early on ill health grounds	**12**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**926**	818

10.4 Exit Packages agreed in 2013-2014

	2013-2014			2012-2013		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	0	0	0	2	11	13
£10,000-£25,000	0	0	0	5	17	22
£25,001-£50,000	0	0	0	7	15	22
£50,001-£100,000	0	0	0	7	1	8
£100,001 - £150,000	0	0	0	2	2	4
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**0**	**0**	**0**	23	46	69
Total resource cost (£000s)	**0**	**0**	**0**	1,075,456	1,195,302	2,270,758

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

10.5 Exit packages - Other Departures analysis

	2013-2014		2012-2013	
	Agreements	**Total value of agreements**	**Agreements**	**Total value of agreements**
	Number	**£000s**	**Number**	**£000s**
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	45	1,082
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	1	113
Non-contractual payments requiring HMT approval	0	0	0	0
Total	0	0	46	1,195

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report, where applicable.

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2013-2014 Number	2013-2014 £000s	2012-2013 Number	2012-2013 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**23,747**	**44,912**	26,229	43,926
Total Non-NHS Trade Invoices Paid Within Target	**23,046**	**41,063**	24,937	37,425
Percentage of NHS Trade Invoices Paid Within Target	**97.05%**	**91.43%**	95.07%	85.20%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**462**	**1,399**	763	**2,984**
Total NHS Trade Invoices Paid Within Target	**373**	**1,216**	694	**2,364**
Percentage of NHS Trade Invoices Paid Within Target	**80.74%**	**86.92%**	90.96%	79.22%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-2014 £000s	2012-2013 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

12 Investment Revenue

	2013-2014 £000s	2012-2013 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**24**	24
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**24**	24
Total investment revenue	**24**	24

13 Other Gains and Losses

	2013-2014 £000s	2012-2013 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**2**	6
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**2**	6

14 Finance Costs

	2013-2014 £000s	2012-2013 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**65**	62
Interest on obligations under PFI contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Total interest expense	**65**	62
Other finance costs	**0**	0
Provisions - unwinding of discount	**0**	0
Total	**65**	62

15.1 Property, plant and equipment

2013-2014	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2013	**18,606**	**27,282**	**0**	**1,028**	**4,817**	**20,556**	**5,480**	**335**	**78,104**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers under Modified Absorption Accounting - Other Bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions of Assets Under Construction				**1,589**					**1,589**
Additions Purchased	0	755	0		744	658	1,481	0	**3,638**
Additions Donated	0	0	0	0	0	0	0	0	**0**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	0	0	(145)	0	0	145	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	(1,247)	0	0	**(1,247)**
Disposals other than for sale	0	0	0	0	0	(205)	(96)	0	**(301)**
Upward revaluation/positive indexation	100	576	0	0	0	0	0	0	**676**
Impairments/negative indexation	0	(25)	0	0	0	0	0	0	**(25)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**18,706**	**28,588**	**0**	**2,472**	**5,561**	**19,762**	**7,010**	**335**	**82,434**
Depreciation									
At 1 April 2013	**0**	**1,296**	**0**	**0**	**3,538**	**9,409**	**3,011**	**268**	**17,522**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0		0	(1,214)	0	0	**(1,214)**
Disposals other than for sale	0	0	0		0	(205)	(96)	0	**(301)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	142	0	0	0	0	0	0	**142**
Reversal of Impairments	0	(526)	0	0	0	0	0	0	**(526)**
Charged During the Year	0	952	0		472	2,488	757	49	**4,718**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		0	0	0	0	**0**
At 31 March 2014	**0**	**1,864**	**0**	**0**	**4,010**	**10,478**	**3,672**	**317**	**20,341**
Net Book Value at 31 March 2014	**18,706**	**26,724**	**0**	**2,472**	**1,551**	**9,284**	**3,338**	**18**	**62,093**
Asset financing:									
Owned - Purchased	18,706	26,078	0	2,472	1,551	9,257	3,338	18	**61,420**
Owned - Donated	0	0	0	0	0	27	0	0	**27**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	646	0	0	0	0	0	0	**646**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**18,706**	**26,724**	**0**	**2,472**	**1,551**	**9,284**	**3,338**	**18**	**62,093**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
At 1 April 2013	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Movements (specify)	5,768	2,097	0	0	43	80	0	0	**7,988**
At 31 March 2014	100	551	0	0	0	(25)	0	0	**626**
	5,868	**2,648**	**0**	**0**	**43**	**55**	**0**	**0**	**8,614**

Additions to Assets Under Construction in 2013/14

	£000's
Land	0
Buildings excl Dwellings	1,077
Dwellings	0
Plant & Machinery	512
Balance as at YTD	**1,589**

15.2 Property, plant and equipment prior-year

2012-2013	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2012	18,606	26,548	0	0	5,227	25,381	4,921	497	81,180
Additions - Assets Under Construction				1,028					1,028
Additions - purchased	0	1,006	0		582	1,389	1,380	14	4,371
Additions - donated	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	(5,599)	0	0	(5,599)
Disposals other than by sale	0	0	0	0	(992)	(615)	(821)	(176)	(2,604)
Revaluation & indexation gains	0	90	0	0	0	0	0	0	90
Impairments	0	(362)	0	0	0	0	0	0	(362)
Reversals of impairments	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	**18,606**	**27,282**	**0**	**1,028**	**4,817**	**20,556**	**5,480**	**335**	**78,104**
Depreciation									
At 1 April 2012	0	0	0	0	3,740	12,959	3,253	380	20,332
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0		0	(5,599)	0	0	(5,599)
Disposals other than for sale	0	0	0		(768)	(522)	(821)	(176)	(2,287)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	395	0	0	0	0	0	0	395
Reversal of Impairments	0	(37)	0	0	0	0	0	0	(37)
Charged During the Year	0	938	0		566	2,571	579	64	4,718
Transfer to NHS Foundation Trust	0	0	0		0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	**0**	**1,296**	**0**	**0**	**3,538**	**9,409**	**3,011**	**268**	**17,522**
Net book value at 31 March 2013	**18,606**	**25,986**	**0**	**1,028**	**1,279**	**11,147**	**2,469**	**67**	**60,582**
Purchased	18,606	25,986	0	1,028	1,244	11,096	2,469	67	60,496
Donated	0	0	0	0	35	51	0	0	86
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**18,606**	**25,986**	**0**	**1,028**	**1,279**	**11,147**	**2,469**	**67**	**60,582**
Asset financing:									
Owned	18,606	25,315	0	1,028	1,279	11,147	2,469	67	59,911
Held on finance lease	0	671	0	0	0	0	0	0	671
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	**18,606**	**25,986**	**0**	**1,028**	**1,279**	**11,147**	**2,469**	**67**	**60,582**

15.3 (cont). Property, plant and equipment

2013 - 2014. The Trust received no new donated assets.

2012 - 2013. The Trust received no new donated assets.

The Trust's land and buildings were revalued as at 31 March 2014 using the Modern Equivalent asset methodology. All valuations were undertaken by the District Valuer.

The outcome of the revaluation is as follows:

	Increase £'000	Decrease £'000
Land	100	0
Buildings	1,102	167

The Trust's land and buildings were revalued as at 31 March 2013 using the Modern Equivalent asset methodology. All valuations were undertaken by the District Valuer.

The outcome of the revaluation is as follows:

	Increase £'000	Decrease £'000
Land	0	0
Buildings	126	757

The minimum and maximum lives of each class of asset are as follows:

Buildings excluding dwellings	0	50
Plant & Machinery	5	15
Transport Equipment	5	7
Information Technology	5	5
Furniture and Fittings	5	5

No amendments have been made to asset lives in the year.

No compensation has been received from any third party for any assets impaired.

2013 - 2014. The Trust made no write downs in assets values excepting those relating to the revaluation of buildings.

2012 - 2013. The Trust made no write downs in assets values excepting those relating to the revaluation of buildings.

The Trust has no temporarily idle assets.

The gross carrying value of fully depreciated assets still in use are as follows:

	2013 - 2014 £ '000	2012 - 2013 £ '000
Land	0	0
Buildings	0	0
Plant & Machinery	3,311	3,016
Vehicles	2,316	2,986
IT	2,254	1,346
Fixtures	289	0

16.1 Intangible non-current assets

2013-2014	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	**138**	**0**	**0**	**0**	**0**	**138**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	**0**	**0**	**0**	**0**	**0**
Transfers under Modified Absorption Accounting - Other Bodies	**0**	**0**	**0**	**0**	**0**	**0**
Additions - purchased	0	42	0	0	0	**42**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Additions - leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	(40)	0	0	0	0	**(40)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	**98**	**42**	**0**	**0**	**0**	**140**
Amortisation						
At 1 April 2013	**123**	**0**	**0**	**0**	**0**	**123**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	(40)	0	0	0	0	**(40)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	15	0	0	0	0	**15**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	**98**	**0**	**0**	**0**	**0**	**98**
Net Book Value at 31 March 2014	**0**	**42**	**0**	**0**	**0**	**42**
Asset Financing: Net book value at 31 March 2014 comprises:						
Purchased	0	42	0	0	0	**42**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	**0**
Total at 31 March 2014	**0**	**42**	**0**	**0**	**0**	**42**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2012-2013	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:						
At 1 April 2012	429	0	0	0	0	429
Additions - purchased	0	0	0	0	0	0
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(291)	0	0	0	0	(291)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2013	138	0	0	0	0	138
Amortisation						
At 1 April 2012	398	0	0	0	0	398
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(291)	0	0	0	0	(291)
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	16	0	0	0	0	16
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2013	123	0	0	0	0	123
Net book value at 31 March 2013	15	0	0	0	0	15
Net book value at 31 March 2013 comprises:						
Purchased	15	0	0	0	0	15
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	15	0	0	0	0	15

16.3 Intangible non-current assets

The Trust has not revalued any intangible assets.

The Trust has no intangible assets with infinite lives.

The minimum and maximum lives of each class of asset are as follows:

Software Licences	5	5
Licences and trademarks	0	0
Patents	0	0
Development Expenditure	0	0

None of the Trust's Intangible Assets have been internally generated.

The gross carrying value of fully depreciated assets still in use are as follows:

	2013 - 2014 £ '000	2012 - 2013 £ '000
Software Licences	97	0
Licences and trademarks	0	0
Patents	0	0
Development Expenditure	0	0

The Trust has no intangible assets acquired by government grant.

The Trust has no intangible assets not recognised as assets.

17 Analysis of impairments and reversals recognised in 2013-2014

	Total	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	**0**	0	0	0	0
Over-specification of assets	**0**	0	0		
Abandonment of assets in the course of construction	**0**	0	0		0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	**0**	0	0		0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**0**	0	0	0	0
Changes in market price	**(384)**	(384)	0		0
Total charged to Annually Managed Expenditure	**(384)**	**(384)**	**0**	**0**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(384)**	**(384)**	**0**	**0**	**0**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

18 Investment property

	31 March 2014 £000s	31 March 2013 £000s
At fair value		
Balance at 1 April 2013	**0**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Loss from Fair Value Adjustments - Reversal of Impairments	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transfer to other NHS Foundation Trust	**0**	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	**0**	0
Other Changes	**0**	0
Balance at 31 March 2014	**0**	0

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014 £000s	31 March 2013 £000s
Property, plant and equipment	**181**	52
Intangible assets	**0**	0
Total	**181**	52

19.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service

	31 March 2014 £000s	31 March 2013 £000s
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	**0**

20 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	2,479	0	4,118	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	92	0	163	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,799	0	8,321	0
At 31 March 2014	**6,370**	**0**	**12,602**	**0**
prior period:				
Balances with other Central Government Bodies	5,649	0	3,763	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	204	0	55	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,750	0	9,431	0
At 31 March 2013	**8,603**	**0**	**13,249**	**0**

21 Inventories	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2013	**119**	**1,703**	**0**	**0**	**0**	**0**	**1,822**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0			0	0		0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0		0
Additions	393	8,635	0	0	0	0	**9,028**	0
Inventories recognised as an expense in the period	(178)	(8,449)	0	0	0	0	**(8,627)**	0
Write-down of inventories (including losses)	(111)	0	0	0	0	0	**(111)**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2014	**223**	**1,889**	**0**	**0**	**0**	**0**	**2,112**	**0**

22.1 Trade and other receivables	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
NHS receivables - revenue	**1,835**	5,395	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**486**	221	**0**	0
Non-NHS receivables - revenue	**865**	686	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**3,034**	2,078	**0**	0
Provision for the impairment of receivables	**(186)**	(31)	**0**	0
VAT	**250**	197	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**86**	57	**0**	0
Total	**6,370**	8,603	**0**	0
Total current and non current	**6,370**	8,603		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups which took over the commissining of services from Primary Care Trusts as at 1 April 2013 . As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired	**31 March 2014 £000s**	31 March 2013 £000s
By up to three months	**2,973**	4,921
By three to six months	**0**	398
By more than six months	**58**	2
Total	**3,031**	5,321

22.3 Provision for impairment of receivables	**2013-2014 £000s**	2012-2013 £000s
Balance at 1 April 2013	**(31)**	(26)
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	
Transfers under Modified Absorption Accounting - Other Bodies	**0**	
Amount written off during the year	**0**	0
Amount recovered during the year	**16**	14
(Increase)/decrease in receivables impaired	**(171)**	(19)
Transfer to NHS Foundation Trust	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	
Balance at 31 March 2014	**(186)**	**(31)**

23 NHS LIFT investments

	Loan £000s	Share capital £000s	Total £000s
Balance at 1 April 2013	**0**	**0**	**0**
Additions	0	0	**0**
Disposals	0	0	**0**
Loan repayments	0	0	**0**
Revaluations	0	0	**0**
Loans repayable within 12 months	0	0	**0**
Balance at 31 March 2014	**0**	**0**	**0**
Balance at 1 April 2012	0	0	0
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2013	0	0	0

24.1 Other Financial Assets - Current

	31 March 2014 £000s	31 March 2013 £000s
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	**0**	0

24.2 Other Financial Assets - Non Current

	31 March 2014 £000s	31 March 2013 £000s
Opening balance 1 April	**0**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Additions	**0**	0
Revaluation	**0**	0
Impairments/reversals taken to Revaluation Reserve	**0**	0
Impairment/reversals taken to SoCI	**0**	0
Change in Fair Value through SoCI	**0**	0
Transferred to current financial assets	**0**	0
Disposals	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Total Other Financial Assets - Non Current	**0**	0

25 Other current assets

	31 March 2014 £000s	31 March 2013 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

26 Cash and Cash Equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	**6,094**	11,652
Net change in year	**(81)**	(5,558)
Closing balance	**6,013**	6,094
Made up of		
Cash with Government Banking Service	**6,011**	6,092
Commercial banks	**0**	0
Cash in hand	**2**	2
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**6,013**	6,094
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**6,013**	6,094
Patients' money held by the Trust, not included above	**0**	0

27 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	0	0	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0			0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	33	0	0	0	0	**33**
Less assets sold in the year	0	0	0	0	0	(33)	0	0	0	0	**(33)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0		**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0		**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0		**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0		**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0		**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0		**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0		**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0		**0**
Revaluation	0	0	0	0	0	0	0	0	0		**0**
Balance at 31 March 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**
Liabilities associated with assets held for sale at 31 March 2013	0	0	0	0	0	0	0	0	0		0

28 Trade and other payables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
NHS payables - revenue	**447**	267	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**208**	31	**0**	0
Non-NHS payables - revenue	**1,361**	591	**0**	0
Non-NHS payables - capital	**151**	597	**0**	0
Non-NHS accruals and deferred income	**6,562**	8,133	**0**	0
Social security costs	**1,138**	1,107		
VAT	**0**	0	**0**	0
Tax	**1,034**	1,062		
Payments received on account	**0**	0	**0**	0
Other	**1,701**	1,461	**0**	0
Total	**12,602**	13,249	**0**	0
Total payables (current and non-current)	**12,602**	**13,249**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**0**	0		

29 Other liabilities

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Borrowings

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**0**	0	**0**	0
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**17**	17	**18**	33
Other	**0**	0	**0**	0
Total	**17**	**17**	**18**	**33**
Total other liabilities (current and non-current)	**35**	**50**		

Loans - repayment of principal falling due in:

	31 March 2014		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	0	17	**17**
1 - 2 Years	0	18	**18**
2 - 5 Years	0	0	**0**
Over 5 Years	0	0	**0**
TOTAL	**0**	**35**	**35**

31 Other financial liabilities

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Embedded Derivatives at Fair Value through SoCI	**0**	0	**0**	0
Financial liabilities carried at fair value through profit and loss	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other financial liabilities (current and non-current)	**0**	0		

32 Deferred revenue

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2013	**125**	729	**0**	0
Deferred revenue addition	**155**	125	**0**	0
Transfer of deferred revenue	**(125)**	(729)	**0**	0
Current deferred Income at 31 March 2014	**155**	125	**0**	0
Total deferred income (current and non-current)	**155**	125		

33 Finance lease obligations as lessee

The finance lease relates to Unit 9 Meridian Business Park, Leicester. The term commenced on 25 March 1991 for a period of 25 years expiring 24 March 2016. The initial rent was £47k per annum and is subject to five yearly rent reviews.

Amounts payable under finance leases (Buildings)	Minimum lease payments		Present value of minimum	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Within one year	**82**	82	**17**	17
Between one and five years	**82**	163	**18**	33
After five years	**0**	0	**0**	0
Less future finance charges	**(129)**	(195)		
Minimum Lease Payments / Present value of minimum lease payments	**35**	50	**35**	50
Included in:				
Current borrowings			**17**	17
Non-current borrowings			**18**	33
			35	50

Amounts payable under finance leases (Land)	Minimum lease payments		Present value of minimum	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	0	0		
Minimum Lease Payments / Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
Total			**0**	0

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	0	0		
Minimum Lease Payments / Present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
			0	0

Finance leases as lessee	**31 March 2014**	31 March 2013
	£000s	£000s
Future Sublease Payments Expected to be received	0	0
Contingent Rents Recognised as an Expense	0	0

34 Finance lease receivables as lessor

The Trust does not act as a lessor

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum**	
Of minimum lease payments	**31 March 2014 £000s**	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Gross Investment in Leases / Present Value of Minimum Lease Payments	**0**	0	**0**	0
Less allowance for uncollectible lease payments:	**0**	0	0	0
Total finance lease receivable recognised in the statement of financial position	**0**	0	**0**	0
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (land)				
Of minimum lease payments	**31 March 2014 £000**	31 March 2013 £000	**31 March 2014 £000**	31 March 2013 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Gross Investment in Leases / Present Value of Minimum Lease Payments	**0**	0	**0**	0
Less allowance for uncollectable lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	**0**	0	**0**	0
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

Amounts receivable under finance leases (Other)				
Of minimum lease payments	**31 March 2014 £000**	31 March 2013 £000	**31 March 2014 £000**	31 March 2013 £000
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	0	0		
Gross Investment in Leases / Present Value of Minimum Lease Payments	**0**	0	**0**	0
Less allowance for uncollectable lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	**0**	0	**0**	0
Included in:				
Current finance lease receivables			**0**	0
Non-current finance lease receivables			**0**	0
			0	0

	31 March 2014 £000	31 March 2013 £000
The unguaranteed residual value accruing to the [organisation]	0	0
Accumulated allowance for uncollectible minimum lease payments receivable	0	0

Rental revenue	**31 March 2014**	31 March 2013
Contingent rent	**0**	0
Other	**0**	0
Total rental revenue	**0**	0

Finance lease commitments	0	0

35 Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2013	**2,152**	0	1,236	0		0	327	589
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0	0	0	0	0	0	0
Arising During the Year	**304**	0	299	0	0	0	5	0
Utilised During the Year	**(768)**	0	(516)	0	0	0	(40)	(212)
Reversed Unused	**(402)**	0	(25)	0	0	0	0	(377)
Unwinding of Discount	**0**	0	0	0	0	0	0	0
Change in Discount Rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2014	**1,286**	**0**	**994**	**0**	**0**	**0**	**292**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**687**	0	428	0	0	0	259	0
Later than One Year and not later than Five Years	**530**	0	497	0	0	0	33	0
Later than Five Years	**69**	0	69	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2014	10,751
As at 31 March 2013	6,854

There is an uncertainty about the timing of cashflows, but these are the best estimates available.

£0 of the Redundancy Provisions relates to the restructure of the Trust following a restructuring of Accident and Emergency Services. (31/03/2013 £589,039)
£249,133 of the Other Provisions relates to 1987 staff frozen leave entitlements. (31/03/2013 £275,552)
£42,558 of the Other Provisions relates to amounts due relating to Pre 1995 Retirements. (31/03/2012 £51,494)

£10,750,617 is included in the provisions of the NHS Litigation Authority at 31/03/2013 in respect of clinical negligence liabilities of the Trust. (31/03/2012 £6,854,318)

Included in provisions are £0 for which reimbursement is expected.

The contingent liability declared in note 36 relates to employee claims declared above.

36 Contingencies

	31 March 2014 £000s	31 March 2013 £000s
Contingent liabilities		
Equal Pay	**0**	0
Other	**(235)**	(460)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(235)**	(460)
Contingent Assets		
Contingent Assets	**0**	0
Net Value of Contingent Assets	**0**	0

The contingent liability shown relates to claims against the Trust for personal injuries allegedly sustained during the course of employment. There is also a provision related to this as declared in note 35.

37 PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2013-2014 £000s**	2012-2013 £000s
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**0**	0
Total	0	0
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0

The estimated annual payments in future years are expected to be materially different from those which the [organisation] is committed to make materially different from those which the [organisation] is committed to make during the next year. The likely financial effect of this is:

Estimated Capital Value of Project - off SOFP PFI	**0**	0
Value of Deferred Assets - off SOFP PFI	**0**	0
Value of Reversionary Interest - off SOFP PFI	**0**	0

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2013-2014 £000s**	2012-2013 £000s
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Subtotal	**0**	0
Less: Interest Element	**0**	0
Total	**0**	0

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2013-2014 £000s**	2012-2013 £000s
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0
Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	**0**	0
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**	0

Present Value Imputed "finance lease" obligations for off SOFP PFI contracts due Analysed by when PFI payments are due	**2013-2014 £000s**	2012-2013 £000s
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0
Number of on SOFP PFI Contracts		
Total Number of off PFI contracts	**0**	0
Number of off PFI contracts which individually have a total commitments value in excess of £500m	**0**	0

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT	**2013-2014 £000s**	2012-2013 £000s
Total Charge to Operating Expenses in year - OFF SOFP LIFT	**0**	0
Service element of on SOFP LIFT charged to operating expenses in year	**0**	0
Total	**0**	0

Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.	**2013-2014 £000s**	2012-2013 £000s
LIFT Scheme Expiry Date:		
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0

37 PFI and LIFT - additional information (Con't)

	2013-2014 £000s	2012-2013 £000s
The estimated annual payments in future years are expected to be materially different from those which the NHS [organisation] is committed to make during the next year. The likely financial effect of this is:		
Estimated capital value of project - off SOFP LIFT	**0**	0
Value of Deferred Assets - off SOFP LIFT	**0**	0
Value of Residual Interest - off SOFP LIFT	**0**	0

Imputed "finance lease" obligations for on SOFP LIFT Contracts due	**2013-2014 £000s**	2012-2013 £000s
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Subtotal	**0**	0
Less: Interest Element	**0**	0
Total	**0**	0

Present Value Imputed "finance lease" obligations for on SOFP LIFT contracts due	**2013-2014**	2012-2013
Analysed by when LIFT payments are due	**£000s**	£000s
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0
Number of on SOFP LIFT Contracts		
Total Number of LIFT contracts	**0**	0
Number of LIFT contracts which individually have a total commitments value in excess of £500m	**0**	0

Present Value Imputed "finance lease" obligations for off SOFP LIFT contracts due	**2013-2014**	2012-2013
Analysed by when LIFT payments are due	**£000s**	£000s
No Later than One Year	**0**	0
Later than One Year, No Later than Five Years	**0**	0
Later than Five Years	**0**	0
Total	**0**	0
Number of off SOFP LIFT Contracts		
Total Number of LIFT contracts	**0**	0
Number of LIFT contracts which individually have a total commitments value in excess of £500m	**0**	0

38 Impact of IFRS treatment - current year

	2013-2014 £000s	2012-2013 £000s
The information below is required by the Department of Heath for budget reconciliation purposes		
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	**0**	0
Interest Expense	**0**	0
Impairment charge - AME	**0**	0
Impairment charge - DEL	**0**	0
Other Expenditure	**0**	0
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**0**	0
Total IFRS Expenditure (IFRIC12)	**0**	**0**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**0**	0
Net IFRS change (IFRIC12)	**0**	**0**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2013-14	**0**	0
UK GAAP capital expenditure 2013-14 (Reversionary Interest)	**0**	0

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0			**0**
Receivables - NHS		1,835		**1,835**
Receivables - non-NHS		679		**679**
Cash at bank and in hand		6,013		**6,013**
Other financial assets	0	0	0	**0**
Total at 31 March 2014	**0**	**8,527**	**0**	**8,527**
Embedded derivatives	0			0
Receivables - NHS		5,395		5,395
Receivables - non-NHS		655		655
Cash at bank and in hand		6,094		6,094
Other financial assets	0	0	0	0
Total at 31 March 2013	0	12,144	0	12,144

39.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0		**0**
NHS payables		447	**447**
Non-NHS payables		2,993	**2,993**
Other borrowings		35	**35**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2014	**0**	**3,475**	**3,475**
Embedded derivatives	0		0
NHS payables		267	267
Non-NHS payables		1,188	1,188
Other borrowings		50	50
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2013	0	1,505	1,505

40 Events after the end of the reporting period

	£000
There are no events after the reporting period which are required to be reported	0

41 Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with East Midlands Ambulance Service NHS Trust.

	Payments to Related Party £000s	Receipts from Related Party £000s	Amounts owed to Related Party £000s	Amounts due from Related Party £000s
2013 - 2014				
Nene CCG	0	17,037	0	322
Southern Derbyshire CCG	0	14,901	0	136
Nottingham City CCG	0	11,420	166	0
Leicester City CCG	0	10,680	0	123
West Leicestershire CCG	0	8,297	0	303
Lincolnshire East CCG	1	8,184	12	85
North Derbyshire CCG	0	7,858	80	0
East Leicestershire And Rutland CCG	0	6,787	0	119
Lincolnshire West CCG	0	6,777	0	71
North Lincolnshire CCG	0	6,348	0	280
North East Lincolnshire CCG	0	6,180	0	188
Mansfield And Ashfield CCG	0	6,088	0	42
South Lincolnshire CCG	0	4,612	0	41
Erewash CCG	0	4,162	0	32
Newark & Sherwood CCG	0	4,133	62	22
Nottingham North And East CCG	0	3,980	0	25
South West Lincolnshire CCG	0	3,865	0	36
Bassetlaw CCG	0	3,847	0	117
Hardwick CCG	0	2,987	0	77
Nottingham West CCG	0	2,372	0	70
2012 - 2013				
Bassetlaw PCT	0	3,776	0	69
Derbyshire County PCT	0	22,498	0	1,436
Leicester City PCT	0	10,718	0	698
Leicestershire County & Rutland PCT	0	16,143	0	489
Lincolnshire PCT	187	24,265	31	966
NHS Derby City	0	7,821	0	38
NHS Northamptonshire	0	19,348	0	1,002
North East Lincolnshire Care Trust Plus	0	5,900	0	54
North Lincolnshire PCT	0	6,063	1	210
Nottingham City PCT	0	12,101	152	3
Nottinghamshire County PCT	37	19,410	0	19
East Midlands SHA	0	2,657	0	309

Members of the Trust Board are also Trustees of the East Midlands Ambulance Service Charitable Fund. During the year the Trust made payments on behalf of the Charitable Fund of £90,040.44 (2012 - 2013 £23,753.28) with no amounts written off.

As at March 2014 there was a balance due to the Trust from the Charitable Fund of £53,817.05 (2012 - 2013 £3,373.81). These transactions are included in the Trustees Annual Report and Accounts of the East Midlands Ambulance Service NHS Trust Charitable Fund.

The Trust engages with the Trustees of the three air ambulance charities that service the East Midlands area.
The Trust has a service agreement with the charities and provides clinical staff in support of the service. No fees or charges are levied between the Trust and the charities.
During the year one member of the Trust's staff and one Non-Executive member of the Trust Board acted as Trustees of Lincolnshire & Nottinghamshire Air Ambulance.

42 Losses and special payments

The total number of losses cases in 2013-2014 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	1,995	8
Special payments	707	4
Total losses and special payments	2,702	12

The total number of losses cases in 2012-2013 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	3,511	8
Special payments	6,096	12
Total losses and special payments	9,607	20

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s
Turnover	0	125,020	134,151	147,587	156,570	161,643	169,533	155,041	**150,131**
Retained surplus/(deficit) for the year	0	238	298	1,564	(7,172)	120	2,396	(328)	**391**
Adjustment for:									
Timing/non-cash impacting distortions:									
Pre FDL(97)24 Agreements	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0								
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0							
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0						
Adjustments for Impairments				0	9,188	347	(994)	358	**(384)**
Adjustments for impact of policy change re donated/government grants assets							0	0	**54**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					0	0	0	0	**0**
Adsorption Accounting Adjustment								0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	**0**	**0**
Break-even in-year position	**0**	**238**	**298**	**1,564**	**2,016**	**467**	**1,402**	**30**	**61**
Break-even cumulative position	**0**	**238**	**536**	**2,100**	**4,116**	**4,583**	**5,985**	**6,015**	**6,076**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %
Materiality test (I.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	0.00	0.19	0.22	1.06	1.29	0.29	0.83	0.02	0.04
Break-even cumulative position as a percentage of turnover	0.00	0.19	0.40	1.42	2.63	2.84	3.53	3.88	4.05

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2013-2014 £000s	2012-2013 £000s
External financing limit (EFL)	**512**	5,744
Cash flow financing	**66**	5,541
Unwinding of Discount Adjustment	**0**	0
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**66**	5,541
Undershoot against EFL	**446**	203

43.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2013-2014 £000s	2012-2013 £000s
Gross capital expenditure	**5,269**	5,399
Less: book value of assets disposed of	**(33)**	(317)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**0**	0
Charge against the capital resource limit	**5,236**	5,082
Capital resource limit	**6,361**	5,392
Underspend against the capital resource limit	**1,125**	310

44 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2014	31 March 2013
	£000s	£000s
Third party assets held by the Trust	**0**	0

Annual Report 2013/2014

Produced by:

East Midlands Ambulance Service NHS Trust

Trust Headquarters

1 Horizon Place

Mellors Way

Nottingham Business Park

Nottingham

NG8 6PY

Call: 0115 884 5000

Email: communications@emas.nhs.uk

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Annual Report

A review of the EMAS year

2012/2013

Annual Report
2012/2013

Foreword

Welcome to the East Midlands Ambulance Service (EMAS) NHS Trust Annual Report for the period 1 April 2012 to 31 March 2013.

Within this report we have identified our main achievements for the year, which are a tribute to the commitment and professionalism of our staff. We also value the support given by many volunteers all of whom provide a valuable resource in the delivery of patient services. In addition, we acknowledge the involvement of patients and their representatives in the work that we do.

We hope you find our Annual Report to be interesting and informative.

If you would like to learn more about East Midlands Ambulance Service please visit us at www.emas.nhs.uk

Chairman's Report

In June 2012, 999 – the world's first emergency phone number – celebrated its 75th anniversary.

At the time people were sceptical as to whether the idea would catch on yet today services like ours prove the opposite is true. On average we receive a call every 45 seconds and demand on our service is rising by around 6 per cent year on year. Widespread ownership of mobile phones means we can often receive more than one call relating to an incident. Today's pace of life is faster than ever before and callers want an immediate solution.

We're committed to responding to the changing expectations of our patients, their families and carers as well as those who commission our service. That's why this year has been a watershed moment for EMAS, where we've recognised the need to examine traditional ways of working and further prioritise innovation.

In common with all NHS organisations we are being asked to do more with less and our response to the challenge was our *Being the Best* programme. This addressed: our management structure; the properties owned and leased by the organisation; our service delivery model and; working practices. You can read more about the specific areas for change within this Annual Report.

We believe *Being the Best* is essential to safeguard our operations both now and in the future. It also showed us the interest people have in their ambulance service. This was evidenced by the number of detailed responses to our 92-day public consultation on the proposals.

It is essential we tackle issues with our response times. We are hitting many of our targets but not consistently throughout the year. The Board and staff throughout the organisation want to ensure our response times are continually improved. Further, we want this improvement to be achieved across the whole area we serve. To do this we had to address our estate and invest in more staff and vehicles as well as update our working practices. For example, we have introduced more emergency care practitioners, with additional skills to paramedics who can treat more patients safely in the comfort of their own home and avoid unnecessary trips to hospital. This work is on-going and you can read more throughout this report but we are looking forward to measuring the results.

Response times, although key, are just one element of a quality service. The Board has continued to make regular visits to each of the service's divisions to ensure we are delivering on the areas covered in our Quality Accounts. These include patient safety, the efficacy of our care and our ability to listen to patient feedback and use it meaningfully to shape services.

Undoubtedly the past 12 months have seen much change and we have been grateful to staff for their trust and commitment to this process. EMAS has perhaps received more scrutiny than ever before but we've embraced this as a chance to demonstrate our commitment to openness and to share decision-making with the partners, patients and members of the public we serve.

We are certainly leaving this year in a unique position, with a real opportunity to fulfil our ambitions to be the best.

Jon Towler
Chairman

Chief Executive's Report

In the year the Olympics and Paralympics came to London there has been lots of talk about who the public view as 'heroes'.

For many it will be the sportsmen and women who had their moment last summer but for others it will be our staff, including those who volunteered to work the Games and ensure the safety of participants and spectators.

Our staff are our strength and I'm reminded of this daily. Earlier this year I presented a number of commendations to staff who had gone above and beyond the call of duty, including: the ambulance crewmates who rescued a man from a blazing car; the paramedic who stopped an assault on his way home from work and; the hazardous area response team (HART) members who rescued a patient from a burning building.

I was also delighted that Lisa Harrison, one of our emergency medical dispatchers, won the BBC's 999 Awards' 'Operator of the Year' title. Lisa gave instructions to a father on how to treat his one-year-old son who had fallen into a pond. Her advice ensured the child had enough oxygen to survive until an ambulance arrived to treat him.

These stories reflect that we are in the business of saving lives. Undoubtedly this year has been focussed on change to make sure we continue to provide the best possible service to the public. Ensuring we are ready to meet patients' needs both now and in the future was the motivation for our *Being the Best* change programme. It took a holistic view of our service in terms of questioning how far our buildings, our management structure and our working practices either contributed to or hindered our performance.

We need to make the most of our resources because in the current climate, funding is always going to be an issue. This, allied with the public's expectations of what we can deliver being greater meant things had to change. Our *Being the Best* programme will allow us to further improve quality by making sure the organisation and our staff have the right skills and equipment to do the job and that the way we manage and deliver our services is fit for purpose. We were grateful to all staff, partners and members of the public who had their say on our proposals. We have started to deliver the changes recommended and know this will result in a better performing, more sustainable service. The presence of a long-term, detailed and coherent strategy will allow us to meet the challenges ahead.

The publication of the Francis Report in early 2013 reminded all NHS organisations that quality care must always be our primary concern. The report's findings are a stark warning of what can happen if targets are put before patients.

Achieving our performance targets, including the time it takes us to respond to calls, must continue to be a clear focus but always in the context of our wider aim to deliver quality care.

We continue to strive for clinical excellence by robustly monitoring our clinical performance indicators and prioritising research. The National Institute of Health Research has identified EMAS as one of the NHS' top performing organisations in this respect and this is important, as research helps us to stay at the forefront of new treatments and clinical best practice.

Investing in our people is a key way to ensure patients have the best experience possible and this year we were the first UK ambulance trust to sign a Joint Learning Agreement with staff unions. This was a very public commitment to support staff's learning and development. We also secured funding for at least 16 study placements at masters degree level and above.

Being the Best has been our most high profile commitment to innovation but its overarching goals are supported by many smaller schemes.

In Northamptonshire, our Crisis Response Falls Team, designed in partnership with Northamptonshire County Council, scooped a National Patient Safety Award. The service was set up in recognition of the large volume of calls the service receives relating to falls, especially from older people. The specialist team can treat those who have fallen and in most cases avoid an unnecessary hospital admission. Patients are then signposted to community and social care services which can help them avoid a repeat incident.

We are also the first ambulance trust to pioneer Radio Frequency Identification (RFID), which uses sensors to reliably record when crews arrive with patients at hospital emergency departments and when that crew has

‘handed over’ the patient and is clear to take other calls. Lengthy hospital handovers threaten our response times and we are working with acute trusts to address this issue in partnership.

Our organisation is committed to improvement but there is still much to do. We hope that by reviewing the year to date we can offer an insight into our challenges and our opportunities. We will continue to work with staff, partners and the public to ensure we are the best we can be.

Phil Milligan
Chief Executive

A profile of the Trust

The East Midlands Ambulance Service (EMAS) provides emergency and urgent care, patient transport, call handling and clinical assessment services for 4.8 million people in an area covering approximately 6,425 square miles across the six counties of Derbyshire, Nottinghamshire, Lincolnshire, Northamptonshire, Leicestershire and Rutland.

We cover the full area of the (former) East Midlands Strategic Health Authority plus North Lincolnshire and North East Lincolnshire within Yorkshire and Humber Strategic Health Authority.

We employ over 2,500 staff at more than 70 locations, including two Emergency Operations Centres at Nottingham and Lincoln, with the largest staff group being our accident and emergency 999 crews. We operate a fleet of around 700 vehicles, including emergency ambulances, fast response cars, specialised vehicles and patient transport vehicles. Our overall annual expenditure budget in the year was £167 million.

Every day we receive around 1,660 calls from members of the public who have rung 999 - this is the equivalent of receiving a 999 call every 45 seconds of every day.

Accident & Emergency Service (A&E)

As well as a resident population of just over 4.8m people, we have to meet the demands placed on us by visitors who fall ill or suffer an injury. With four large cities, major arterial roads, an international airport, a lengthy coastline and several country parks, this extra activity, especially during the summer months, is significant. Apart from the challenges posed by our geographical boundaries and the region's infrastructure, EMAS has to cope with year on year increases in the number of 999 calls made by the public.

In support of our conventional ambulances, we receive valuable assistance from a large number of Community First Responder Schemes (CFR) which provide emergency cover mainly in the more rural areas we serve. We also benefit from the presence of three separate air ambulances which permanently operate across the area we serve which are operated by registered charities. In addition, we have a team of doctors who provide both a primary response role to life-threatening calls and clinical support for crews at serious clinical incidents such as road traffic collisions.

We also operate a Hazardous Area Response Team which comprises of over 40 personnel specially trained in dealing with Chemical, Biological, Radioactive and Nuclear (CBRN) incidents and Urban Search and Rescue techniques.

We will further improve patient care, by ensuring that patients consistently receive the right response, the first time and on time. Our approach also means that more patients will be treated in the community, and fewer people will go to A&E unnecessarily.

Patient Transport Service (PTS)

Non-emergency PTS is provided for people who need to attend a hospital or clinic for routine outpatient appointments or day care sessions. This service provides much needed support to patients (and their carers) as part of the overall health-care package. Following a competitive tendering exercise, from July 2012, EMAS no longer provides PTS other than in North and North East Lincolnshire. The loss of this work had a significant impact on EMAS' financial position.

Call handling and clinical assessment

Our Clinical Assessment and Advice Service dealt with 39,991 calls during the year. This allows the Trust to provide patients with an alternative care pathway leading to fewer admissions to accident and emergency departments. We are committed to further improving the speed and quality of our call handling and work in a more integrated way with partners to ensure consistent clinical advice for patients who need urgent care.

The EMAS Trust Board

The EMAS Trust Board comprises of 13 members:

- Chairman
- Chief Executive
- 6 Executive directors
- 5 Non-Executive directors

The Board's role is to:

- Agree a common set of objectives that set the high-level direction of the Trust - Objectives
- Determine whether it can robustly achieve its objectives based on - Risk analysis
- Establish governance systems enabling it to monitor and achieve its objectives – Controls
- Understand what information it needs – Assurance.

The Trust Board's main functions encompass:

- Formulating policy and foresight (in relation to the external environment). Stating purpose, vision, values, culture and climate
- Thinking strategically. Positioning in the health community, setting corporate direction, reviewing and deciding key resources, deciding implementation processes
- Supervising management (the patterns not detail). Monitoring budgetary control, reviewing key results, ensuring organisational capability
- Exercising accountability to stakeholders and ensuring directorial audits.

Executive directors are responsible for managing EMAS' affairs on a day-to-day basis under approved Board policy and statutory requirements.

In accordance with good governance practice, the Board of directors includes a balance of independent Non-Executive directors with skills and expertise in the public and private business sectors which complement those of our executive directors. None of our directors or Non-Executive directors have declared any interests which conflict with their responsibilities to the Trust.

The Trust Board and management operate within an assurance framework based on the 'Combined Code of Corporate Governance' articulated through its Governance Strategy (2007). This strategy clearly identifies the types of decisions reserved to the Board and which may be taken by management. The Board takes assurance for the performance management of delivery of its objectives to the Audit and Clinical Quality & Governance Committees which receive their assurances from lead managers and directors through the Trust's integrated performance management system.

On-going self-assessments to monitor the performance of our key committees are carried out as part of our review process.

The following tables identify the number of attendances made by each Board member at our three key meetings:

Board meetings

Executive Directors	Possible attendances	Actual attendances
P Milligan	8	8
J Sargeant	6	6
D Farrelly	8	8
K Glover	8	7
J Gray	8	8
P Ripley	5	5
S Cascarino	3	3
A Schofield	3	3
I Turnbull*	2	2

* Attended as Acting Director of Finance

Non-Executive Directors	Possible attendances	Actual attendances
J Towler	8	7
G Austin	8	8
P Tagg	8	8
G Newton	8	8
S Dawkins	8	8
D Toberty	8	8

Audit Committee meetings

Non-Executive Directors	Possible attendances	Actual attendances
G Austin	6	5
S Dawkins	6	6
D Toberty (Chair)	6	4
G Newton	6	6

Quality & Governance meetings

Executive Directors	Possible Attendances	Actual Attendances
J Gray (Lead Executive)	7	6
K Glover	7	5
K Gulliver*	1	1
D Farrelly	5	4
P Ripley	6	5
Sheila Cascarino	1	0

* Attended as Acting Director of Workforce

Non-Executive Directors	Possible attendances	Actual attendances
P Tagg (Chair)	7	7
J Towler	7	7
S Dawkins	7	7
G Newton	7	6

The operating environment

Becoming the best ambulance service

In 2012, EMAS developed a vision, to become “a leading provider of high quality and value for money clinical assessment and mobile healthcare.” We have captured our plans under the banner of ‘Being the best ambulance service’. In pursuit of this target, a comprehensive review was carried out and key change programmes developed to ensure the Trust can provide high quality care, be financially sustainable and be effectively managed. Plans were captured in the following documents:

- **Quality strategy** (which sets out how we will provide high quality clinical care to the patient throughout their clinical journey)
- **Service model** (how we will organise clinical services to respond to patient’s needs)
- **Estates strategy** (how we will use buildings to support clinical activity)
- **Workforce strategy** (how we will ensure that we always have trained, motivated staff with the right skills and experience)
- **Operating model** (how we will organise the management approach, including the roles of executive team members, the Trust Operational Management structure and our committee structure)

The proposals contained in the above documents were submitted to the Trust Board in April 2012 and agreement reached to proceed (where appropriate) to the consultation phase. This was a cornerstone of EMAS' work during 2012/2013 and pivotal to the organisations performance.

The financial environment

As in the year under review, EMAS continues to face significant financial challenges in 2013/2014 to reduce its operating scale combined with the drive to improve efficiency and productivity. Again, the greatest challenge will be to embed delivery of national performance standards within available funds. This will provide mitigation against a number of key financial risks and continue to build EMAS' reputation as a strong brand in the delivery of emergency and urgent care.

The financial plan reflects the challenges we face during the next 12 months and proposed methods of mitigating them. It is designed to deliver:

- 1.5% revenue surplus
- National performance standards regionally
- Cost Improvement Programme savings of £6,050k (£m)
- Financial Risk Rating 4
- Achievement of statutory financial duties whilst an NHS Trust
- Tripartite Financial Milestones (these identify the key strategic and operational issues, the actions to address them and the key milestones that will need to be met to enable our FT application to be submitted on the agreed date)

Service improvement

Business Planning Managers deal with the implementation of the strategic direction by developing new models of care and adopting methods of transformational change. This means:

- Ensuring EMAS has robust links with the Emergency Care Networks (other organisations providing emergency care services)
- Improving the understanding of EMAS' role in the redesign of service delivery
- Avoiding the duplication of work programmes across the Emergency Care Networks
- Tackling national and local priorities and developing action plans
- Promoting new ways of working across the EMAS area in true partnership with the healthcare
- community, including NHS Direct, Acute and Primary care, Social Care and Mental Health

Foundation Trust status

EMAS reviewed its planned Foundation Trust (FT) submission in October 2012, with the Midlands and East SHA Cluster and undertook a further review in February 2013.

The SHA concluded that overall, the EMAS' application was on the right trajectory and they were very confident that EMAS would be in a stronger position by delaying the submission of a FT application by a further period of 4-5 months to give time to demonstrate a credible track record of delivery against Cost Improvement Plans (CIPs) and service performance with the aim of achieving NHS Foundation Trust status in 2014.

In preparation for our application to the Department of Health and subsequently Monitor (independent regulator of foundation trusts), we will continue to focus on the development of our five year Integrated Business Plan (IBP), our Long Term Financial Model (LTFM) and the enabling strategies that will support the delivery of our five year IBP.

The application process to become a NHS Foundation Trust is a well-structured and robust process set out by the Department of Health and Monitor and results in a sixteen week rigorous assessment process by Monitor.

To ensure we are successful in our application for Foundation Trust status, EMAS must be able to demonstrate that we have a clear strategic direction of travel (IBP), that we are and can remain financially viable for the longer term (LTFM) and that we have robust governance structures in place (IBP and assessment by Monitor).

One of the many benefits of applying to become a NHS Foundation Trust is that we can recruit members and governors. This means that EMAS is accountable to its local population, enabling local ownership and service influence. NHS Foundation Trusts remain part of the NHS and we will continue to be subject to NHS standards, providing care paid for by the NHS, to NHS patients.

The Trust has proudly recruited over 19,000 staff and public members since announcing our plans to apply for NHS Foundation Trust status and we will continue to recruit and engage with our members to enhance our local accountability and involve local people in our future service developments.

Our achievements at a glance

During the period under review, EMAS continued to make significant progress on a broad range of initiatives. The following information provides a snapshot of key developments within each of our Directorates.

Operations Directorate

Operational performance

During 2012/2013, we received 763,948 emergency 999 calls from members of the public. Our accident and emergency crews responded to 570,110 of these calls, which equates to 1562 responses every day. Of these, 234,508 were Category A (serious, life threatening calls). There are two national performance standard for Category A, life-threatening calls, the first requires us to respond to at least 75% of incidents in 8 minutes (or less), the second requires us to provide a support vehicle within 19 minutes (or less) for 95% of calls. In the year under review, we achieved a response rate of 75.21% (response within 8 minutes) and 91.85% (support vehicle within 19 minutes). We were pleased to exceed the 75% target but accept that more work needs to be done in 2013/2014 to achieve the 95% standard.

39,991 calls were dealt with by our Clinical Assessment and Advice Service. This allows the Trust to provide patients with an alternative care pathway leading to fewer admissions to accident and emergency departments. We are committed to further improving the speed and quality of our call handling and working with partners to ensure consistent clinical advice for patients who need urgent care.

EMAS wide developments

Whilst our Divisions have the freedom to make localised changes, some issues affect all Divisions and are managed on an EMAS' wide basis. Key developments during the year were:

Restructure

As an integral part of our Being the Best agenda, the operations Directorate was restructured to support and enhance the quality of care, with clinical leadership embedded through the roles of Consultant Paramedics, Locality Quality Managers and Clinical Team Mentors. The restructure will ensure effective communication by creating clear lines of accountability and fewer managerial tiers. Also, new rotas were developed to ensure we aligned our resource levels to reflect 999 demand trends. Our Divisions were also rationalised from 5 to 3.

HALO initiative

The introduction of Hospital Ambulance Liaison Officers (HALO) based at the main A&E Units we serve to ensure patients are not delayed when arriving at hospital, to support crews and build effective relationships between the hospital and Ambulance staff

Directory of Services (DoS)

This now gives all frontline staff access to a database of resources allowing them to explore the alternative treatment pathways available in the area. This approach means more patients are now treated in their home (or local) environment and reduces unnecessary admissions to A&E. As more pathways are introduced, these are added to the DoS giving staff instant access to the most up-to-date information available.

Resource Management Centre (RMC)

This was launched in March 2012 and now plays a key role in coordinating frontline A&E and EOC (Control) staff resources (rota management, annual leave, absence and sickness) as well as A&E vehicles resources (vehicle tracking and allocation based upon demand trends. This facility replaced the previous approach of managing resources on a Divisional basis which led to some inconsistencies and lack of coordination. We now have a comprehensive picture of the resources available across the Trust - enabling us to plan how many staff are on shift and at what times of day and how many vehicle resources are available at specific times and in

specific areas. This improves the way we match resources to predicted patient demand - providing improved services to our patients and offering improved working arrangements for our frontline staff.

Radio Frequency Identification

To ensure the arrival and departure times of ambulance at A&E departments are accurately recorded, in early 2013 we introduced a pilot scheme in which patient carrying equipment is fitted with transmitters (and hospital departments with receivers) so the movement of patients is automatically recorded. The pilot scheme was successful and during 2013, the system will be expanded to all of the main A&E receiving units we serve.

Electronic Patient Record (EPR)

This system has now been rolled-out to all Divisions. It allows us to connect with GPs and send a copy of the ePRF to them direct so they are aware of the nature of the injury or illness suffered by their patient and the treatment given by EMAS medics. This provides greater continuity in patient care. It gives us the ability to access patients' summary care record (which is based upon an extract of the GP record). This will improve patient safety as, for example, staff will know about pre-existing medical conditions, medications and allergies and, in the longer term, information about the patient's wishes such as end of life care.

Clinical Assessment

Our Clinical Assessment facility (which operates at both our Emergency Operations Centres) is staffed by experienced Nurses and Emergency Care Practitioners (ECPs) with a vast range of skills over and above basic triage assessment. The staff are from a wide variety of backgrounds and clinical settings and provide evidence based practice to support clinical decision making. After a detailed assessment, the nurses refer patients on to an appropriate service to meet their clinical needs and provide the appropriate care pathway, often in the community, without the need for the patients to attend hospital. During the year we increased staffing levels to enable the team to assess all categories of call. Each week, around 25% of calls (below Category A level) are dealt with without the need to send an ambulance.

High Volume Service User (HVSU)

Our HVSU process continues to allow us to work with PCTs, Acute Trusts, Mental Health Trusts, Social Services and other agencies to manage patients appropriately in the right health community service setting. Our approach to managing HVSUs has been acknowledged locally and nationally as good practice. In conjunction with the Local Security Management Specialist (LSMS), individuals identified as abusing the 999 service are also being managed through partnership working with local Police Forces and Community Protection Teams. In some instances this has led to prosecution and other sanctions being taken.

Community First Responders (CFR)

During the year, we continued to recruit people to this highly valued scheme. Community First Responders (CFR) are trained to deliver early Basic Life Support and early defibrillation prior to the arrival of an ambulance resource. They support EMAS by providing assessment, oxygen therapy and general patient care in their local community. Several different types of scheme operate across EMAS' area, all of which come under the generic description of CFRs - Lincolnshire Integrated Voluntary Emergency Service (LIVES), East Midlands Immediate Care Scheme (EMICS), Fire Co-responder schemes and independent CFR schemes.

Hazardous Area Response Team (HART)

Our HART Team provided invaluable support to patients in areas or environments that require staff to use specialist skills, techniques or equipment. The team has worked closely and formed excellent working relationships with colleagues from the Police Forces and Fire and Rescue Services across our Region. Our HART team can enter and provide treatment to patients in the inner cordon or the 'hot zone' of incidents and save lives that may otherwise have been be lost. The longer-term medical implications for patients rescued from hazardous environments have been reduced due to early clinical assessment, triage and treatment and the overall health service response to dealing with hazardous incidents is now being managed more effectively than ever before. Many members of our HART team provided support to the London Ambulance Service during the Olympics 2012.

Emergency Preparedness

The Emergency Preparedness Team continued to be busy meeting a number of challenges in 2012 and took part in a series of exercises to test plans for dealing with incidents. During 2012, the team became increasingly involved with the Multi Agency planning processes associated with the Olympic and Paralympic Games. This included operational planning for the Olympic Torch relay visits to the East Midlands and providing a number of EMAS staff to support colleagues from the London Ambulance Service during the games period.

The Emergency Preparedness team continued to work in partnership with a range of external agencies and have received significant support from within EMAS to help the Trust meet its obligations for maintaining resilience against known and potential risks.

Events Team

This team continued to support operational delivery by providing an ambulance presence at a wide range of major sporting venues within the region such as football grounds, race courses, rugby clubs and cricket clubs. The team also attends other public events across our area with high numbers of visitors. During the year, the team enjoyed a good track-record of successful clinical interventions thus demonstrating the benefit of having professional first aid cover available at large scale public events. Contracts have been agreed with all our major customers and the events team will continue to provide an excellent service to each of them.

111 scheme

During the year we worked with existing and new providers and Primary Care Trusts to ensure processes were in place to guarantee that patients who required an ambulance following assessment through NHS Pathways received it without delay. Furthermore, to ensure a prompt ambulance response, we introduced a direct feed from 111 providers into our Computer Aided Despatch (CAD) system so EMAS dispatchers can see immediately when a response is required from EMAS.

Estates

During 2012/2013, the team was heavily involved in developing a new estates model which formed a key part of our Being the Best improvement plan. This work included an assessment of existing property values, developing proposals for a rationalisation of premises, researching potential locations and establishing how the new proposals would impact on response times to emergencies.

Logistics

We continued to build on the improvement plan by making further improvements to overall efficiency and performance and refining our supply chain systems and processes (including developing good Corporate Citizen activities). The team continued to work closely with the Infection Prevention & Control team to ensure appropriate cleaning and patient care materials are sourced and readily available across EMAS.

Our in house medical equipment servicing / engineering team, based at Alfreton, Derbyshire is now fully established and carry out much of their work from a mobile workshop which provides medical engineering services across our area. The engineers have been trained by the manufactures of the medical devices used by EMAS and are continually updated as new equipment is introduced. During 2012, the team extended their maintenance services to include equipment utilised by volunteer Community First Responder groups.

Security Management

Our Local Security Management Specialist (LSMS) continues to provide support and advice to managers and staff involved in aggressive or violent incidents.

During 2012 /2013, our Accident and Emergency crews reported 592 aggressive or abusive or other criminal incidents, compared to 343 for 2011/2012. Our LSMS reported 87 intentional physical assaults to NHS Protect for information.

We prosecuted 53 people for assaulting or abusing front-line EMAS staff (securing criminal convictions) and have a further 27 cases currently under investigation by Police. We also currently have 10 cases awaiting court /trial for offences committed in 2012 /2013 and obtained other sanctions such as issuing warning letters against 177 people who had assaulted or abused our staff. We are satisfied that this approach will convey the

message to the public that abusing or assaulting EMAS staff is not acceptable and that EMAS will take action. Drugs and alcohol were identified as influencing factors in 240 of the 592 reported incidents.

Media interest continues in this specialist area of work, with several cases receiving national coverage. This highlights the efforts EMAS makes to protect staff. Our figures for sanction delivery against those who assault our staff are the highest within the entire NHS for the third year in a row.

Fleet

A new strategy was developed to have a Michelin cold weather tyre on all operational vehicles all year round to provide resilience and business continuity – this is totally safe and more economical with no additional down time that we had with previous tyre programmes

30 new double crewed Accident and Emergency Ambulances with a traction control facility (that assists them when operating in harsh weather conditions) were commissioned into service based on standardised layout with improvements suggested by staff. 7 Accident and Emergency Fast Response Cars (with a standardised layout mirroring the successful work we have seen with the double crewed ambulances) were designed and built. 4 bespoke PolAmb response vehicles for Nottinghamshire and Leicestershire were introduced and 2 bespoke Falls Service vehicles for Nottinghamshire.

To provide improved and safer care of bariatric patients, 3 Bariatric support vehicles (one for each new division) were commissioned and 3 more will be purchased in 2013.

Following the loss of PTS contracts, the fleet profile was consolidated to cater for a reduction in the overall fleet size by some 200 vehicles.

Tenders for vehicle recovery and vehicle body repair were invited from with third party providers to ensure cost efficiency and effective services are available.

Divisional developments

The following section identifies the main achievement of each of our (former) Divisions:

Managers and staff in Derbyshire Division:

Developed and introduced a pathway in conjunction with Derby city and Amber Valley Falls service allowing staff to contact the service and mutually agree what services and assistance is available for those at risk of having further falls with the aim of preventing potential injury which may lead to hospitalisation. This will make the home environment safer and reduce future calls to EMAS.

Introduced a single point of access (SPA) procedure (in association with the healthcare community and social services) to provide urgent care transport to appropriate patients leading to fewer travelling on frontline ambulances.

Managers and staff in Lincolnshire Division:

Improved care management for conditions that could safely be dealt with over the telephone by the secondment of an Emergency Care Practitioner (ECP) into our Emergency Operations Centre.

Developed a number of alternative referral pathways into primary care and other healthcare providers in Lincolnshire to better manage patients who need assistance outside of normal hours. This approach is now being rolled-out in North and North east Lincolnshire.

To better manage patients who need assistance during daytime hours and can be more appropriately cared for in the community, worked in association with Clinical Commissioning Groups (CCG) to develop referral pathways.

Introduced new referral pathways (to mobile outreach teams) for patients at risk of suffering 'repeat episodes' (such as hypoglycaemia). This built on the initiatives already in place for falls prevention and management of patients with chronic conditions.

Managers and staff in Northamptonshire Division:

Won the National Patient Safety Award 2012 for working in partnership working with other healthcare providers and launching a Crisis Response Falls Team (CRFT). This integrated service for patients who have suffered a fall aims to limit the effects of fall and promote independence into the future. Patients are assessed and if hospital admission is not necessary, a holistic approach is taken where the patient and the home environment is assessed to prevent repetition. The Crisis Response Falls Team has access to Community Consultant Geriatricians, Community Pharmacists and Community Psychologists and can also take patients direct to a Specialist (fall) Care Centre. The CRFT initiative was also a finalist in the Health Service Journal Awards 2012, Nursing Times Awards 2012, Great British Care Awards, Care Integration 2012 Awards and the Local Government Chronicle 2013 Awards.

Our Crisis Response Falls Team, designed in partnership with Northamptonshire County Council, scooped a National Patient Safety Award. The service was set up in recognition of the large volume of calls the service receives relating to falls, especially from older people. The specialist team can treat those who have fallen and in most cases avoid an unnecessary hospital admission.

Managers and staff in Leicestershire & Rutland Division:

Extended to Loughborough town centre the Polamb scheme (already operating in Leicester city centre) in which a Police / Ambulance vehicle is staffed by a paramedic and a Police Officer to achieve an excellent non-conveyance rate as well as reducing the risk of verbal or physical aggression towards ambulance crews.

Continued to build and develop the workforce by introducing more Emergency Care Practitioners (ECPs) with additional training and a wider range of skills than a paramedic. ECPs can refer patients to appropriate services or provide treatment in their homes, thereby saving unnecessary journeys to A&E. Also, a pilot of two ECPs for GPs to refer patients directly to has also been created to build relationships with local surgeries and care homes, again preventing admissions to hospital.

Extended the availability of the Ambulance Support Vehicle (ASV) for patients with low level medical conditions who can walk without assistance. The vehicle is staffed by a Paramedic and an Emergency Care Assistant and allows the treatment and transportation of multiple patients (up to three where appropriate), ensuring we are saving many hours of traditional ambulance time.

Piloted a 'GP in a car' scheme also to reduce A&E admissions. The scheme sees three GPs on duty each day, each going out with a paramedic from EMAS in response to calls from patients. During March 2013, more than 100 patients (nearly 60% of those seen) were able to have treatment at home.

Managers and staff in Nottinghamshire Division:

Secured funding to operate two Polamb vehicles, one in the Nottingham city centre, the other in Mansfield town centre. The vehicles are also available to be used at large scale public events.

Developed a series of urgent care pilot schemes to provide a dedicated resource for the transport of non-critical patients between hospitals and more appropriate pathways for patients who do not need to attend A&E.

One of the pilots involves a dedicated resource working with the (out of hours) Nottingham Emergency Medical Service and the Queen's Medical Centre to transport GP booked patients to hospital earlier in the day. This allows a full diagnostic assessment to be carried out and more timely decision made to admit/discharge the patient.

Emergency Operations Centres

Managers and staff:

Introduced an enhanced clinical assessment model to ensure that any patient subject to a delay in response would receive a follow-up telephone clinical assessment to correctly identify the most resource was deployed.

Introduced a new facility in which a dedicated Helicopter Emergency Service and Hazardous Area Response Team desk operates to ensure either (or both) of these specialised resources are deployed to incidents requiring their presence. The same approach was used to improve the deployment of voluntary and private provider resources to emergencies.

Developed new ways of working with other emergency services to manage ambulance attendances at serious incidents (where, for reason of safety, our staff stand-by close to the scene). New procedures also now give Police officers the ability to speak directly with EMAS operators rather than having to communicate via the Police control room.

Carried out a comprehensive update of address databases and introduced a monthly database updates process to ensure the road and street gazetteer is no more than 4 weeks old.

Undertook a series of modelling exercises to fully assess the potential impact of the Being the Best proposals on resource deployment practices and made plans for the restructuring of the department to cater for the new divisional structure

Provided Majax scenario training for all Dispatch and Duty Managers in Marauding Firearms Terrorist Attack (MTFA) protocols to provide the most up to date information and training to staff

Achieved re-accreditation as a Centre of Excellence for AMPDS; becoming the only multi-site agency globally to achieve this status.

Introduced a dedicated Safeguarding role with a specific function to receive all referrals for vulnerable adult and children and ensure these are passed to the appropriate agency.

Clinical Services and Nursing & Quality Directorates

Our Clinical Services Directorate and Nursing & Quality Directorate operate as two independent functions. However, they have shared responsibilities in many areas and therefore operate in close liaison with one another.

The achievements of both are detailed separately below.

Clinical Services Directorate

Research and Development

In 2012/2013, the Directorate continued to build on EMAS' excellent profile in the field of research and development at a National and International level. Collaboration on several key trials focussed on increasing the quality of care delivered to patients and led to improvements across a range of key clinical quality areas. This helped us support the evaluation of some key interventions both through external collaboration and some 'in-house' studies, for example, looking at early warning scores as a potential prognostic indicator. We also built on the success of previous years with work accepted for poster and oral presentation at key meetings and we continue to liaise with the newly forming Academic Health Science Networks as they develop. In

2013/2014, several new projects will be introduced to further develop EMAS' evidence based approach to the delivery of high quality pre-hospital care.

Clinical audit and involving practitioners in quality improvements

The Directorate continues to coordinate the submission and monitoring / reporting of national Clinical Performance Indicators for UK ambulance services and is now working to help further develop the clinical quality indicators used by other UK ambulance services to improve performance. We continued to work as part of the (Health Foundation funded) Ambulance Services Cardiovascular Quality Initiative (ASCQI), measuring and improve clinical care for heart attack and stroke patients and are now using the techniques and skills developed by our quality improvement fellows to drive through additional clinical changes.

We introduced new clinical performance indicators for Chronic Obstructive Pulmonary Disease and lower limb fracture management and carried out audits on our response times to stroke patients and the benefits of intra-osseous (direct into the bone) cannulation (infusion of liquids). The clinical audit department is now becoming more integrated with other branches of EMAS to support service reviews such as the safety of clinical assessment by telephone (hear and treat).

Working with our partners to improve the patient experience

During 2012/2013, the amount of Primary Percutaneous Coronary Intervention (PPCI) catheter suites either opening or moving to 24/7 status across our patch increased again. PPCI is a treatment for heart attack patients; it unblocks an artery carrying blood to the heart by the insertion of a small balloon on the end of a long thin tube (catheter) via an artery. EMAS front-line staff are now seeing the benefits of this approach as more patients are treated using the technique. As a result, we are carrying out very few pre-hospital thrombolysis treatments (where a drug is used to break down the blockage) and during the year, we removed this drug from most frontline vehicles, except in some areas which are very rural and remote. The savings being made from using fewer drugs are now being re-invested into other areas of clinical care, for example, major haemorrhage management and airway management. Further clinical developments using the remaining funds are also underway.

We have worked closely with our commissioning and acute trust partners to ensure a smooth launch of Major Trauma networks in this past year. EMAS is taking more patients than ever before direct to a specialist Major Trauma centre rather than via the nearest available A&E department. We have been able to coordinate our responses effectively across three different trauma networks and this is now providing the best possible care for patients whatever their geographical location.

During the year, we have continued to build effective links into the changing NHS structure, particularly with the newly forming Clinical Commissioning Groups (CCGs). This led to an increase in the care pathways available for patients calling for our assistance, including the ability to refer patients back to primary care or to utilise alternative care routes rather than admission to an Emergency Department. In future, this will see more patients receiving the right care when needed. The Directorate will continue to work in close liaison with partners to develop our approach and deliver care close to home wherever possible.

Practitioner Performance

In 2011, we launched our Health Professions Council (HPC) Decision Panel, a peer led approach to managing the performance of EMAS staff by reviewing cases (where a clinical concern is raised) to identify whether or not, referral to the HPC is necessary. This process has continued and been recognised by the HPC as a marker of good practice. In 2012/2013, we built on this initiative by working with staff to develop individual 'clinical reports.' This approach allows staff performance to me assessed against key patient care criteria.

Consultant Paramedics

As part of the EMAS "Being the Best" programme 2012/2013 saw the introduction of three consultant paramedic roles within EMAS. The introduction of these senior clinical posts demonstrates EMAS' commitment to the delivery of the highest possible standards of clinical care and will further strengthen our ability to work closely with our clinical colleagues outside of the organisation.

Nursing and Quality Directorate

Infection Prevention and Control (IPC) team

In 2012/2013, the IPC team continued to maintain a high profile, working collaboratively with Operational colleagues to build on and sustain the successes of the previous year. The team also worked closely with the Organisational Learning department to develop the existing auditing tools into a joint inspection tool designed to assess compliance with all aspects of the Hygiene Code, Risk and Safety standards and Safeguarding. This is now being used both by specialist teams and operational managers to assess compliance and provide assurances to the Board. The results from the IPC inspections continue to demonstrate a high level of compliance with IPC policy over the year and corrective action for any non-compliant areas is taken until full assurances are received.

IPC continues to play a key part in supporting frontline services by ensuring accurate and timely information on communicable diseases is disseminated to frontline staff in Divisions; working with logistics to introduce and evaluate equipment and consumables, continually driving improvements in practice and by promoting a zero tolerance approach to poor compliance with IPC standards.

The Operational Infection Prevention and Control group (a sub group to the Strategic IPC Group) is key to sharing IPC information and gaining meaningful feedback from Operational Managers and continues to be well supported. The Link Champions IPC Group has been reformed into a 'virtual group' using educational opportunities and newsletters as a means of communicating key IPC messages.

Close working with other health partners and the Health Protection Agency has continued through building strong links with health economy IPC Groups in each county, Health Protection Agency attendance at EMAS' Strategic Infection Prevention and Control Group meetings and the regular provision of outbreak information across the Trust.

Close working with the new Occupational Health provider (appointed in July 2012) has enabled the introduction of a more robust monitoring system for instances of inoculation injuries.

Patient and Staff Safety

Health and Safety aims to ensure that our staff, patients, their relatives or members of the public are not harmed as a result of our activities. During the year, as part of our work to ensure the health and safety of our staff, patients and partners, we further developed our Risk Management Audit Programme to produce a fully integrated performance review programme. This ensures we are meeting compliance standards and strengthening both staff and patient safety by identifying areas of risk, applying mitigations and introducing harm reduction strategies. The programme includes observed practice, premise inspections, and vehicle audits across the key areas of infection prevention and control, patient safety and staff safety.

As part of our on-going Trust-wide Risk Assessment Programme in, we also reviewed our approach to the risk assessments of roles, premises and equipment.

In early 2012, we introduced an incident telephone reporting line and continued to promote the facility to staff. By the end of the financial year, approximately 40% of all incidents were being reported by this method. In early 2013, we also purchased an integrated on-line incident reporting system which allows staff to report incidents electronically. Following the introductory phase, this will be rolled out across EMAS during 2013/2014. Both of these initiatives facilitate reporting of untoward incidents and allow us to investigate incidents in a more effective and timely way.

We introduced a central health and safety advice request service which provides managers with access to timely, up-to-date and accurate health and safety guidance. This allows them to manage the health and safety of their staff more effectively.

We continue to develop our Essential Education Programme to ensure all staff have targeted health and safety training. During 2012/2013, the focus was on fire safety and incident investigation training.

Learning from our Strategic Learning Review Group

To build on our solid track-record, it is imperative that we continue to learn and implement service improvements. Learning is captured through our Divisional Learning Review Groups and disseminated to managers and staff through the Strategic Learning Review Group (SLRG). Some examples of service improvement made during the year are:

- Improved communication links with Infection Prevention and Control stakeholders to identify infectious outbreaks across the region promptly
- Appointment of a Clinical Coordinator within our Emergency Operational Centre (EOC) to provide support to frontline staff on alternative care pathways and to conduct welfare checks on patients
- Development of standardised Diagnosis of Death procedure
- Introduction of detailed 'deep dive' analysis of serious incidents, complaints and claims to identify common themes and develop initiatives to prevent recurrence. Examples of such analyses in 2012/2013 include spinal injuries and maternity related incident.

Learning is influenced through serious incidents, claims and patient experience reviews which are collated through Divisional and Strategic Learning Review Groups. EMAS' Organisational Learning Team uses these channels to formulate a Training Needs Analysis, develops and then delivers learning packages (using real-life examples of cases) to make the education relevant to frontline staff.

Patient Experience

EMAS continually strives to create a patient focused organisation that is responsive to patient need and to ensure lessons are learned and disseminated across the organisation. Throughout the year, we have introduced a number of innovative methods to capture patient experience, one of which was the introduction of an electronic "Facebook" style system in February 2013 to capture staff ideas and experiences. Following the campaign, we developed an action plan to ensure suggestions and recommendations put forward by staff were considered and, where appropriate, implemented.

We continued to submit 'patient stories' to the Board on a regular basis. These accounts from patients (or their relatives/carers) allow for personal experiences to be heard. This has been very useful in understanding the whole experience of our patients and has allowed us to introduce real improvements in service provision.

We continue to survey our A&E and PTS patients on a regular basis to capture patient feedback. We have reviewed the questions we ask within our patient surveys to simplify the process and make our surveys more accessible to patients. We have also agreed core questions with colleagues in other ambulance services to allow comparison and encourage learning between the organisations.

We have strived to meet the challenging timeframes we set ourselves in early 2012 for timely response to formal complaints and have met the 20 day response target in approximately 75% of cases. In addition the quality of our investigations has continued to improve since the introduction of our Investigation Team which provides support to complainants throughout the process. As a result, the number of second letters received from complainants requesting additional information has significantly reduced.

During 2012/2013, we developed a Patient Experience Forum from our FT membership. We have gained targeted feedback from patients on key areas of patient experience including how to improve our patient surveys and how to encourage feedback from patients with learning disabilities.

Safeguarding children and vulnerable adults

The referral rate for children and adults continues to increase during 2012/2013 as a result of our focus on safeguarding. This has been achieved through a comprehensive safeguarding awareness campaign and education with an emphasis on 'Think Family'. Key improvement areas include:

- Increased awareness of Dignity in Care. Dignity is integral to all Education modules and we now have over 500 dignity champions, 80% of which have patient contact. There has also been the development and consultation of Dignity Pledges for the organisation.
- Improved systems to identify when complaints or safeguarding referrals relate to people with learning disability (to allow identification of themes or trends) and to ensure the issues raised are addressed. We have developed a communications booklet for each vehicle to help support staff when interacting with vulnerable groups.
- The development of education programmes to promote awareness of 'Domestic Violence and Abuse' and the Department of Health 'Prevent' agenda, ensuring that staff can recognise the 'right support at the right time', move towards integrated working and consideration of the impact on others within the household.
- The development of a Domestic Violence and Abuse Policy alongside a communication campaign for staff and service users.
- Signing up to the Prime Minister's Dementia Challenge, highlighting EMAS' dedication to the agenda to improve awareness; promoting early identification and referrals

During 2013/2014, the Safeguarding Team will:

- Continue to develop alternative referral pathways for 'care concern' issues and consider the potential to utilise Multi-Agency Safeguarding Hubs (MASH) which are being introduced in the region to streamline referrals and ensure appropriate agencies are informed.
- Develop a bespoke safeguarding database to ensure trends and early identification of complex cases and supporting effective and timely information sharing
- Remain responsive to emerging plans to make Adult Safeguarding a statutory responsibility
- Further develop the role of the Dignity Champion integrating themes from the Dementia agenda
- Develop supportive tools to strengthen documentation of the mental capacity assessment
- Launch a Mental Health education campaign for all staff with a focus on Self Harm & Suicide
- Achieve consistent engagement across the Divisions in community projects and forums in relation to learning disability, mental health and safeguarding

Workforce Directorate

During 2012/2013, we updated our Workforce Strategy, 'Driving Quality, Delivering Change 2012-2016'. This sets out what we will do to ensure a highly skilled, motivated and engaged workforce to meet the health needs of the local population. The strategy also details our cultural aims to ensure our organisational environment is focused on patient safety; driven by quality and value; a commitment to learning and development; with a high level of employee engagement and empowerment. It seeks to develop an environment where innovation and entrepreneurialism is encouraged; and where equality of opportunity is embedded in everything we do.

The strategy identifies 10 workforce goals which are to:

- Deliver robust and compliant workforce planning to ensure capacity and capability
- Embed Equality, Diversity & Human Rights to achieve greater awareness, equal opportunities, and responsiveness to patient needs
- Excel in human resourcing to attract and recruit the best candidates

- Deliver best practice in human resource management to drive cultural change and encourage discretionary behaviour
- Embed a model of organisational development
- Deliver excellence in education, training and development to support the delivery of high quality healthcare
- Promote an engaged workforce and deliver our staff engagement strategy to support the development of a motivated workforce
- Improve the well-being of our workforce and their levels of attendance
- Develop talent in our organisation and plan succession into key roles
- Support delivery of quality, innovation and productivity strategies

EMAS' 'Being the Best' transformational change programme required significant workforce redesign to deliver capacity and capability at every level and the Directorate played a key role in developing the necessary support for its implementation. This will ensure the service model and operational management structure support delivery of strategic aims and objectives that include: better quality of care; improved performance; increased job satisfaction, and improved staff health and wellbeing.

The key achievements of the Directorate during the year under review were:

Workforce Planning to ensure Capacity and Capability

We strengthened our workforce plans to ensure a focus on capacity and capability, and support transformation to the new service model and operational management structure. This included commissioning independent external expertise to review the resourcing levels required to meet operational demand, ensure business continuity and meet the regional and national standards.

This led to the introduction of additional frontline posts with 115 Emergency Care Assistants (ECAs) recruited and trained and our paramedic workforce increased by 26 during the year. Our workforce plans will also see a further 108 ECAs complete their training and commence frontline duties in early 2013/2014

In addition to increasing frontline staff numbers, we implemented the operational management restructure aiming to:

- Embed clinical leadership at every level, ensuring quality is our first priority
- Ensure the fewest number of managerial layers, to streamline communications and decision making
- Ensure clear accountability for the delivery of key performance indicators, where each individual knows what they are accountable for
- Adopt a model of devolved responsibility in service line management
- Support an environment of health and wellbeing

Following a three month staff consultation exercise from September to December 2012, the Board approved proposals to implement the new structure and the assessment and selection process commenced. The new structure became fully operational following robust assessment, selection and development in April 2013.

Equality performance

EMAS is required to publish information annually to demonstrate compliance with the Public Sector Equality Duty. In addition, the Equality Act requires that specific and measurable equality objectives are prepared and published. In response, during 2012/2013, the Directorate developed a dedicated page on EMAS' website 'Meeting the Requirements of the Public Sector Equality Duty'. This is the main avenue through which we publish information to demonstrate a commitment to and progress on equality matters. This information ranges from workforce data through to patient experience survey results and was locally acknowledged as a model of good practice. The information is updated regularly in line with developments and to reflect annual requirements.

Our website was reviewed for accessibility and it meets the W3C standards for access. We officially retained the use of the 'Disability 2 Ticks Symbol and were accepted onto the 'Stonewall Health Champions Program'. These are nationally recognised standards for good practice in equality and diversity.

Through a broad range of internal and external stakeholder events and forums, we continued to develop our equality objectives by working in partnership with stakeholders including other local Trusts; local community groups; stakeholders representing protected characteristics; local authority networks and Local Involvement Networks.

Our Stonewall Health Champions work resulted in a dedicated action plan to support Lesbian, Gay and Bisexual members of staff and the public and the first Emergency Services Joint Gay staff network for Nottinghamshire involving The Police, Fire and Rescue and EMAS. This development has been strongly supported by Trade Union colleagues from GMB and UNISON and included collaborative working and EMAS' attendance at the Nottinghamshire and Leicestershire Gay Pride Festivals.

The Directorate enhanced EMAS' profile by attending Leicester MELA, one of the biggest South Asian Festivals in the UK and several staff provided interviews for community focussed radio stations to raise awareness of health and wellbeing during periods of fasting or religious observance.

Following feedback from a member of the deaf community at an engagement event, EMAS purchased a portable induction loop and amended the specification for all new vehicles to include the fitting of induction loops to improve communication and provide better support for members of the deaf community.

One of our Paramedics was supported to participate in the 'European Hope Exchange Programme' which was established to develop good healthcare practice across Europe. The Paramedic also undertook a placement in Latvia and played a key role in the organisation of a return visit to EMAS by health professionals from European countries participating in the Hope Exchange Programme.

During 2013/2014 we will further develop our Equality Action Plan and Equality and Diversity Strategy to ensure the principles of equality and diversity are understood and embedded in everything we do.

Employment Relations

1 July 2012 marked the end of an era for EMAS as many staff from our Patient Transport Service (PTS) transferred to private providers due to our loss of PTS contracts following a competitive tendering exercise. The Directorate played a pivotal role in coordinating the Transfer of Undertakings Protection of Employment (TUPE) process to ensure the successful transfer of 525 staff to the new providers, supporting staff throughout the process and assisting line managers to reconfigure individual responsibilities as a consequence of the structural change.

During 2012/2013, a number of issues were successfully concluded including:

- A range of Agenda for Change (A4C) and Job Evaluation issues. Of particular significance was the settlement of pay issues related to the original transfer of staff to A4C terms and conditions of service
- A programme of retrospective Criminal Record Bureau checks on over 1,600 frontline staff. This was an extremely successful exercise which was fully supported by both Trade Union representatives and staff

With the launch of our 'Being the Best' workforce transformation process, a number of work packages were introduced during the year including a rota review; overtime arrangements; and bank holiday working. These initiatives provided consistency across EMAS in the application, standardisation and viability of staffing issues.

Leadership and management development

During the year, we continued to invest in and develop our leaders and managers to support cultural development, improve leadership capability from Board to front line, support organisational development and meet our plans to achieve Foundation Trust status. This included a range of activities including accredited programmes such as Chartered Management Institute (CMI) First Line Manager; and CMI Coaching and Mentoring; bespoke team and management development programmes; a formal Board Development Programme and staff access to a range of management tools and diagnostics.

In response to feedback from staff, we also developed and implemented a bespoke Supportive Management Behaviour programme. The programme focuses on recognising and valuing staff, improving management behaviour, teamwork and interpersonal relations, motivating, empowering and supporting staff. The programme started in 2012/2013 and will continue throughout 2013/2014.

Our Leadership Framework and Development Plan for 2013/2014 was drafted and will feature opportunities to address the findings of the capability gap analysis carried out as part of the Operational Management restructure exercise. The plan includes supportive management behaviour; managing attendance; undertaking appraisal and development planning.

Clinical leadership and clinical education, training and development

During 2012/2013, in line with the realisation of our workforce plan, the Directorate's Education Team supported the on-going education and development of staff and we implemented the annual Essential Education programme supporting essential standards of quality and safety, statutory & mandatory requirements and clinical updates.

The Directorate also provided a range of continuous professional development opportunities. These included e-learning resources, internal classroom based workshops, access to National Vocational Qualifications and external higher education modules. These mechanisms were used to support continuing professional development and clinical leadership and examples include:

Improving End of Life Care	Pre Hospital Assessment and Disposition
Managing Clinical Risk	BSc Professional Practice
Samaritan training – handling difficult contacts	Interview Skills training
Level 4 Awards in Anatomy and Physiology	NVQ levels 2 & 3 in: Health, Business Administration, Customer Services

During 2012/2013, we continued to support the national apprenticeship programme by the recruitment of apprentices into a range of support and operational support positions.

During 2012/2013, we introduced the Individual Practice Review (IPR). This is a web based integrated solution bringing together clinical supervision, performance appraisal, and the range of audit activities.

Towards the end of the year, we began developing our Education and Talent Management Strategy. This takes account of the changing national and regional education & training infrastructure, the introduction of LETBs, the Trust's new service model and the outcomes of the national College of Paramedics Curricula Review and Career Framework and Paramedic Evidence Based Education Project. The strategy sets out EMAS' vision for education and talent management, including our plans for workforce planning, values based recruitment, induction, education, development and career progression, management and engagement, retention and succession planning.

Staff engagement

One of the workforce goals and objectives detailed in the Workforce Strategy, Driving Quality Delivering Change 2012 - 2016 is to 'promote an engaged workforce and deliver our Staff Engagement Strategy'. To achieve this aspiration and build upon existing work, we liaised closely with staff to develop the Staff Engagement Strategy which identified the issues that mattered to staff and the factors they say impact on their feelings of being engaged.

The purpose of this strategy was to build on and learn from the feedback from the original EMAS Organisational Risk Assessment (ORA) culture audit carried out in 2010 as well as from more recent initiatives addressing workforce engagement issues, for example, our Big and our Local Conversation events at which staff from a broad range of disciplines drawn from across the EMAS area were invited to 'have their say' about things that mattered to them. To further develop our strategy, we interviewed staff ranging from frontline to members of the Board to establish a common understanding of what engagement means and how it can be improved. Eight key target areas were identified that enable and enhance staff engagement and these now form an integral part of our strategy. This work will take EMAS forward in raising awareness of the importance of employee engagement and offer practical recommendations on how existing levels of staff engagement can be improved.

Work on the strategy led to the development of a supporting implementation plan which combines feedback from engagement initiatives (outlined above) as well as the results of Staff Opinion Surveys. We implemented a range of actions during the year under review and others will be introduced in 2013/2014. These include:

- A new Service Delivery Model
- The Operational Management restructure programme
- Health and wellbeing activity
- The Supportive management behaviour programme
- Implementation of quarterly temperature check short staff surveys to gain a more frequent sense of the level of staff engagement and matters of staff concern
- The Education and Talent Management Strategy
- Gathering of Staff Stories
- The introduction of Staff Reward and Recognition Schemes including Long Service and the EMAS Values Scheme. In association with this, the launch of an Annual Award Event to celebrate and acknowledge the commitment and achievements of our staff.

In late 2012, we carried out the annual Staff Opinion Survey. EMAS's response rate was 37.6%. The average response rate for the 6 Ambulance Trusts who used the same survey contractor (the Picker Institute) was 38.9%. A brief summary of key areas of improvement and key areas of deterioration is set out below. This information is being used to identify the further actions EMAS needs to take to further improve the satisfaction levels of our staff.

The top 3 areas of improvement (compared to 2011) were:

- Training in how to deliver a good patient/service user experience (15% improvement)
- Senior managers involving staff in important decisions (11% improvement)
- Communication between senior and staff is not effective. (15% improvement)

The top 3 areas of deterioration were:

- My job is not good for my health (12% deterioration)
- Felt unwell due to work related stress in last 12 months(11% deterioration)
- In last 3 months, haves come to work despite not feeling well enough to perform duties (7% deterioration)

Staff health and well being

We placed significant focus on supporting the wellbeing of our staff and improving levels of attendance during 2012/2013 and this remains a high priority for the Trust. Good progress has been made and a number of positive initiatives come to fruition, including:

- A complete review of the Occupational Health service requirements resulting in a competitive tendering process being carried out and new Occupational Health (OH) and Employee Assistance

Programme providers appointed on 1 August 2012. Their focus is on taking proactive and preventative measures to support staff wellbeing.

- Support from NHS Employers 5 High Impact Changes programme developed by the Department of Health supporting the Boorman recommendations.
- A range of education and training programmes to support management capability carried out
- The introduction of a Physiotherapy Information Line providing staff with day 1 (of onset of symptoms) triage and advice directly from our OH providers
- Day 1 referrals (of staff reporting absence from work due to sickness) to a trained practitioner who can assess the condition and advise on the appropriate course of remedial treatment

Following these measures being introduced, EMAS has achieved a downward trend in sickness absence rates when compared against previous years. Our overall absence rate in 2011/2012 was 7.81%, in 2012/2013, it was 6.30%.

Our focus on health and wellbeing remains a key priorities for 2013/2014 when we will implement our Health and Wellbeing Strategy; introduce early intervention and rehabilitation programmes for staff with long term conditions (muscular-skeletal and mental health); and carry out a range of Health Promotion Events across all divisions.

Corporate Governance

Compliments & formal complaints

During the year, we received just over 500 expressions of appreciation from patients or members of the public. Where the staff involved in any particular incident can be identified, a copy of the letter of thanks is sent to the person involved and a copy placed on their personal file.

The following table provides information on the receipt and handling of complaints:

Number relating to A&E	215
% rate in relation to journeys provided	0.0377%
Number relating to PTS	7
% rate in relation to journeys provided	0.0002%
Number acknowledged within 3 working days*	100%
Number receiving a formal response in 20 working days*	151 of 207 (73%)
Number of complaints proved to be justified	47 of the 207 closed (22%)
Number referred to the Parliamentary and Health Service Ombudsman (PHSO) for Independent Review	4 (the PHSO declined to 3, a decision is awaited on the other)

Communications and Community Relations

This team is located in the Chief Executive's Directorate and helps to develop our services by promoting dialogue with patients and the public, staff, health community colleagues, the media and other stakeholders.

The ambulance service is very much in the public eye and is therefore the focus of considerable media attention, the team fielding approximately 1,600 media enquiries per annum from the 85+ news outlets located in EMAS' area. In addition, the team is proactive in issuing press releases, helping to bring recognition to the good work done by our staff in the service of the community.

We place great emphasis on delivering good internal communication. The weekly Chief Executive's Bulletin is very popular with staff and the monthly Chief Executive video conference gives managers and staff the opportunity to be updated on EMAS business and to have their questions responded to directly by the Chief Executive. Video conferencing facilities have significantly reduced the amount of time and money we spend on travel costs associated with manager's meetings. Our staff website is run by the communication team and is increasingly becoming the best route for staff to keep in touch with the latest news. We also have dedicated communications campaigns on key issues for staff (e.g. dignity in care, patient safety, infection prevention and control, safeguarding vulnerable people). All staff are given the opportunity to sign up to Communications Direct (whereby they receive email updates on their home PC) and this has also proven to be popular with just over 1,000 staff registered as subscribers.

On the external communications and engagement front, our stakeholder newsletter *EMAS Aspect* was issued monthly electronically to over 700 named individuals and the address list continues to grow. Our website had just under 500,000 visitors over the year. In conjunction with colleagues, the team is implementing EMAS' Community Engagement Strategy. We also started to make much better use of social media options such as Twitter (with over 3,100 followers) and You Tube.

To support the public and staff consultation process associated with Being the Best, the team supported various communications including the production of a consultation document, a dedicated web page, Twitter and Facebook pages. The team also responded to public and media questions about the proposals, including supporting filming in our Emergency Operations Centre and out on the road with a double crew ambulance. The footage was subsequently broadcast in a 20 minute BBC TV Inside Out feature on the proposals.

We work closely with Local Involvement Networks (LINks) and a particular highlight was to secure the involvement of patients and the public in the creation of the Trust's 2010 / 2011 Quality Account which included a summary document for the public – believed to be the first created by a UK ambulance trust. The team also works closely with the Foundation Trust office in attending events, helping to recruit members and managing production of the members' magazine *FT Matters*. During 2012, we worked on re-launching a Foundation Trust consultation programme which ran from 10 April to 3 July 2012.

In December 2012, an appointment to the new post of Assistant to the Chief Executive was made. Following this appointment, a review of the management structure was carried out leading to the incorporation of the Foundation Trust and Governance teams into the Communications and Community Engagement team and for this branch of EMAS to be re-named Corporate Affairs.

Finance and ICT Directorate

Finance team

The team played a key role during in supporting EMAS' strategic objectives and organisational development initiatives. This included developing, implementing and monitoring the delivery of Cost Improvement plans, providing support to the Being the Best initiative and Foundation Trust application process.

During the year the objectives of the Cost Improvement Plan (CIP) Programme were set as follows:

- To align with national policy to save £20billion by 2015 (5% per year) by making continuous efficiency improvements to maintain patient-focused, high quality and safe care

- To deliver financial improvement to support EMAS towards becoming a Foundation Trust

The CIP programme is the key enabler to achievement of these objectives and has focussed on:

- Strengthening the CIP governance structure
- Strengthening the CIP planning, monitoring and reporting processes
- Planning and delivering the 2012/2013 CIP target
- Planning the 2013/14 CIP target
- Delivering the required actions in 2012/2013 for the 2013/2014 schemes to be effective
- Setting up a rolling two-year CIP process, to include developing greater capability and capacity within EMAS to generate, plan and deliver CIPs.

In 2012/2013 BDO, an international firm of accountants (experienced in helping NHS organisations deliver performance improvements) were engaged to offer professional advice, validate current and new schemes with managers and ensure these are embedded to support transformation of services and improve patient experience.

Robust governance arrangements were implemented ensuring that these were aligned with the CIP process. The aim of the governance process was to ensure staff are not burdened by excessive bureaucracy whilst being able to easily communicate progress and exceptions that require action.

The development and integration of a structured and focused programme of staff engagement helped the CIP Programme to gain traction and support from key individuals to ensure the programme is successful. This included putting in place core processes to give the Board confidence that individual CIP plans would be delivered on time and to a very high standard with exceptions highlighted. A key aspect of the governance arrangements was the development of a structured benefits realisation plan and process. This provided the Board with the assurance that benefits are fully understood, monitored and on-track for realisation. Furthermore, a central reporting has enabled the Board to keep up to date with any risks, issues and progress, as well as regular project updates, formal milestone meetings and a number of informal meetings to ensure there were 'no surprises' throughout the lifecycle of the CIP Programme.

In July 2012 the directorate welcomed a new Director of Finance, Jon Sargeant, who has significant NHS experience and knowledge on the operation of Foundation Trusts.

In December 2012, the finance and accounting system provided by NHS Shared Business Services (NHS SBS), was upgraded from Oracle Release 11.5.10 to the latest Oracle Release 12 (R12). The Finance, Procurement and ICT teams worked closely with the Conversion Team from NHS SBS to identify new methods of working, data validation and migration, a review of the IT infrastructure and training for staff.

The finance team continued to offer support to the Audit Committee and monitor progress against implementation of audit recommendations. Working relationships with the new provider of internal audit and counter fraud services continued to prosper.

Our key priorities to progress in 2013/2014 are to:

- Support EMAS' Being the Best initiative
- Proactively support delivery of the 2013/2014 cost improvement programme
- Support the Foundation Trust application process
- Support evaluation of outsourcing options

Information Communication Technology (ICT)

The ICT department continued to make substantial progress with National developments such as the Electronic Patient Record Form (e-PRF). It also delivered a number of key projects aimed at delivering better patient care, achieving greater cost effectiveness and delivery against local service targets.

ICT brought support for Toughbooks (e-PRF) in-house to improve the quality of the service provided to crews and reduce costs. The service is now fully established and achieving the set targets with feedback to date being extremely positive.

We successfully completed a project to provide a home and remote working solution to replace the previous 3G system. This has allowed for further flexible working across the workforce and will provide better support for the imminent changes in EMAS' estate.

ICT rolled-out Microsoft Office 2010 and, by moving to a more up-to-date product, provided many functional advantages to help EMAS develop.

The team introduced video conferencing facilities using Microsoft Lync and more than 200 staff are now able to utilise the system. This has improved communication links (where distance is a barrier) reduced time spent on travel and reduced costs.

As part of ICTs contribution to the cost improvement programme, EMAS' mobile telephony requirements were subjected to competitive tender leading to significant cost savings.

Business Intelligence Unit

Following transfer to the Finance Directorate during the year, the BIU unit:

Responded to an increased level of information requests, allowing requests associated with the Being the Best programme and public consultation process to be addressed in a timely manner.

Started to carry-out detailed reviews of its working practices and led by the newly introduced role of Head of Performance Management.

Consolidate existing performance monitoring systems into a single 'dashboard' facility. This provides a simple visual representation of how EMAS is performing against a series of key targets

Began to implement a new system to improve day-to-day reporting and increase the analytical capabilities of the information system. This new approach will provide end users with a degree of 'self-service' access to statistical databases.

Information Governance

During 2012/2013 the focus on Information Governance has remained high and the Information Governance and Compliance Team continue to respond to increasing numbers of requests for information, both under the Data Protection Act and Freedom of Information Act. Following the annual assessment of the Information Governance Toolkit by Internal Audit, EMAS was graded as providing significant assurance around its Information Governance arrangements. The Information Governance Toolkit submission for 2012/2013 was 91% - Satisfactory. It is envisaged that we will continue to improve on this score in 2013/2014.

Summary of personal data related incidents in 2012/2013		
Category	**Nature of Incident**	**Total**
V	Other	0
IV	Unauthorised disclosure	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS Premises	1
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS Premises	1

Summary of serious untoward incidents involving personal data as reported to the Information Commissioner's office in 2012/2013				
Date of incident (month)	**Nature of incident**	**Nature of data involved**	**Number of people potentially affected**	**Notification steps**
December	Unauthorised disclosure	Name, address, NI no., phone nos., driving licence no.	1009	Individuals notified by email or letter
Further action on information risk	EMAS will continue to monitor and assess its information risks (in light of the events noted above) to identify and address any weaknesses and ensure continuous improvement of its systems. The recommendation has been made to cease working with the supplier responsible for the disclosure.			

The annual staff Information Governance Awareness Survey also demonstrated that staff are more aware of their responsibilities in this area and that the annual mandatory training they receive is relevant to their role.

Charitable Funds

During the period under review, we continued to receive donations from members of the public who have made use of our services either in an emergency or to attend an outpatient appointment or visit a day care unit. Our on-line and text giving facilities now make it easier for members of the public to make donations.

Although a few donors make specific requests on how they would like the money to be spent, the majority ask for the funds to be used for the benefit of patients and/or staff. During the period under review, our charitable funds committee approved the spending of donations on new pieces of medical equipment and improved recreational facilities for our staff. The Committee also took steps to encourage staff to put forward suggestions on innovative projects which could be supported from Charitable Funds.

The fund is registered with the Charity Commission and is managed by EMAS' charitable funds committee which includes Non-Executive and executive directors and other EMAS representatives. Day to day administration is undertaken within our finance department. Our charitable funds are subject to an internal audit and external audit.

Sustainability Report

Estates

As part of the *Being the Best change programme,* we are currently engaging and collaborating with a wide range of internal and external stakeholders to deliver a strategy to support our corporate vision of improving the care patients receive. This strategy will be aligned with our Operational and Service Models to ensure our future estate holdings continue to support the delivery of efficient, quality and equitable emergency and non-emergency healthcare services. The strategy will also enhance our resilience to extreme weather conditions and ensure our estate is flexible to meet the rising, changing and diverse demand for EMAS services.

Sustainable Development Management Plan (SDMP)

As part of our commitment to embedding sustainability and climate change adaptation into the way we deliver healthcare services, a new post of Environment Manager was introduced in 2012. The holder is responsible for coordinating the delivery of EMAS' environmental objectives and monitoring / reporting on sustainability performance. Our Sustainable Development Management Plan (SDMP) harmonises all existing environmental programmes and will serve as the framework to deliver our environmental objectives.

The SDMP was devised in line with the 9 sustainability strands prescribed by the NHS Sustainable Development Unit (SDU) and these strands have been linked to our Estate Strategy, Cost Improvement Programme (CIP) and our Operating and Service Models. The SDMP covers the following aspects which represents the major areas in which a typical healthcare organisation interacts with the environment. For EMAS, these are:

- Travel, transportation and access;
    - Grey fleet (business miles);
    - Ambulance fleet; and
    - Logistics.
- Procurement and commissioning;
- Waste generation, management and disposal;
- Estates: design, new-build and refurbishment;
- Climate change adaptation;
- Energy and carbon management;
- Governance and finance;
- Organisation and workforce development; and
- Partnership and network.

Our 2011/2012 environmental footprint was used as the baseline for developing the SDMP. This baseline encompasses the Carbon (CO_2e) emitted from the energy used across our estate, fuel used by our fleet, our business travels and the major goods and services we procured.

Sustainability Performance

In 2012/2013 we emitted 27,775 tCO_2e of which the goods and services we procure, the energy used across our estate and transportation and travel accounts for 51%, 17%, and 32% respectively. In addition, we used 52,444 m^3 of water and approximately 31 tonnes of clinical waste was collected from our ambulance stations and operations sites. We continue to actively manage our environmental footprint and implement good environmental practices.

We continue to promote and implement projects and programmes to enhance our resilience to external challenges and have continually upgraded our ambulance fleet which significantly improves fuel use efficiency and results in reduced greenhouse gas (GHG) emissions. Additionally, our estate maintenance regime is focused on meeting regulatory compliance, improving heating, ventilation, air-conditioning (HVAC), lighting systems and the fabric of our premises.

We recognise that as the demand for our services increases, the goods and services we buy will invariably increase. As part of our Cost Improvement Programme (CIP) and commitment to embed the tenets of sustainability into the way we deliver services, we will continue to identify ways to promote and deliver resource efficiency and good environmental practices through our procurement and commissioning processes. As part of our environmental objectives, we currently include sustainability specifications into all relevant aspects of our procurement and commissioning processes and actively engage with our major suppliers and contractors to improve their sustainability performance and corporate social responsibilities.

We currently segregate all clinical and general waste and will continue to actively work with our waste collection contractors to reduce the proportion of our wastes that are disposed on landfill. A reduction in landfill waste will be included as a specification in the renewal of our waste collection contract. Waste segregation, reduction and recycling will continue to be promoted and our existing printing rationalisation policy (in operation at EMAS' Headquarters) will be rolled-out to all Divisional Headquarters to reduce the volume of waste paper we generate.

Waste minimisation forms an integral part of our corporate induction programme and this will be expanded to cover all aspects of our sustainability objectives. We will continue to engage all staff groups by promoting the benefits of embedding good environmental practices into the delivery of healthcare services as well as all other aspects of our operations. Collaboration with our partners and all relevant stakeholders on appropriate initiatives and programmes that deliver health benefits as well as improve the resilience of the population we serve to the consequences of adverse weather conditions will be promoted.

The EMAS Board will continue to provide strategic leadership and support, embedding good environmental practices across EMAS as part of the delivery of the SDMP.

Remuneration Report

Executive Directors

Name	Role	Date Appointed	Date left
P Milligan	Chief Executive	1.12.2011	
D Farrelly	Deputy Chief Executive	1.7.2006	
K Glover	Director of Nursing	14.9.2009	
P Ripley	Director of Operations	8.8.2011	14.01.2013
Dr J Gray	Director of Clinical Services	1.11.2010	
A Spice	Commercial Director	3.1.2012	
K Gulliver	Director of Workforce (Acting)	26.9.2011	31.7.2012
S Cascarino	Chief Operating Officer (Interim)	8.1.2013	
A Schofield	Assistant to the Chief Executive (Corporate Affairs)	3.12.2012	
I Turnbull	Director of Finance (Acting)	1.4.2012	11.7.2012
J Sargeant	Director of Finance and Performance	11.7.2012	

Notes

Directors' salaries are agreed by the Remuneration Committee (with reference to similar posts in the NHS).

Directors are employed on a permanent contract which may be terminated by retirement, resignation or, in the event of unsatisfactory performance, by dismissal. The notice period for all Directors contracts is 3 months. In the event of a contract being terminated, EMAS meets all statutory and standard NHS termination payments which are dependent on the individual's age and length of service in the NHS.

All Executive Directors are Trustees of the EMAS Charitable Fund.

P Ripley, K Gulliver and I Turnbull returned to other substantive posts within the Trust on ceasing to act as Executive Directors.

Non-Executive directors

All Non-Executive Directors are members of the Remuneration Committee, Nomination Committee and Foundation Trust Programme Board. All Non Executive Directors are Trustees of the EMAS Charitable Fund.

Some of the Board's responsibilities are delegated to committees, chaired by an elected Non-Executive director (as detailed below):

Name	Date of appointment	Date left	EMAS Committees	External interests
J Towler	1.7.2011		Remuneration and Nominations Committee Quality and Governance Committee Investments Committee Charitable Funds Committee (Chair)	None
G Austin	1.7.2006		Remuneration and Nominations Committee (Chair) Investments Committee (Chair) Audit Committee	None
S Dawkins	11.10. 2011		Remuneration and Nominations Committee Investments Committee Quality and Governance Committee Audit Committee	None
P Tagg	11.10. 2011		Remuneration and Nominations Committee Charitable Funds Committee Quality and Governance Committee (Chair)	None
G Newton	11.10. 2011		Remuneration and Nominations Committee Quality and Governance Committee Charitable Funds Committee Audit Committee	None
D Toberty	7.11.2011		Remuneration and Nominations Committee Investments Committee Audit Committee (Chair)	None

All Directors have confirmed that as far as they are aware, there is no relevant audit information of which EMAS' auditors are unaware and that they have taken all the steps that they ought to have taken as a Director to make themselves aware of any relevant audit information and to establish that EMAS' auditors are aware of that information.

The following remuneration report for the year ended 31 March 2013 has been audited. This consists of the tables of senior managers' salaries and allowances and pension benefits, and the accompanying narrative.

Senior Managers' Remuneration

Remuneration Report for the year ended 31 March 2013.

Executive Directors remuneration is paid in accordance with the Department of Health Pay Framework for Very Senior Managers (VSM) in Strategic and Special Health Authorities, Primary Care and Ambulance Trusts. The Trust's Remuneration Committee has delegated responsibility for setting remuneration for the Chief Executive and all Executive Directors in accordance with the VSM Framework.

The Trust operates in accordance with the VSM Pay Framework Performance Related Pay Awards Scheme and Department of Health annual updates concerning its application. In addition, the Trust applies its policy of annual Performance Development Reviews in order to assess individual performance. The Trust's Remuneration Committee is authorised to monitor and evaluate individual performance in accordance with the provisions of the VSM Pay Framework and the requirements of the Department of Health.

As set out above the Trust operates in accordance with the VSM Pay Framework Performance Related Pay Awards Scheme and Department of Health updates concerning its application. The Trust did not award any annual uplifts or performance bonus payments to senior managers during 2012/2013.

Remuneration Report For The Year Ended 31 March 2013

Salaries and Allowances			31 March 2013 Salary Bands of £5,000 £'000	Other Remuneration Bands of £5,000 £'000	Bonus Payments Bands of £5,000 £'000	Benefits in Kind Rounded to nearest £100 £'00	31 March 2012 Salary Bands of £5,000 £'000	Other Remuneration Bands of £5,000 £'000	Bonus Payments Bands of £5,000 £'000	Benefits in Kind Rounded to nearest £100 £'00
Phil Milligan		Chief Executive Director	140 - 145	0	0	0	45 - 50	0	0	0
David Farrelly		Director of Workforce	100 - 105	0	0	0	105 - 110	0	0	0
Jon Sargeant	Commenced 11 July 2012	Director of Finance and Performance	85 - 90	0	0	0	N/A	N/A	N/A	N/A
Ian Turnbull	Ceased 11 July 2012	Acting Director of Finance and Performance	25 - 30	0	0	8	N/A	N/A	N/A	N/A
Karen Glover		Director of Nursing	90 - 95	0	0	49	90 - 95	0	0	49
Peter Ripley	Ceased 6 January 2013	Director of Operations	65 - 70	0	0	38	40 - 45	0	0	33
Sheila Cascarino[1]	Commenced 7 January 2013	Chief Operating Officer	70 - 75	0	0	0	N/A	N/A	N/A	N/A
James Gray		Director of Clinical Services	130 - 135	0	0	0	120 - 125	0	0	0
Kerry Gulliver	Ceased 31 July 2012	Director of Workforce (Acting)	20 - 25	0	0	10	35 - 40	0	0	15
Andrew Spice		Commercial Director	85 - 90	0	0	0	20 - 25	0	0	0
Jon Towler		Chairman	35 -40	0	0	0	25 - 30	0	0	0
Gary Austin		Non-Executive Director	5 - 10	0	0	0	5 - 10	0	0	0
Stuart Dawkins		Non-Executive Director	5 - 10	0	0	0	0 - 5	0	0	0
Pauline Tagg		Non-Executive Director	5 - 10	0	0	0	0 - 5	0	0	0
Gillian Newton		Non-Executive Director	5 - 10	0	0	0	0 - 5	0	0	0
Dermot Toberty		Non-Executive Director	5 - 10	0	0	0	0 - 5	0	0	0

[1] The Trust obtained the services of Sheila Cascarino from Odgers Interim.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2012/2013 was £142,500 (2011/2012 £142,500) This was 4.55 times (2011/2012 5.06 times) the median remuneration of the workforce, which was £31,316 (2011/2012 £28,167). The change in the multiple is a result of the Trust no longer providing Patient Transport Services for the majority of the East midlands region. Due to this change a significant number of staff members were transferred to the new provider of these services. These staff members were mainly in the lower remuneration bands and thus the median pay has increased for 2012/2013.

In 2012/2013 and 2011/2012 no employees received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension Benefits			Real Increase in Pension at Age 60 £'000	Real Increase in Pension Lump Sum at Age 60 £'000	Total Accrued Pension at Age 60 at 31 March 2013 £'000	Lump Sum at Age 60 Related to Accrued Pension at 31 March 2013 Bands of £5,000 £'000	Cash Equivalent Transfer Value at 31March 2013 £'000	Cash Equivalent Transfer Value at' 31 March 2012 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Employer's Contribution to Stakeholder Pension £'00
Phil Milligan		Chief Executive Director	0.0 - 2.5	5.0 - 7.5	55 - 60	165 - 170	1,144	1,018	72	0
David Farrelly		Deputy Chief Executive	0.0 - (2.5)	(5.0) - (7.5)	25 - 30	75 - 80	418	421	(25)	0
Jon Sargeant	Commenced 11 July 2012	Director of Finance and Performance	0.0 - (2.5)	(5.0) - (7.5)	30 - 35	100 - 105	557	553	(18)	0
Ian Turnbull	Ceased 11 July 2012	Acting Director of Finance and Performance	0.0 - 2.5	2.5 - 5.0	5 - 10	15 - 20	91	0	25	0
Karen Glover		Director of Nursing	0.0 - (2.5)	0.0 - (2.5)	20 - 25	65 - 70	359	333	9	0
Peter Ripley	Ceased 6 January 2013	Director of Operations	25.0 - 27.5	80.0 - 82.5	35 - 40	105 - 110	709	9	539	0
James Gray		Director of Clinical Services	2.5 - 5.0	7.5 - 10.0	20 - 25	65 - 70	286	235	39	0
Kerry Gulliver	Ceased 31 July 2012	Director of Workforce (Acting)	0.0 - 2.5	0.0 - 2.5	10 - 15	35 - 40	198	165	8	0
Andrew Spice		Commercial Director	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	19	4	15	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members

Signed: 5 June 2013

Phil Milligan
Chief Executive

Statement of the Chief Executive's responsibilities

As the accountable officer of the trust

The Chief Executive Officer of the NHS has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed: 5 June 2013

Phil Milligan
Chief Executive

Annual Governance Statement 2012/2013

As Accountable Officer I have taken advice and assurance from a range of sources from reviews.

Scope of responsibility
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

In order to meet my responsibilities as Accountable Officer I have processes in place to ensure good working arrangements with partner organisations including the Strategic Health Authority, the NHS Commissioning Board and commissioners.

The governance framework of the organisation
The Board has established the following committees to support it in its role:

- a Quality and Governance Committee which monitors the effectiveness of the Trust's assurance framework, oversees compliance with legislative requirements, best practice in governance and regulatory standards and ensures that a greater awareness of clinical quality is fostered throughout the Trust;

- an Audit Committee which is responsible for reviewing the Trust's governance, risk management and internal control systems and also monitors the integrity of the Trust's financial statements and financial reporting mechanisms;

- a Remuneration and Nominations Committee which has responsibility for setting the remuneration of the Chief Executive and Executive Directors and any groups not included within the Agenda for Change Pay Framework;

- an Investments Committee which oversees the Trust's arrangements in relation to cash forecasting and investment and monitors the capital programme.

The Trust also has a Charitable Funds Committee which monitors and administers the East Midlands Ambulance Service Charitable Fund.

Minimum requirements are set for attendance at meetings against which performance is monitored.

The main issues considered by Board committees and highlighted to the Board during the year were:

- compliance against the Care Quality Commission Essential Standards of Quality and Safety

- arrangements for ensuring Criminal Records Bureau checks are undertaken for volunteers

- the adequacy of formal agreements with third parties for the provision of ambulance services

- the adequacy of arrangements for tracking medical devices to ensure servicing can be undertaken and any alerts from manufacturers regarding faults addressed

- post-handover delays at acute trusts

- the high number of adverse incidents relating to less urgent calls (those categorised as green calls)

- several serious incidents arising from an inadequate assessment of C-Spine injuries

- failure to notify incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 in a timely manner.

The Trust has arrangements in place to ensure the discharge of statutory functions. Responsibility for functions is clearly allocated to individual Executive Directors. Regular reports are presented to the Board and appropriate committees to provide assurance that statutory requirements are met and compliance ensured for

individual functions. The Scheme of Delegation identifies responsibility for specific statutory roles and details delegated authority to undertake the functions.

The Trust is compliant with the five main principles of the UK Corporate Governance Code as set out below.

Leadership – The Trust is headed by a Board with collective responsibility for the long-term success of the organisation. The division of responsibilities between executive functions and the running of the Board are set out in the Trust's Standing Orders and Scheme of Delegation. There have been some changes to the membership of the Board during 2012/13. A new Director of Finance and Performance was appointed. The Director of Operations post was replaced with a Chief Operating Officer role towards the end of the year. The Chief Operating Officer role is currently being filled on an interim basis. The new Chief Operating Officer will take up post in May 2013. There have been no changes to the Chairman and non executive director positions during the year.

Effectiveness – Directors received an induction on joining the Board. This is supplemented with a Board Development Programme to enable Board members to keep their skills and knowledge up to date. Individual directors, the Chief Executive and the Chairman undertake annual performance appraisals. The Board undertook an assessment of its role and performance in September 2012. It determined that the composition of the Board was appropriate and that the members had sufficient experience and expertise to fulfil their role. It also determined that the Board had been performing effectively during the year. Areas of improvement were identified as part of the self-assessment and will inform the Board Development Programme and the annual business cycle of meetings.

Accountability – The Board recognises its responsibility for determining the nature and extent of the significant risks involved in achieving the Trust's strategic objectives. The Board ensures the Trust has sound risk management arrangements and internal control principles and has sought assurance that these arrangements were operating effectively through its committees and the reports it receives during the year.

Remuneration – A Remuneration and Nominations Committee, consisting entirely of non-executive directors, has operated throughout the year to set the remuneration of the Chief Executive and executive directors. The committee ensures a transparent process for developing policy on executive remuneration and agreeing the remuneration of individual executive directors.

Relations with Members – The Board has responsibility for ensuring the Trust engages with its members. The Trust holds regular member events and undertakes other engagement and consultation activity to obtain the views of patients, carers and others. It engages formally with all stakeholders through its Annual General Meeting.

Risk assessment

The Trust has a Risk Management Policy which is reviewed and approved annually by the Board. There is a systematic process for the identification of risk throughout the organisation through local or divisional risk registers and a Board Assurance Framework. The risk management process was reviewed and revised during 2012/13 to clarify roles and responsibilities of individuals and groups involved in the process and to confirm the arrangements for escalating strategic level risks for inclusion in the Board Assurance Framework. A revised format for risk registers was also produced towards the end of the year. This will make the identification and monitoring of risk mitigation actions easier and will ensure a consistency of approach across the Trust. Further work is required during the first part of 2013/14 to ensure the new arrangements and risk register format is fully embedded across the organisation. The risk registers and Board Assurance Framework are reviewed regularly to ensure risks are managed effectively in accordance with the Risk Management Policy.

Risks are scored for impact and likelihood using a risk evaluation model. The significance of a risk to the achievement of the Trust's strategic objectives determines whether a risk is managed locally or escalated for inclusion in the Board Assurance Framework. The Trust's strategic-level risks are contained in the Board Assurance Framework which details the risk and any mitigation through the application of controls, together with evidence that demonstrates the application of those controls.

The main risks identified during 2012/13 were:

- failure to consistently perform against national performance targets, particularly those relating to accident and emergency response and the impact of this on quality;
- achievement of financial targets including the Cost Improvement Programme, the impact of performance penalties and responding to increased competition;

- achievement of Foundation Trust status;
- workforce issues including staff engagement, sickness absence levels and compliance with training requirements; and
- the capacity and capability to implement the organisational change programme.

A number of these challenges are likely to continue into 2013/14.

Risk management is further embedded within the Trust through service management responsibilities. Equality impact assessments are carried out against core business policies, and risk assessments and quality impact assessments are completed on proposed business activities and changes. Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has registered compliance with the NHS Equality Delivery System from January 2012.

The public and patients are involved in identifying risk and for bringing this to the attention of the Trust in a variety of ways including patient satisfaction surveys, complaints, litigation claims and Patient Advice and Liaison (PALS) concerns.

In August 2012 the Care Quality Commission (CQC) inspected the Trust to assess progress against addressing the minor concerns regarding Outcome 12 – Requirements Relating to Workers which had been identified by the commission at the last inspection. The CQC confirmed that the Trust was compliant with Outcome 12.

The Trust received a further visit from the CQC in March 2013. This was the annual inspection visit. The CQC examined the following outcomes:

- Respecting and involving people who use services (outcome 1)
- Care and welfare of people who use services (outcome 4)
- Co-operating with other providers (outcome 6)
- Staffing (outcome 13)
- Supporting workers (outcome 14)
- Assessing and monitoring the quality of service provision (outcome 16).

The CQC concluded that the Trust met the standards for outcomes 1, 6 and 16 but identified a number of issues in relation to the other standards. It was found that minimum response standards to life-threatening calls were not being met, the Trust did not have enough qualified, skilled and experienced staff to meet people's needs and some staff did not feel supported or have confidence in management to deal with issues and had not received a recent performance appraisal.

The Trust was aware of the issues identified and had been working to address these prior to the inspection. Action plans are in place to:

- improve response times to calls;
- recruit additional staff; and
- ensure that staff members receive regular clinical supervision checks and appraisals.

The Trust's internal auditors have provided a significant assurance opinion for 2012/13. This means that there is a generally sound system of internal control within the Trust, designed to meet its objectives, and that controls are generally being applied consistently. The auditors identified some high risk issues during the year in relation to medical devices. They noted that the data contained within the computerised system used for managing medical devices was incomplete. This could make it difficult to locate the equipment and ensure that it is serviced regularly or recalled where a defect is identified. The auditors identified that servicing of medical devices was not always undertaken in a timely manner and that the checklist for checking equipment on vehicles was not routinely completed at the start of each shift. Plans are in place to address these issues. None of these risks resulted in the need to highlight significant issues in this statement.

During 2012/13 the following lapses of data security occurred:

- a data breach involving lease car information which had been posted on the internet in error by a third party supplier. This has been reported to the Information Commissioner and appropriate action was taken to remove the information immediately and notify those individuals affected ; and

- an incident where documents were found in a public place. This has been treated as a Serious Incident but is still being investigated.

The Trust has sound information governance policies and processes in place to prevent data security breaches and to address any issues which arise. This was demonstrated through achieving an assessment score of 91% against the national Information Governance Toolkit in 2012/13.

The risk and control framework

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

As Accountable Officer I have responsibility for the overall direction of the risk management systems and processes within the Trust. The Director of Nursing and Quality was the identified lead for risk and quality during 2012/13 and had responsibility for the management and development of the infrastructure on which the processes are based.

The Trust provides statutory and mandatory training and guidance to ensure that risk management is integrated into all policies and procedures which:

- raises awareness of incident reporting and near misses;

- ensures compliance with professional registration requirements;

- provides a consistent approach to the management of risk; and

- develops systems and processes which have the capacity to manage and mitigate risk.

Good practice and lessons learnt were widely shared during the year through mechanisms such as the Strategic and Divisional Learning Review Groups, the Operational Governance Group, Clinical Governance Group, Workforce Governance Group and various publications produced by the Trust.

The Board Assurance Framework is the key tool used by the Trust to provide assurance of that risk and control mechanisms are in place and operating effectively. Through regular monitoring of the Board Assurance Framework and the operational risk registers, which underpin the risk management process, the Executive Team and the Trust Board ensure that current risks are managed appropriately and there are suitable arrangements for preventing and deterring risk.

The risk management arrangements are supported by a system of management control throughout the organisation which governs how the organisation operates. This includes the existence of clear policies and procedures to guide staff in their everyday work, a scheme of delegation which explains which groups and individuals have specific decision-making and financial authority, arrangements for the supervision and appraisal of staff and a system of audits and reviews of the Trust's processes to ensure compliance with legislation and internal requirements, particularly in relation to patient safety and effectiveness. These measures ensure that the organisation's statutory obligations and requirements from external regulators including the CQC are complied with and risks are effectively managed including the prevention and deterrence of those risks.

The Trust's quality impact assessment and equality impact assessment processes ensure that risks which could arise from changes to services, new initiatives or proposals for efficiency savings are identified early, prevented and deterred as appropriate and managed effectively.

The Trust has an annual Counter Fraud work programme in place and the result of the reviews undertaken are monitored by the Trust's Audit Committee. The Board receives the Board Assurance Framework regularly and

discusses the principle risks and the controls in place. The Board also receives integrated performance reports which provide data in respect of financial, clinical and national targets and objectives. Any areas of risk are highlighted through the use of a red, amber and green (RAG) rating system.

Review of the effectiveness of risk management and internal control
As Accountable Officer, I have responsibility for reviewing the effectiveness of risk management and the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Governance Committee. Plans to address weaknesses and ensure continuous improvement of the system are in place.

Executive directors within the Trust, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed and managed appropriately. This is reinforced by assurance from the Board Assurance Framework.

My review is also informed by debate and reports at the Audit Committee, reports from the Quality and Governance Committee and meetings of the Executive Team and the Board.

My review is also informed by the annual audit plan and the outcomes of audits, clinical audit reports and performance monitoring.

The Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The priorities identified for 2013/14 were consulted on through the Local Involvement Networks and the Health Overview and Scrutiny Committees to ensure that the Trust prioritised those areas of interest to the public. The Trust Board reviews the Quality Account prior to publication and seeks assurance from the Executive Directors regarding the accuracy of the document. The Trust Board approves the Quality Account prior to publication.

A Quality Strategy was approved by the Trust Board in July 2012 and this document sets out the key documents, the key strategic priorities, the key Board assurances that are in place, and the key metrics in place to underpin the strategy. An update on the Quality Account Priorities is presented at regular intervals to the Trust Board. The Trust Board also receives an Integrated Board Report at each meeting which includes the key performance indicators identified in the Quality Strategy.

Significant Issues

There are no significant issues to report.

Accountable Officer : Phil Milligan **Organisation:** East Midlands Ambulance Service NHS Trust

Phil Milligan
Chief Executive
5 June 2013

Operating and Financial Review

During the period to 31 March 2013, the Trust achieved the following financial duties:

Description of Target	Target	Actual Result
Adjusted Surplus	£1,400k	£ 30k (excluding impairment write back)
3.5% Return on Capital	3.5%	3.5 %
Compliance with Capital Resource Limit	£5,392k	£5,082k

The financial position for 2012/2013 shows a retained deficit of £328k for the year. This figure is inclusive of net impairment write backs to buildings of £358k in recognition of the revaluation exercise carried out by the District Valuer at 31 March 2013. The adjusted surplus reported is within the parameters agreed with the Midlands and East Strategic Health Authority.

Revaluation gains on buildings of £90k are shown in the accounts. An increase in value arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure. In this case it is credited to expenditure to the extent of the decrease previously charged there. This has created an impairment reversal of £36k in the accounts to the benefit of the Trust. £770k relates to 2011/2012 and £237k from the previous financial year.

In July 2012, the Trust lost the majority of its Patient Transport Services (PTS) business. Primary Care Trusts in the East Midlands engaged East Midlands Procurement and Commissioning Transformation (EMPACT) to coordinate a competitive tendering exercise regarding the provision of PTS. Unfortunately, decisions were taken by our Commissioners to award the contracts to external providers.

As a result of this loss of business, the amount of income received by the Trust from Primary Care Trusts reduced by approximately 10%. This caused significant financial challenges for the Trust. In response to the loss of our PTS income, management and infrastructure costs across Support Service functions were reduced by approximately £1.9m on a full year basis. 35 whole time equivalent posts were eliminated from the establishment which led to Redundancy costs of £926k. During the year, a further MARS scheme was operated by the Trust, this reduced the workforce by 40 whole time equivalents at a cost of £1m.

The 2012/2013 results have been achieved with a 4.5% Cost Improvement Programme (CIP) equating to around £6.7million. CIP's totalling £6m have been drawn up for 2013/2014. This compares with delivery in the current year which is broadly in line with the level in the previous year.

Levels of CIP in the four subsequent financial years range between 4.0% and 5.9% as the Trust will move into a more conventional operational environment.

From April 2012, following a national policy change, Payment by Results (PbR) has been extended into the ambulance sector. PbR is a system for the payment of NHS providers within the NHS in England. It is a way of paying providers a standard national price or 'tariff' for each individual episode of treatment they supply.

This represented a significant change for the Trust from 1 April 2012.

The national roll out into the ambulance sector is under pinned by the principle of mandated national categories with local prices. The Trust's 2012/2013 A&E contract has been structured to reflect this.

The following income has been received from our Commissioners against the national categories:

	£000k
• Calls	4,512
• Hear and Treat	397
• See and Treat	38,890
• See, Treat and Convey	82,425
Total	126,224

Local tariffs are applicable to the above.

During 2012/2013 the Trust spent the majority of its available Capital as measured by the Capital Resource Limit (94%). As in previous years, a significant proportion of the Capital Programme is allocated to the purchase of extra vehicles (£1.1m) and improvements to the Estate (£1 million). A further £1m has been spent on preparation work associated with the Being the Best initiative. The Trust has also purchased 2 specialised Polamb vehicles (operated in partnership with the Police) which are used in the Nottinghamshire and Leicestershire Divisions at a cost of £240k.

Included in the Capital Resource Limit is an additional amount of £1m that has been acquired from within the local Health Economy

The Trust's performance regarding its compliance with The Better Payment Practice Code is set out within the Summarised Financial Statements.

Following a tendering exercise throughout the NHS, KPMG became the sole provider of External Audit services to EMAS from 01 April 2012. The expenditure on External Audit services for the year was £91k.

In 2012/2013 KPMG received £8k in respect of Other Auditors' Remuneration.

All other non-financial performance indicators are covered elsewhere in the Annual Report.

The Accounts have been prepared in accordance with the guidance outlined in the 2012/2013 NHS Manual for Accounts and have been produced under International Financial Reporting Standards (IFRS). The accounting policies have been approved by the Audit Committee.

The Trust operates income generation activities covering vehicle maintenance training and operational cover for public events e.g. football matches. These are not significant areas of income (approximately 0.7% of total income). All are priced to cover costs of providing the service plus a contribution to the fixed costs of the organisation.

EMAS does not make any professional indemnity insurance payments for its Directors or Officers.

Pension Liabilities (see Note 10.5 in the full audited accounts) and Annual Governance Statement are contained in the full set of audited accounts available free of charge from the Finance Department at East Midlands Ambulance Service NHS Trust, Trust Headquarters, 1 Horizon Place, Mellors Way, Nottingham Business Park, Nottingham, NG8 6PY. Telephone: 0115 844 5000. Copies of the Annual Report are available from the same address.

The Trust confirms that it had not entered into any off payroll arrangements costing in excess of £58,220 per annum that were in place at 31 January 2012 nor had entered into new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months.

Summarised Financial Statements

Statement Of Comprehensive Income for year ended 31 March 2013

	2012 - 2013 £000	2011 - 2012 £000 (restated)
Revenue		
Gross employee Benefits	(112,275)	(118,459)
Other Costs	(41,208)	(46,899)
Revenue from patient care activities	149,815	165,192
Other Operating revenue	5,226	4,341
Operating surplus	1,558	4,175
Investment revenue	24	32
Other gains	6	1
Finance costs	(62)	(69)
Surplus for the financial year	1,526	4,139
Public dividend capital dividends payable	(1,854)	(1,743)
Retained (deficit)/surplus for the year	(328)	2,396

Other comprehensive income	**2012 - 2013 £000**	2011 - 2012 £000
Impairments and reversals	(362)	(2)
Net gain on revaluation of property, plant & equipment	90	641
Total comprehensive income for the year	(600)	3,035

Financial performance for the year

Retained (deficit)/surplus for the year	(328)	2,396
Impairments	358	(994)
Adjusted retained surplus	30	1,402

Statement Of Financial Position as at 31 March 2013

	31 March 2013	31 March 2012
	£000	£000
Non-current assets		
Property, plant and equipment (PPE)	60,582	60,848
Intangible assets	15	31
Total non-current assets	60,597	60,879
Current assets		
Inventories	1,822	1,308
Trade and other receivables	8,603	7,564
Cash and cash equivalents	6,094	11,652
	16,519	20,524
Non-current assets held for sale	0	0
Total current assets	16,519	20,524
Total assets	77,116	81,403
Current liabilities		
Trade and other payables	(13,249)	(16,079)
Provisions	(1,155)	(2,189)
Borrowings	(17)	(17)
Total current liabilities	(14,421)	(18,285)
Non-current assets plus/less net current asstes/liabilities	62,695	63,118
Non-current liabilities		
Provisions	(997)	(802)
Borrowings	(33)	(51)
Total non-current liabilities	(1,030)	(853)
Total Assets Employed	61,665	62,265
FINANCED BY:		
TAXPAYERS' EQUITY		
Public Dividend Capital	62,228	62,228
Retained earnings	(8,551)	(8,299)
Revaluation reserve	7,988	8,336
Total Taxpayers' Equity	61,665	62,265

The financial statements on pages 46 to 51 were approved by the Board on 5 June 2013 and signed on its behalf by:

Phil Milligan
Chief Executive

Jon Sargeant
Director of Finance & Performance

Statement Of Changes In Taxpayers' Equity
For the year ended 31 March 2013

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2012	62,228	(8,299)	8,336	62,265
Changes in taxpayers' equity for 2012 - 2013				
Retained deficit for the year	0	(328)	0	(328)
Net gain on revaluation of property, plant, equipment	0	0	90	90
Impairments and reversals	0	0	(362)	(362)
Transfers between reserves	0	76	(76)	0
Net recognised (expense) for the year	0	(252)	(348)	(600)
Balance at 31 March 2013	62,228	(8,551)	7,988	61,665
Balance at 1 April 2011	60,534	(10,713)	7,715	57,536
Changes in taxpayers' equity for the year ended 31 March 2012				
Retained surplus for the year	0	2,396	0	2,396
Net gain on revaluation of property, plant, equipment	0	0	641	641
Impairments and reversals	0	0	(2)	(2)
Transfers between reserves	0	18	(18)	0
New PDC received	1,694	0	0	1,694
Net recognised revenue for the year	1,694	2,414	621	4,729
Balance at 31 March 2012	62,228	(8,299)	8,336	62,265

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	2012 - 2013 £000s	2011 - 2012 £000s
Cash Flows from Operating Activities		
Operating Surplus	1,558	4,175
Depreciation and amortisation	4,734	4,522
Impairments and reversals	358	(994)
Interest Paid	(62)	(69)
Dividends (Paid)	(1,894)	(1,634)
(Increase) in Inventories	(514)	(407)
(Increase)/Decrease in Trade and Other Receivables	(999)	468
Increase/(Decrease) in Trade and Other Payables	(1,307)	1,777
Provisions Utilised	(1,842)	(387)
Increase in provisions	1,003	1,550
Net Cash Inflow from Operating Activities	1,035	9,001
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	24	32
(Payments) for property, plant and equipment	(6,922)	(6,861)
Proceeds of disposal of assets held for sale (PPE)	322	46
Net Cash (Outflow) from Investing Activities	(6,576)	(6,783)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	(5,541)	2,218
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	0	1,694
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(17)	(17)
Net Cash Inflow/(Outflow) from Financing Activities	(17)	1,677
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(5,558)	3,895
Cash and cash equivalents (and bank overdraft) at the beginning of the period	11,652	7,757
Cash and cash equivalents (and bank overdrafts) at the year end	6,094	11,652

1. Capital Programme Year Ended 31 March 2013

	2012/2013 £'000	2011/2012 £'000
Purchased Assets		
Replacement Vehicles	1,389	5,555
Medical Equipment	547	118
IT Equipment	1,380	496
Estates	1,006	1,618
Assets Under Construction	1,028	0
Other	49	0
Donated Assets		
Vehicles	0	0
Less:- Book Value of assets disposed of	(317)	(45)
Less:- Donations towards acquisition of non current assets	0	0
Charge against Capital Resource Limit	5,082	7,742
Capital Resource Limit	5,392	8,014
Underspend against the Capital Resource Limit	310	272

2. Better Payments Practice Code

The Better Payments Practice Code is a measure of the promptness of payment made to our suppliers. The NHS Executive requires that Trusts pay their non-NHS and NHS trade creditors in accordance with the CBI prompt payment code and government accounting rules. The target is to pay non-NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Results achieved this year have been as follows:

	Number (Total)	£'000 (Total)
Total Non-NHS invoices paid 2012/2013	26,229	43,926
Total Non-NHS invoices paid within target	24,937	37,425
% of Non-NHS invoices paid within target	95.07%	85.20%
Total NHS invoices paid 2012/2013	763	2,984
Total NHS invoices paid within target	694	2,364
% of NHS invoices paid within target	90.96%	79.22%

3. Staff Sickness Absence

	2012/2013	2011/2012
Total Days Lost	41,466	48,907
Total Staff Years	2,905	3,125
Average working Days Lost	14	16

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF EAST MIDLANDS AMBULANCE SERVICE NHS TRUST ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2013 East Midlands Ambulance Service NHS Trust, which consists of Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, and supporting notes 1 to 3.

This report is made solely to the East Midlands Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the East Midlands Ambulance Service NHS Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the East Midlands Ambulance Service NHS Trust for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

Basis of opinion

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of East Midlands Ambulance Service NHS Trust for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Neil Bellamy for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 Waterloo Way
Leicester LE1 6LP
United Kingdom

7 June 2013

Glossary of financial terms

Remuneration

Monetary payment made for services rendered to an employer. Remuneration includes the following: base salary, bonuses, allowances, the benefit of a company car and all other payments receivable by the Applicant.

External Financing Limit

The amount of additional funding the Trust is required to repay or borrow from the Department of Health.

Better Payment Practice Code

A measure of the promptness of payment to our suppliers. The target is to pay suppliers within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Private Finance Initiative

A government initiative where the public sector contracts to purchase services, with defined outputs, on a long-term basis from the private sector, including the construction and maintenance of the necessary infrastructure.

Agenda for Change

The NHS pay system which supports service modernisation

Efficiency

In the public sector this involves making the best use of the resources available

Value for Money

Is a measurement of quality that compares the resources used to procure goods or services with the benefit obtained from those goods or services

Income generation

Income generation activities relate to the provision of services, supplies or products for financial gain to parties 'outside the NHS'. 'Outside the NHS' means parties other than fellow NHS organisations, NHS staff and NHS patients.

Annual Report
2012/2013

East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY

Call 0115 884 5000
Email communications@emas.nhs.uk
Visit www.emas.nhs.uk

To receive this information in large print, audio or in another language, please call us on 0845 299 4112.

communications@emas.nhs.uk

Annual Report

A review of the EMAS year

2011/2012

Annual Report
2011/2012

Foreword

Welcome to the East Midlands Ambulance Service (EMAS) NHS Trust Annual Report for the period 1 April 2011 to 31 March 2012.

Within this report we have identified our main achievements for the year, which are a tribute to the commitment and professionalism of our staff. We also value the support given by many volunteers all of whom provide a valuable resource in the delivery of patient services. In addition, we acknowledge the involvement of patients and their representatives in the work that we do.

We hope you find our Annual Report to be interesting and informative.

If you would like to learn more about East Midlands Ambulance Service please visit us at www.emas.nhs.uk

Chairman's Report

This is my first report as Chairman of EMAS, a role to which I was delighted to be appointed on 1 July 2011. Since my arrival, there have been several changes at Board level and we now have a very effective and skilled team of Executive and Non-Executive Directors leading the organisation forward.

We expect to be busy as an emergency service, and the last twelve months have been no exception. We have responded to over 593,000 incidents during the year including a significant amount of distressing and traumatic situations, where people have needed high quality clinical care, often in challenging environments.

Our staff do great things day in day out, 24 hours a day, and we are very proud of them. I would like to thank all our hard working staff, colleagues from voluntary organisations across the region and within the wider healthcare community for their efforts in helping us to provide the best possible emergency care to patients during the year.

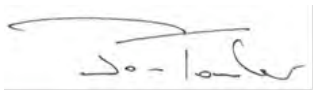
We continually monitor our performance and we are now measured nationally on how effective the treatment we provide is, including the outcomes of that treatment as well as how quickly we reach patients. Introduced on 1 April 2011, the Ambulance Quality Indicators provide monthly updates that show how we are doing and how we compare to our sister services on each of the quality measures. We publish this information every month on our website giving the public the chance to see how we are progressing. Whilst we did experience challenges in relation to our response times during parts of the year, I am pleased to say that the quality of clinical care provided by staff is of a very high standard which reflects the training provided to staff and their professionalism. In addition, we made significant steps forward against our national eight minute response target for life threatening emergencies and achieved this target for the first time in three years.

We are always looking for ways to improve our service for the benefit of staff and patients. A good example of this was the fitting of cold weather tyres to all frontline emergency ambulance vehicles before winter conditions set in. When bad weather did hit our region in early 2012, we received over 1,000 emergency calls each day from people reporting a life-threatening illness or injury (approximately 200 more than for a normal day). Together with the skill and determination from our crews, the cold weather tyres made a real difference and helped us get to people a little bit faster and more safely.

Over 90 people were attracted to our Annual General Meeting in 2011 – our best ever turnout. Attendees were able to talk to members of EMAS staff, including our Hazardous Area Response Team, view displays about our work – and even have their blood pressure taken. As part of our on-going work to involve the public, local people were given the opportunity to meet EMAS staff and managers from their area at a series of divisionally based community engagement events which we arranged during the year. We are grateful to the people who took the time to come and see and hear about the service.

Looking to the future, the Board has discussed plans to help us to become the best ambulance service possible. Towards the end of 2012, we aim to launch a full public consultation exercise into those plans and I urge you to get involved and share your views. In the meantime, you can read more about our proposals by visiting the Trust Board section of our website.

Whilst we have made considerable progress this year, we have much more work to do. I can assure all readers of our Annual Report that we are committed to further improving the service we provide and to delivering the highest standard of care to the people we serve.



Jon Towler
Chairman

Chief Executive's Report

Welcome to our Annual Report for 2011/2012.

I had the pleasure of being appointed Chief Executive in December 2011 when it was eight months into the performing year. It was a challenging time and I realised improvements were needed to enable our staff to do the job they are trained to do, and get to people quickly in an emergency.

Everyone in the organisation has worked hard to achieve improvements. With the support of colleagues in the acute hospitals to improve the handover times allowing our crews to get back to their ambulance and onto the road ready to respond to the next 999 call and with the financial support from our commissioners, I was very pleased that we achieved the A8 national target for responding to life-threatening emergencies. Achieving the A19 target is one of the areas where I expect us to improve during 2012/2013 and based on our results since December 2011, I believe that we can deliver both national targets next March. I thank our staff for their tremendous effort.

The new contract agreement with our commissioners will allow us to deliver our ambition to support more care closer to home for patients, using the extensive skills of our Emergency Care Practitioners and our Paramedics. Our *Being the best* modernisation plan has five components:

- our quality strategy which sets out how we will provide high quality clinical care to our patients
- the service model which sets out how we will organise our clinical services to respond to the needs of our patients
- the estate strategy which looks at how we will use buildings to support clinical activity
- our workforce strategy states how we will ensure that we always have trained, motivated staff with the right skills and experience
- the operating model which covers our management approach.

At Board level, there has been a significant change in membership because I am not the only one to join EMAS recently. Chairman Jon Towler, joined the service in July 2011 and is providing a clear guide on the strategic direction we need to be taking to meet current challenges and how we will operate in the future. We also had four new Non-Executive directors join EMAS in 2011, offering us the benefit of their wider experience, challenging us where necessary and providing advice on alternative ways of doing things. Their contribution will really benefit us and the patients we serve. Furthermore, we appointed a new Director of Operations and a Commercial Director during the year and welcomed a new Director of Finance to the team in early 2012. This new team have the knowledge, experience and skill to drive the changes needed to ensure patients get an excellent ambulance service.

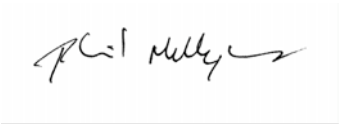
During the past few months we have also reviewed our governance structures. These ensure that we make the right decisions, at the right time and the right people make these decisions. The governance structure also ensures that we know how well we are managing the quality of the service and the resources that we have. The changes that we have made will help us to ensure that quality is at the top of our agenda and that the Board 'knows its business.

Our vehicles are changing too! We made a £9m investment in new ambulance vehicles during the year and 80 new state of the art ambulances will enter service during 2012. Design changes to improve staff safety and the comfort or patient care have been made – all based on staff suggestion and feedback. Using the skills and experience of staff who will redesign services will be a key component to how we will work in future.

Of course we were very disappointed to have lost the Patient Transport Service contract. However, we worked diligently to ensure the transfer of services to the new providers on 1 July 2012 was managed effectively.

Becoming an NHS Foundation Trust (FT) continues to be an important goal for us and we look forward to the challenges and opportunities this presents. This work is taking place in tandem with the need to achieve significant cost reductions and introduce a new service model.

We have the staff to be the best ambulance service possible, they are well trained and dedicated and are passionate about the services we provide. Together with their motivation and professionalism, and our *Being the best* modernisation plan, I hope you can see we are building a service fit for the future.



Phil Milligan
Chief Executive

A profile of the Trust

The East Midlands Ambulance Service (EMAS) provides emergency and urgent care, patient transport, call handling and clinical assessment services for 4.8 million people in an area covering approximately 6,425 square miles across the six counties of Derbyshire, Nottinghamshire, Lincolnshire, Northamptonshire, Leicestershire and Rutland.

We cover the full area of the East Midlands Strategic Health Authority plus North Lincolnshire and North East Lincolnshire within Yorkshire and Humber Strategic Health Authority.

We employ over 3,200 staff at more than 70 locations, including two Emergency Operations Centres at Nottingham and Lincoln, with the largest staff group being our accident and emergency 999 crews. We operate a fleet of around 780 vehicles, including emergency ambulances, fast response cars, specialised vehicles and patient transport vehicles. Our overall annual expenditure budget in the year was £159 million.

Every day we receive around 1,620 calls from members of the public who have rang 999 - this is the equivalent of receiving a 999 call every 45 seconds of every day.

Accident & Emergency Service (A&E)

As well as a resident population of just over 4.8m people, we have to meet the demands placed on us by visitors who fall ill or suffer an injury. With five large cities, major arterial roads, an international airport, a lengthy coastline and several country parks, this extra activity, especially during the summer months, is significant. Apart from the challenges posed by our geographical boundaries and the region's infrastructure, EMAS has to cope with year on year increases in the number of 999 calls made by the public.

In support of our conventional ambulances, we receive valuable assistance from a large number of Community First Responder Schemes (CFR) which provide emergency cover mainly in the more rural areas we serve. We also benefit from the presence of three separate air ambulances which permanently operate across the area we serve. These are operated by registered charities and feature EMAS paramedics amongst their crews. In addition, we have a team of doctors who provide both a primary response role to life-threatening calls and clinical support for crews at serious clinical incidents such as road traffic collisions.

We also operate a Hazardous Area Response Team which comprises of over 40 personnel specially trained in dealing with Chemical, Biological, Radioactive and Nuclear (CBRN) incidents and Urban Search and Rescue techniques.

We will further improve patient care, by ensuring that patients consistently receive the right response, the first time and on time. Our approach also means that more patients will be treated in the community, and fewer people will go to A&E unnecessarily.

Patient Transport Service (PTS)

Non-emergency PTS is provided for people who need to attend a hospital or clinic for routine outpatient appointments or day care sessions. This service provides much needed support to patients (and their carers) as part of the overall health-care package.

In contrast to A&E services, demand for this important element of our work is fairly constant. During the period we provided 1,082,804 journeys.

Following a competitive tendering exercise, from July 2012, EMAS will no longer provide PTS other than in North and North East Lincolnshire. The loss of this work had a significant impact on EMAS' financial position and on learning the news; attention was focused on what changes would have to be made as a consequence.

Call handling and clinical assessment

Our Clinical Assessment and Advice Service dealt with 39,991 calls during the year. This allows the Trust to provide patients with an alternative care pathway leading to fewer admissions to accident and emergency departments. We are committed to further improving the speed and quality of our call handling and work in a more integrated way with partners to ensure consistent clinical advice for patients who need urgent care.

The EMAS Trust Board

During the initial months of the year under review, there were several changes in the membership of the Board at Executive and Non-Executive level. By November 2011, all Non-Executive positions had been permanently filled.

The EMAS Trust Board comprises of 13 members:

- Chairman
- Chief Executive
- 6 Executive directors
- 5 Non-Executive directors

The Board's role is to:

- Agree a common set of objectives that set the high-level direction of the Trust - Objectives
- Determine whether it can robustly achieve its objectives based on - Risk analysis
- Establish governance systems enabling it to monitor and achieve its objectives – Controls
- Understand what information it needs – Assurance.

The Trust Board's main functions encompass:

- Formulating policy and foresight (in relation to the external environment). Stating purpose, vision, values, culture and climate
- Thinking strategically. Positioning in the health community, setting corporate direction, reviewing and deciding key resources, deciding implementation processes
- Supervising management (the patterns not detail). Monitoring budgetary control, reviewing key results, ensuring organisational capability
- Exercising accountability to stakeholders and ensuring directorial audits.

Executive directors are responsible for managing EMAS' affairs on a day-to-day basis under approved Board policy and statutory requirements.

In accordance with good governance practice, the Board of directors includes a balance of independent Non-Executive directors with skills and expertise in the public and private business sectors which complement those of our executive directors. None of our directors or Non-Executive directors have declared any interests which conflict with their responsibilities to the Trust.

The Trust Board and management operate within an assurance framework based on the 'Combined Code of Corporate Governance' articulated through its Integrated Governance Policy and Strategy (2007). This strategy clearly identifies the types of decisions reserved to the Board and which may be taken by management. The Board takes assurance for the performance management of delivery of its objectives to the Audit and Clinical Quality & Governance Committees which receive their assurances from lead managers and directors through the Trust's integrated performance management system.

Ongoing self-assessments to monitor the performance of our key committees are carried out as part of our review process.

The following tables identify the number of attendances made by each Board member at our three key meetings:

Board meetings

Executive Directors	Possible attendances	Actual attendances
P Milligan	2	2
B Brewster	8	8
D Farrelly	8	8
K Glover	8	7
D Lee	4	3
J Gray	8	7
P Ripley	4	4

Non-Executive directors	Possible attendances	Actual attendances
C Faircliffe	3	3
G Austin	8	8
B Baker	4	3
R Whitehouse	5	5
J Williams	5	5
L Jackson	5	5
J Towler	5	5
P Tagg	3	2
G Newton	3	3
S Dawkins	3	3
D Toberty	3	3

Audit Committee meetings

Non-Executive directors	Possible attendances	Actual attendances
G Austin	6	6
R Whitehouse	4	4
J Williams	4	4
S Dawkins	2	2
D Toberty	2	2
G Newton	2	2

Quality & Governance meetings

Executive Directors	Possible Attendances	Actual Attendances
J Gray (Lead Executive)	6	6
K Glover	6	5
K Gulliver	3	3
P Ripley	4	3

Non-Executive directors	Possible attendances	Actual attendances
P Tagg (Chair)	2	2
J Towler	4	3
S Dawkins	2	2
G Newton	2	2

The operating environment

Becoming the best ambulance service

Following the appointment of a new Chairman, Chief Executive and Non-Executive Directors during the year, EMAS developed a vision, to become "*a leading provider of high quality and value for money clinical assessment and mobile healthcare*." We have captured our plans under the banner of 'Becoming the best ambulance service'. In pursuit of this target, a comprehensive review was carried out and key change programmes developed to ensure the Trust can provide high quality care, be financially sustainable and be effectively managed. Plans were captured in the following documents:

- **Quality strategy** (which sets out how we will provide high quality clinical care to the patient throughout their clinical journey)
- **Service model** (how we will organise clinical services to respond to patient's needs)
- **Estates strategy** (how we will use buildings to support clinical activity)
- **Workforce strategy** (how we will ensure that we always have trained, motivated staff with the right skills and experience)
- **Operating model** (how we will organise the management approach, including the roles of executive team members, the Trust Operational Management structure and our committee structure)

The proposals contained in the above were submitted to the Trust Board in April 2012 and agreement reached to proceed to the consultation phase. This will be a cornerstone of EMAS' work during 2012/2013 and pivotal to the organisations performance.

The financial environment

The Trust faces a significant challenge in 2012/2013 to right-size the organisation and restructure its reduced operating scale as a result of the loss of PTS business, falling core response demand in 2011/2012 and the drive to improve efficiency and productivity. Our greatest challenge will be to embed delivery of national performance standards within available funds as the normal operating status for the Trust. That will provide mitigation against a number of key financial risks and help build EMAS' reputation as a strong brand in the delivery of emergency and urgent care.

Our financial plan reflects the challenges we face during 2012/2013 and proposed methods of mitigating them. It is designed to deliver:

- 1.5% revenue surplus
- National performance standards regionally for A8 and A19
- Cost Improvement Programme savings 4.5% (£6.7m)
- Financial Risk Rating 4
- Achievement of statutory financial duties whilst an NHS Trust
- Tripartite Financial Milestones (these identify the key strategic and operational issues, the actions to address them and the key milestones that will need to be met to enable our FT application to be submitted on the agreed date).

Service improvement

Business Planning Managers deal with the implementation of the strategic direction by developing new models of care and adopting methods of transformational change. This means:

- Ensuring EMAS has robust links with the Emergency Care Networks (other organisations providing emergency care services)
- Improving the understanding of EMAS' role in the redesign of service delivery
- Avoiding the duplication of work programmes across the Emergency Care Networks
- Tackling national and local priorities and developing action plans
- Promoting new ways of working across the EMAS area in true partnership with the healthcare
- community, including NHS Direct, Acute and Primary care, Social Care and Mental Health

Foundation Trust status

EMAS continues to progress its NHS Foundation Trust application and is aiming to become an NHS Foundation Trust in 2013.

We initially went out to public consultation in 2009 and as we drew nearer to submitting our application, we decided to launch a refreshed public consultation exercise. This ran from 10 April 2012 to 3 July 2012.

In preparation for our application to the Department of Health and subsequently Monitor (independent regulator of foundation trusts), we have been focusing on the development of our five year Integrated Business Plan (IBP), our Long Term Financial Model (LTFM) and the enabling strategies that will support the delivery of our five year IBP.

The application process to become a NHS Foundation Trust is a well structured and robust process set out by the Department of Health and Monitor and results in a sixteen week rigorous assessment process by Monitor. To ensure that we are successful in our application for Foundation Trust status, the Trust must be able to demonstrate that we have a clear strategic direction of travel (IBP), that we are and can remain financially viable for the longer term (LTFM) and that we have robust governance structures in place (IBP and assessment by Monitor).

One of the many benefits of applying to become a NHS Foundation Trust is that we can recruit members and governors. This means that the Trust is accountable to its local population, enabling local ownership and

service influence. NHS Foundation Trusts remain part of the NHS and we will continue to be subject to NHS standards, providing care paid for by the NHS, to NHS patients.

The Trust has proudly recruited over 19,000 staff and public members since announcing our plans to apply for NHS Foundation Trust status and we will continue to recruit and engage with our members to enhance our local accountability and involve local people in our future service developments.

Our achievements at a glance

During the period under review, EMAS continued to make significant progress on a broad range of initiatives. The following information provides a snapshot of key developments within each of our Directorates.

Operations Directorate

Operational performance

During 2011/2012, we received 776,083 emergency 999 calls from members of the public. Our accident and emergency crews responded to 593,065 of these calls, which equates to 1,620 responses every day. Of these, 222,360 were Category A (serious, life threatening calls). There are two national performance standard for Category A calls, the first requires us to respond to at least 75% of incidents in 8 minutes (or less), the second requires us to provide a double crew support vehicle within 19 minutes (or less) for 95% of calls. In the year under review, we achieved a response rate of 75.15% (response within 8 minutes) and 92.32% (support vehicle within 19 minutes). We were pleased to exceed the 75% target and accept that more work needs to be done in 2012 / 2013 to achieve the 95% standard.

39,991 calls were dealt with by our Clinical Assessment and Advice Service. This allows the Trust to provide patients with an alternative care pathway leading to fewer admissions to accident and emergency departments. We are committed to further improving the speed and quality of our call handling and working with partners to ensure consistent clinical advice for patients who need urgent care.

Divisional developments

This section identifies the main achievements of each of our Divisions:

Managers and staff in Derbyshire Division:

Worked in conjunction with the Police and successfully developed a new approach to dealing with emergency calls associated with high concentrations of the public. The new Police / Ambulance facility involves a police officer travelling with the ambulance crew on occasions when public unrest is likely, for example, over the Christmas and New Year period. This scheme has successfully reduced the likelihood of aggression towards our staff.

Introduced a Single Point of Access scheme for patients in the north of Derbyshire leading to fewer admissions to hospital and better use of community healthcare and social care services.

Developed new pathways allowing ambulance crews to take patients with diabetes and / or chronic obstructive pulmonary disease direct to a specialised unit rather than them attending accident & emergency first

Introduced a scheme in which all GPs and out of hours providers agreed to a procedure whereby ambulance crews can contact a GP for advice or support about the clinical care or social management needed by patients who have called 999. When calls for assistance are made, ambulance staff are guaranteed a call-back within 15 minutes.

Managers and staff in Lincolnshire Division:

Began deploying an emergency care practitioner (ECP) in the Emergency Operations Centre (Control Room).The aim of this initiative was to identify patients whose presenting condition could be dealt with by an operational ECP thus reducing the unnecessary transportation of patients to an A&E Department.

Introduced an Urgent Care team to provide an improved and more timely service to patients who had been seen by a GP and needed to be admitted to hospital. This scheme is staffed by personnel with intermediate skills as the patients involved do not need the skills of a fully trained paramedic.

Introduced hospital ambulance liaison officers (HALO) at the main A&E departments to improve clinical and crew turnaround times and provide better liaison between hospital and ambulance staff.

Managers and staff in Northamptonshire Division:

Worked with other healthcare providers to introduce Crisis Response Falls Team providing an integrated service to patients who have suffered a fall, the aim being to limit the effects of the fall (post-fall syndrome) and promote independence for patient. Ambulance crews who respond to such calls assess patients to establish if hospital admission is required or whether the patient can be safely supported by other health or social care services in the community. At this point, a holistic approach is taken where the patient and the home environment are assessed to prevent further incidents occurring. The Crisis Response Falls Team has access to Community Consultant Geriatricians, Community Pharmacists and Community Psychologists and can also take patients direct to a Specialist (fall) Care Centre.

Managers and staff in Leicestershire & Rutland Division:

Introduced a scheme in which 50 GP practices in West Leicestershire now offer a priority referral service whereby they will accept direct referrals from EMAS for their patients. EMAS clinician can now discuss the patient's situation and condition with their own surgery and arrange a same day appointment or home visit by the GP or other healthcare professional, as agreed with the GP.

Introduced an Ambulance Support Vehicle (ASV) for patients with low level medical conditions who can walk without assistance. The vehicle is staffed by a Paramedic and an Emergency Care Assistant and operates from 1400 to 0200, 7 days per week. On average, this new facility transports just over 8 patients each day which frees-up front-line A&E resources to respond to other 999 calls.

Introduced a Police / Ambulance vehicle in Leicester city centre on Friday and Saturday nights. The vehicle is staffed by a paramedic and a Police Officer and achieves an excellent non-conveyance rate as well as reducing the risk of verbal or physical aggression towards ambulance crews.

Managers and staff in Nottinghamshire Division:

Launched a project (at Kings Mill hospital, Mansfield) to speed up the transfer of patients from EMAS' care to hospital clinicians. All stretchers and toughbooks of vehicles which operate in the area were 'tagged' and the system automatically records when crews enter and leave the emergency department. This provides very accurate information on patient flows and early identification of when hold-ups occur – allowing remedial action to be taken.

Participated in a trial (at the Queen's Medical Centre, Nottingham) to provide a dedicated crew between 1200-2000, Monday-Friday to provide an improved quality of service to patients who have been seen by a GP and referred to the hospital for further tests. Previously, such patients were conveyed by front-line A&E crews and this frequently resulted in transport delays (at times when 999 call volumes were high). Now, the crew work in close liaison with hospital staff and respond to transport requests which enables patients to be brought in to hospital much earlier than before. Patient can then access a full range of diagnostics, which allows an early decision to be taken on whether or not they should be admitted. This approach means front-line A& E crews spend much less time responding to GP urgent transport requests and more time dealing with 999 calls.

Emergency Operations Centres

Our historic approach was focussed on answering 999 calls quickly; identifying the incident location and deploying the nearest resource promptly. Typically, this resulted in the majority of patients being treated at scene and routinely being taken to hospital. We have now begun to modify our approach to focus on meeting the needs of patients more effectively. This will result in more patients having care provided over the telephone

(hear & treat) and more being managed in the home environment (see and treat). By targeting clinicians to 999 calls where their skills can be properly utilised, we will give the right care to patients in the right place. This will reduce the number of patients who are conveyed to hospital.

In 2011 we introduced 'Call Virtualisation.' This facility allows 999 calls to be answered by call takers in either of our Emergency Operations Centres (EOC), regardless of the caller's geographical location. This enables both of our EOC sites to work 'as one' for answering 999 calls and dispatching appropriate resources to the scene. As well as providing resilience against the possible failure of an EOC, this new approach allows calls to be equally shared between the two sites thus giving an equal balance in demand. Now this facility is fully functional, we aim to answer 95% of all 999 calls within 5 seconds. To help achieve this, we have introduced a new call taker rota to ensure staffing levels are in harmony with demand trends. During the year under review, we responded to 88% of calls within 5 seconds.

Resource Management Centre

In 2011/2012, the Trust Board approved plans for the introduction of a new centralised facility to manage our resources flexibly and efficiently to meet the ever-increasing demand for our services. Our Resource Management Centre (RMC) was launched in March 2012 and now plays a key role in coordinating frontline A&E and EOC (Control) staff resources (rota management, annual leave, absence and sickness) as well as A&E vehicles resources (vehicle tracking and allocation based upon demand trends.

This facility replaced the previous approach of managing resources on a Divisional basis which led to some inconsistencies and lack of coordination. We now have a comprehensive picture of the resources available across the Trust - enabling us to plan how many staff are on shift and at what times of day and how many vehicle resources are available at specific times and in specific areas. This improves the way we match resources to predicted patient demand - providing improved services to our patients and offering improved working arrangements for our frontline staff.

Electronic Patient Record (EPR)

In early 2011, we started the third and final phase of the roll-out programme which integrated our Northamptonshire and Leicestershire divisions onto the EPR system. All vehicles which operate in these divisions were fitted-out with the necessary equipment and staff training started in April 2011.

The system allows us to connect with GPs and send a copy of the ePRF to them direct so they are aware of the nature of the injury or illness suffered by their patient and the treatment given by EMAS medics. This provides greater continuity in patient care.

A further upgrade of the system was released in summer 2011. This gave us the ability to access patients' summary care record (which is based upon an extract of the GP record). This will improve patient safety as, for example, staff will know about pre-existing medical conditions, medications and allergies and, in the longer term, information about the patient's wishes such as end of life care.

During 2011, we upgraded the software which drives our current ePRF system. EMAS has been nominated by the Regional e-PRF Group to lead on the introduction of the next version which will allow staff to access a new facility called NHS Pathways when attending patients who do not require transportation to hospital. NHS Pathways provides a clinical assessment tool to aid diagnosis and also links into an electronic directory of services which will allow staff to identify the availability of alternative treatment pathways (within the Primary Care setting) and then refer the patient to the service direct. NHS Pathways will be piloted in one of our divisions before being rolled-out across EMAS.

Clinical Assessment

Our Clinical Assessment facility (which operates at both our Emergency Operations Centres) is staffed by experienced Nurses and Emergency Care Practitioners (ECPs) with a vast range of skills over and above

basic triage assessment. The staff are from a wide variety of backgrounds and clinical settings and provide evidence based practice to support clinical decision making. After a detailed assessment, the nurses refer patients on to an appropriate service to meet their clinical needs and provide the appropriate care pathway, often in the community, without the need for the patients to attend hospital. During the year we increased staffing levels to enable the team to assess all categories of call..

Each week, around 25% of calls (below Category A level) are dealt with without the need to send an ambulance.

High Volume Service User (HVSU)

During the year, high volume service users (HVSU) have accounted for 2.9% of the Emergency calls received. Our HVSU lead has a case load of 280 patients some of whom, with the agreement of their GP, are being managed by the Clinical assessment team. That is, if they call 999, their needs are assessed before a resource is sent. This allows us to refer patients to an appropriate care pathway which has been identified following multi-agency working involving the person's key worker. Our HVSU process has allowed us to work with PCTs, Acute Trusts, Mental Health Trusts, Social Services and other agencies to manage patients appropriately in the right health community service setting. Our approach to managing HVSUs has been acknowledged locally and nationally as good practice.

In conjunction with the Local Security Management Specialist (LSMS), individuals identified as abusing the 999 service are also being managed through partnership working with local Police Forces and Community Protection Teams. In some instances this has led to prosecution and other sanctions being taken.

Community First Responders (CFR)

During the year, we continued to recruit people to this highly valued scheme. Community First Responders (CFR) are trained to deliver early Basic Life Support and early defibrillation prior to the arrival of an ambulance resource. They support EMAS by providing assessment, oxygen therapy and general patient care in their local community. Several different types of scheme operate across EMAS' area, all of which come under the generic description of CFRs - Lincolnshire Integrated Voluntary Emergency Service (LIVES), East Midlands Immediate Care Scheme (EMICS), Fire Co-responder schemes and independent CFR schemes (numbering over 250 and with 1,300 volunteers).

Hazardous Area Response Team (HART)

Our HART Team provided invaluable support to patients in areas or environments that require staff to use specialist skills, techniques or equipment. The team has worked closely and formed excellent working relationships with colleagues from the Police Forces and Fire and Rescue Services across our Region. Our HART team can enter and provide treatment to patients in the inner cordon or the 'hot zone' of incidents and save lives that may otherwise have been be lost. The longer-term medical implications for patients rescued from hazardous environments have been reduced due to early clinical assessment, triage and treatment and the overall health service response to dealing with hazardous incidents is now being managed more effectively than ever before. During the year, a number of HART staff were trained to operate in a firearms situation using the correct personal protective equipment.

Emergency Preparedness

The Emergency Preparedness Team continued to be busy meeting a number of challenges in 2011/2012. The Team have delivered Bronze and Silver Commander training for all Managers and Paramedic Team Leaders and gone on to test and exercise these command arrangements in a series of exercises. Two large exercises were carried out during the year to test plans for dealing with a Mass Flooding scenario (exercise Watermark) and evacuation of Mass Casualties.

A large amount of work has been undertaken to ensure robust business continuity arrangements are in place for our two Emergency Operations Centres and training for Major Incident management has been undertaken with all EOC staff in the past year.

Towards the end of 2011, the team became increasingly involved with the Multi Agency planning processes associated with the Olympic and Paralympic Games 2012. This commitment included operational planning for the Olympic Torch relay visits to the East Midlands and the deployment of a small number of EMAS staff to support colleagues from the London Ambulance Service during the games period.

The Emergency Preparedness team continued to work in partnership with a range of external agencies and have received significant support from within EMAS to help the Trust meet its obligations for maintaining resilience against known and potential risks.

Events Team

This team continued to support operational delivery by providing an ambulance presence at a wide range of major sporting venues within the region such as football grounds, race courses, rugby clubs and cricket clubs. The team also attends other public events across our area with high numbers of visitors. During the year, the team enjoyed a good track-record of successful clinical interventions thus demonstrating the benefit of having professional first aid cover available at large scale public events. Contracts have been agreed with all our major customers and the events team will continue to provide an excellent service to each of them.

Patient Transport Services (PTS)

The Commissioners via East Midlands Procurement and Commissioning Transformation (EMPACT) undertook an assessment in 2010 / 2011 to explore whether service provision could be improved. In May 2011, the decision was taken to put the contract for provision of PTS across the east midlands region out to competitive tender for a 5 year period from 1 April 2012 onwards.

Despite EMAS achieving a successful outcome in the market testing of PTS in North and North East Lincolnshire in 2010, our bid was not successful for the remainder of the East Midlands region and in December 2011, EMPACT notified us that the contracts had been awarded to two private providers; Arriva and NSL.

Although the contract was due to transfer to the new providers on 1 April 2012, delays in the overall process led to EMAS being asked to extend provision until 1 July 2012. We agreed to this to ensure a smooth handover to the new providers and give continuity of service for the population of the East Midlands who use this service.

EMAS now only holds 10% of the market share of PTS in the region and the impact of losing such a significant piece of workload has significant ramifications for the staff concerned as well as our financial position. This became clear in early 2012 when the EMAS Trust Board considered proposals to account for the loss in contribution to overheads.

111 scheme

During 2011/2012 three areas went live with a pilot 111 service - Nottingham City, Lincolnshire and Derbyshire. If the 111 scheme is implemented beyond the pilot stage, the longer term aim will be to phase out the services provided by NHS Direct.

We worked with the PCTs in the above areas to ensure processes were in place to guarantee that patients who required an ambulance following assessment through NHS Pathways received it without delay. Furthermore, to ensure a prompt ambulance response, we introduced a direct feed from these 111 service areas into our Computer Aided Despatch (CAD) system so EMAS dispatchers can see immediately that a response is required from EMAS.

During 2012, more pilots will be introduced across the East Midlands and EMAS will be bidding for any new business opportunities that present themselves as the principles behind the 111 scheme are very closely aligned to the role performed by staff in our Emergency Operations Centres. We therefore feel the organisation is ideally placed to extend its operating base into this field.

Fleet

In 2011/2012 we began to introduce cameras onto front-line A&E vehicles for both patient and staff safety. These systems will also provide information in the event of a road traffic collision that will allow the Trust to deal with claims more efficiently. This will be more cost effective for the Trust.

To improve fuel consumption, lower CO_2 emissions and reduce wear and tear on engines, we began fitting speed limiters to all Patient Transport Services (PTS) and support service vehicles. We expect this to reduce overall costs in this area by 15% - although the loss of the PTS contract will lead to a consequent reduction in the number of PTS vehicles we operate.

In conjunction with colleagues from other Ambulance trusts, we successfully set up the Ambulance Vehicle Supply Framework. All Ambulance Trusts in the UK now use this framework to purchase vehicles at very competitive rates and from a much wider range of suppliers that in the past.

In 2011 we designed and built 30 new vehicles for use on the North and North East Lincolnshire PTS contract.

Following the harsh winter in 2010 / 2011, we evaluated Michelin Cold Weather Tyres on an EMAS A&E ambulance at the Motor Industry Research Association test-track. The test was very successful and demonstrated the tyres improved the handling of the vehicle in wet conditions and at temperatures under 7 degrees centigrade. We subsequently placed an order for these specialist tyres and started a fitting programme in October 2011. Although the winter of 2011/2012 was not harsh, the tyres do improve safety for patients and staff when operating in the seasonal conditions we experience at that time of year and are, therefore, a good investment.

In 2011/2012 we purchased 62 new Skoda Scout Fast Response Vehicles to replace old cars on our fleet. This investment provides us with more reliable, new vehicles all supplied with the latest satellite navigation systems which, on receipt of a 999 call through the vehicle's mobile data terminal, automatically displays the location where help is needed. This saves the driver (or crew) valuable seconds on time critical responses.

As a member of the Ambulance Trusts Insurance Association, EMAS took part in the tender process to award our insurance business for the next 3 years. The process resulted in lower premiums for the Trust at a time when (in general) premiums are trending upwards, particularly in the private car insurance market.

In association with staff, we further developed the design of our A&E Ambulance. Based on a Peugeot chassis, two prototypes were introduced and staff feedback invited. We fine-tuned the vehicle design to take account of the ideas put forward by staff and placed an order for 80 vehicles, each of which have a stretcher capable of taking a patient of up to 700 lbs in weight (50 Stones). This initiative attracted keen interest from the media which had a very positive effect on the staff involved in the design process. The vehicles all have a standardised clinical area layout resulting in a safer and more ergonomic environment for staff and patients. At the end of this programme, 63% of our A&E fleet will have this standard clinical area layout making it easier for staff to locate items irrespective of the vehicle they are using.

Estates

During 2011/2012, the team continued to work on issues concerning clinical waste management, utility, maintenance and repairs. To improve performance, we have invited competitive tenders for a range of estates support and maintenance services.

The team is also leading on the Trust's sustainability and adaptation planning process. A group, led by a Director will be developing strategies for Adaptation and Sustainability to enable us to respond to medium and

long term environmental changes and drive down our carbon footprint. This work will be linked closely with the further development of the overall Trust estates strategy.

The estates team designed and delivered the new premises which our HART team operates from. The new facility was officially opened in August 2011.

Logistics

We continued to build on the improvement plan started two years ago by improving overall efficiency and performance and refining our supply chain systems and processes (including developing good Corporate Citizen activities). We are now supplying goods to the Lincolnshire Division which led to further rescheduling of deliveries to accommodate the additional deliveries.

During 2011, we assessed the supply of medicines to the Trust and introduced a new streamlined service leading to reduced overall costs.

We continued to work closely with the Infection Prevention & Control team to ensure appropriate cleaning and patient care materials are sourced and readily available across EMAS.

Through partnership working with the National Ambulance Procurement Project, we introduced market testing for the supply of staff uniforms and medical gasses.

In partnership with Royal Derby Hospital, we completed the project to bring medical equipment maintenance 'in-house' and during 2011, we focussed on consolidating and fully integrating this approach into EMAS' normal operational practices. Our engineering team is based at Alfreton, Derbyshire and carry out much of their work from a mobile workshop which is equipped to provide medical engineering services across our area. The engineers have been trained by the manufactures of the medical devices used by EMAS and are continually updated as new equipment is introduced. During 2012, the team will extend their maintenance services to include equipment utilised by volunteer Community First Responder groups.

Security Management

Our Local Security Management Specialist (LSMS) continues to provide support and advice to managers and staff involved in aggressive or violent incidents.

During 2011 /2012, our Accident and Emergency crews reported 209 aggressive or abusive incidents (down from 217 the previous year). The LSMS reported 80 assaults (up from 71 the previous year) to NHS Protect for information.

We prosecuted 18 people for assaulting front-line EMAS staff (securing criminal convictions) and obtained sanctions against 47 people who had assaulted or abused our staff. We are satisfied that this approach will convey the message to the public that abusing or assaulting EMAS staff is not acceptable and that EMAS will take action. Drugs and alcohol were identified as influencing factors in 116 of the 209 reported incidents.

Media interest continues in this specialist area of work, with several cases receiving national coverage. This highlights the efforts EMAS makes to protect staff. Our figures for sanction delivery against those who assault our staff are the highest within the entire NHS for the third year in a row.

One particular case of note concerned a Derbyshire man, who had called 999 an astonishing 1,736 times since 2005 for non-medical emergencies such as needing his hearing aid battery changed or his computer mending. Regretfully, he was also very abusive to the staff who answered his calls and ambulance staff who attended him. Magistrates found him guilty of several cases of abuse of the 999 system and handed a 4 week suspended sentence for each offence, together with an Anti-Social Behaviour Order (not to misuse the 999 system) lasting 3 years.

Our LSMS delivered a range of security strategies as part of the work of the National Ambulance Security Group and provided security training to a range of EMAS staff. He continues to pro-actively promote our efforts to maintain the security of premises, property and our personnel.

Clinical Services and Nursing & Quality Directorates

Our Clinical Services Directorate and Nursing & Quality Directorate operate as two independent functions. However, they have shared responsibilities in many areas and therefore operate in close liaison with one another.

The achievements of both are detailed separately below.

Clinical Services Directorate

Research and Development

In 2011/2012, we continued to build on EMAS' excellent profile in the field of research and development team at a National and International level. Collaboration on several key trials focussed on increasing the quality of care delivered by EMAS to patients and led to improvements across a range of key clinical quality areas. This helped us to support the evaluation of some key interventions such as pre-hospital thrombolysis compared to emergency angioplasty. Recently the team have had two posters accepted for presentation at a European conference and this demonstrates the calibre of work produced. In 2012 / 2013, several new projects will be introduced to further develop the EMAS evidence base in this specialist area.

Clinical audit and involving practitioners in quality improvements

EMAS continues to coordinate the submission and monitoring / reporting of national Clinical Performance Indicators for UK ambulance services and we are now working to help further develop the clinical quality indicators used by other services to further improve performance. We have continued to work as part of the (Health Foundation funded) Ambulance Services Cardiovascular Quality Initiative (ASCQI), measuring and improve clinical care for heart attack and stroke patients. This work has lead to improvements in this important area of pre-hospital care. We are also carrying out the preliminary work necessary which will lead to the development of patient reported outcome measures for cardiovascular emergencies.

We continued to develop our work on pain management, overdose and cannulation during the period under review and look at new performance measures such as 'on-scene' times and clinical assessment by telephone (hear and treat). We are also looking at the way sepsis is managed – led by our clinicians on the front line – with a view to this work resulting in an overall improvement in the standard of care delivered to these patients.

Working with our partners to improve the patient experience

During 2011, the amount of Primary Percutaneous Coronary Intervention (PPCI) catheter suites either opening or moving to 24/7 status across our patch increased. PPCI is a treatment for heart attack patients, it unblocks an artery carrying blood to the heart by insertion of a small balloon on the end of a long thin tube (catheter) via an artery. EMAS front-line staff are now seeing the benefits of this approach as more patients are treated

using this technique. As a result, we are carrying out very few pre-hospital thrombolysis (where a drug is used to break down the blockage) treatments. The savings being made from using less drugs are now being re-invested into other areas of clinical care, for example, major haemorrhage management and airway management.

We have worked closely with commissioning and acute trust partners to ensure that we are fully prepared for the launch of Major Trauma networks in 2012. This will result in EMAS changing its normal operating protocols for patient experiencing critical injuries. That is, we will take more patients than before direct to a specialist Major trauma centre rather than via the nearest available A&E department.

During the year, we began to build relationships with the forming Clinical Commissioning Groups (CCGs). This has delivered improvement in the care pathways available for patients calling for our assistance, including the ability to refer patients back to primary care or to utilise alternative care routes rather than admission to an Emergency Department. In future, this will see more patients receiving the right care when needed.

Practitioner Performance

In 2011, we launched our Health Professions Council (HPC) Decision Panel. This is a peer led approach to managing ambulance staff's performance, specifically by reviewing cases (where a clinical concern is raised) to identify whether or not, referral to the HPC is necessary. This process is also designed to provide support to staff to ensure any issues are dealt with swiftly and appropriately. The HPC have seen this as an excellent example of good practice and are particularly interested in monitoring its future development.

Deputy Medical Director

On 1 November 2011, we appointed Dr Steven Dykes as EMAS' Deputy Medical Director. This new role designed to continue strengthening clinical leadership of the organisation. Dr Dykes has previously worked as an anaesthetist at Mid Yorkshire Hospitals NHS Trust and is a trained pre-hospital responder. One area he is focussing on is the changing delivery of clinical care in our Emergency Operations Centres.

Nursing and Quality Directorate

Infection Prevention and Control (IPC) team

During 2011/2012, we have worked collaboratively with colleagues in the Operational directorate to sustain and further develop the significant improvements carried out previously. The IPC team has been instrumental in sharing best practice to ensure all components of the Hygiene Code are delivered to a high standard. We have introduced a range of new IPC audit tools which enables the team and Operational managers to monitor progress and ensure corrective action is undertaken in a timely way. Audit results throughout the year show that there is excellent application of IPC policy. The team ensures that audit results continually drive improvements in practice and promote a zero tolerance to poor compliance with IPC standards. The high profile of the IPC team 'in the field' has proved vital in supporting and assisting front line staff to deliver high quality care.
In support of this work, the team have worked closely with EMAS' communications team to ensure key messages are cascaded to frontline staff. EMAS' network of IPC Champions has continued to grow this year which has been very beneficial in driving forward excellence in IPC best practice.

In 2011, work started on building partnership working with the Health Protection Agency and other NHS organisations throughout the East Midlands to aloe the team to access and utilise timely information about outbreaks of infection which could potentially impact on EMAS' delivery of services.

Risk Management

Risk management aims to prevent harm from occurring by understanding potential risks. As part of our work to reduce avoidable harm, in 2011, we developed a risk management audit programme which includes observed

practice, premises, and vehicle audits. These allow us to ensure we are meeting compliance standards and strengthening patient safety by identifying areas of risk, applying mitigations and introducing harm reduction strategies. During 2011/2012, we achieved a 100% standard in risk assessments of roles, equipment and vehicles.

In early 2012, we introduced a telephone 'hot-line' so front-line staff can report incidents straight away (rather than having to wait until they return to station at the end of their shift and completing a paper based report). These allowed us to provide a high quality, patient focused service, investigating and responding to incidents and complaints in a more effective and timely way. We continue to develop our essential education programme to ensure our staff have targeted risk management training. During 2011/2012, the focus was on patient safety and dynamic risk assessments.

Learning from our Strategic Learning Review Group

It is imperative that we continue to learn and implement service improvements where required. Learning is captured through our Divisional Learning Review Groups and disseminated through the Strategic Learning Review Group (SLRG). Some examples of service improvement are:

- A new referral system for safeguarding concerns
- A new process for managing patient's property
- A review of the number of PTS patients that can be conveyed in a saloon car
- An improved complaints process
- A review of GP Urgent requests

Trust-wide Learning is influenced through serious incidents, claims, patient experience reviews and collated through divisional and strategic learning review groups. The Organisational Learning Team formulates a Training Needs Analysis, develops and then delivers learning packages using real-life examples of cases to make the education relevant.

Patient Experience

The key objectives of our Patient Experience strategy are to 'Improve the experience patients receive in our care, to create a patient focused organisation that is responsive to patient need and to ensure lessons are learned and disseminated across the Trust'.

Throughout the year, EMAS has introduced a number of innovative methods to capture patient experience, one of which is by studying the patient experience by mapping patient journeys. An illustration of the benefit of this approach is that when we mapped PTS, the study revealed patients were waiting an unacceptable amount of time for transport and too many were seated in cars making the journey cramped and uncomfortable. The Trust Board subsequently agreed that cars should not transport more than 4 people at any one time.

During 2011, we also began to take 'patient stories' to the Trust Board on a regular basis. The accounts of patients (or their relatives/carers) allow for the personal experiences to be heard. These have been useful in understanding the whole experience of our patients and allow us to introduce real improvements to our service provision.

We continue to survey our A&E and PTS patients on a regular basis and have continued to work closely with our Foundation Trust (FT) and Community Engagement (CE) teams to capture patient feedback.

Complaints and compliments are discussed at both the Divisional Learning Review Groups and the Strategic Learning Review Group. Key learning is identified and shared with frontline staff via our internal communications system. For example EMAS received a complaint regarding the complaints procedure, which identified our customer service could be improved. As a result we introduced our local resolution initiative.

We regularly review our internal systems and processes to improve our complaints procedures. In late 2011, we re-structured our patient experience team and set ourselves demanding targets to ensure a timely and satisfactory response. The quality of our investigations has continued to improve since the introduction of our Investigation Team whose members provide support to complainants throughout the process. As a result we have had no referrals to the Health Service ombudsman taken forward for investigation which represents a significant improvement.

During 2012 / 2013, we will develop a patient experience forum from within our FT membership. We will also focus our attention on gaining targeted feedback from patients treated at home by our crews and from people with learning disabilities.

Safeguarding children and vulnerable adults

The referral rates for both children and adults continued to increase during 2011/2012 as a result of our continued focus on safeguarding. This has been achieved through a comprehensive safeguarding awareness campaign and education with an emphasis on 'Think Family'. Key improvement areas include:

– Increase awareness of Dignity in Care. Dignity is integral within all Education modules and we now have over 400 dignity champions, 80% of which have patient contact. EMAS received a Dignity in Care Bronze Challenge in recognition of the progress made on developing services in line with the Dignity Challenge and a Dignity campaign.

– Improved systems to be able to identify when complaints or safeguarding referrals relate to people with Learning Disability (to allow identification of themes or trends) and to ensure issues raised are addressed. Information on how to make a complaint, an information booklet on Adult Safeguarding and a Foundation Trust membership form have been developed in an accessible 'Easy Read' format.

– The development of education programmes to promote 'Think Family' ensuing that staff begin to recognise the 'right support at the right time' and a move towards integrated working and considering the impact on others within the household building the contextual information around the family.

During 2012/2013, the Safeguarding Team will:

- Provide a booklet on each vehicle to help staff communicate with vulnerable groups such as people with learning disabilities, dementia and those who are non-English speaking.
- Run a Domestic Abuse/Violence education campaign for all staff
- In conjunction with health and social care agencies, develop alternative referral pathways for 'care concern' issues (that crews presently refer through the safeguarding channels) and consider the potential to utilise Multi-agency Safeguarding Hubs (MASH) which are being introduced within the region to streamline referrals and ensue appropriate agencies are informed.
- Develop a bespoke safeguarding database to ensure trends and early identification of complex cases
- Remain vigilant on plans to make Adult Safeguarding a statutory responsibility
- Build upon systems and mechanisms to identify people with Learning Disability to enable us to capture trends especially with regard to access, complaints and safeguarding
- Further increase the number of Dignity champions among frontline staff and develop EMAS Dignity Pledges
- Achieve consistent engagement across the divisions in community projects and forums in relation to learning disability, mental health and safeguarding

Patient Safety

EMAS' aspiration is to become 'the safest ambulance service in the country by 2015'. In pursuit of this goal, we launched a number of patient safety projects in 2011:

- A Patient Medicine Bag (Green Bag) to ensure all patients' medicines travel with them when they come into hospital
- Non-Conveyance leaflets to improve safety for patients not conveyed to hospital
- Improved 'call to needle' times for patients presenting with ST elevation myocardial infarction (STEMI)
- Improved the recognition and reporting of patient safety incidents
- Introduced a falls prevention team
- Introduced a structured communication tool to improve clinical handover procedures
- Introduced a tool for identifying the potential for harm. Each month, over 900 patient record forms are reviewed and the results are shared with front line staff to drive improvements in the care we deliver

We invested in developing the capacity of key staff through the Patient Safety Leaders programme and Leading Improvements in Patient Safety (LIPS) programme with the NHS Institute for Innovation and Improvement.

Members of our Board continue to visit stations and emergency departments as part of our programme of safety visits, which give staff an opportunity to raise concerns and highlight areas of positive practice.

In September, we held a Patient Safety Week called 'It starts with me.' This involved developing a range of posters and communications relating, for example, to stroke care to raise the profile of patient safety across EMAS.

Workforce Directorate

During 2011/2012, we continued to work towards the aims set out in our Workforce Strategy 'Driving Quality, Delivering Change' 2010-2015. Our focus has been to support service and cultural change through our Moving Forward Together transformational change programme; and to build upon key improvement themes of:

- Clinical leadership and clinical education, training and development
- Leadership and management development
- Staff engagement
- Staff health and well being
- Employment relations
- Equality performance

Clinical leadership and clinical education, training and development

During 2011/2012, we introduced year 2 of our clinical supervision programme for all patient facing staff to ensure support and development in the workplace. We also provided a range of continuous professional development opportunities including e-learning resources, internal class based workshops, and access to National Vocational Qualifications and external higher education modules to support continuing professional development and clinical leadership.

In line with the realisation of the workforce plan, 102 paramedics, through the EMAS paramedic programme, 36 Emergency Care Assistants and 18 Ambulance Care Assistants were trained.

Additionally, we implemented Year 2 of our essential education programme themed around patient safety to support statutory and mandatory requirements, clinical updates and an awareness of particular patient groups such as end of life care, learning disabilities and dementia. The preparation work for learning disabilities encompassed a regional wide engagement plan with key organisations and service users. As a result of this work, EMAS gained national recognition through leading the development of a CD ROM and associated workbook to raise awareness for individuals with learning disabilities and their carers about when to call 999 and what they can expect when they do.

During 2011/2012 we continued to support the national apprenticeship programme by the development of apprentices in administration skills across support and operational directorates.

Leadership and management development

One of the first priorities of our Moving Forward Together People Programme was to develop a leadership and management development plan to improve leadership capability from Board level to front-line staff to support organisational development and Foundation Trust plans. This was carried out in response to feedback through a range of reviews and assessments including an EMAS Cultural Survey and our results in the National Staff Opinion Survey.

Our Leadership Plan was successfully developed and implemented during 2011/2012 and a number of leadership and management development opportunities are now in place, including a range of Chartered Management Institute accredited programmes - including First Line Manager and Coaching and Mentoring programmes; bespoke team and management development programmes; Board and Senior Manager development programmes; and access to a range of management tools and diagnostic assessments.

Staff engagement

Our employees are crucial to our success as an organisation because we can only meet the challenges we face with an engaged and motivated workforce.

Our response rate in the annual NHS Staff Opinion Survey was 36.6%. In November 2011, we held an EMAS wide event to start an interactive approach to staff engagement. The 'Big Conversation' was the start of on-going dialogue with staff, which offered the opportunity to get involved in service development, highlight how staff feel, and identify what matters most. This is being built on by holding Local Conversations in our Divisions divisions/areas and the themes we are currently progressing are recognition, how to give staff a greater say in the workplace, supportive management behaviours, team and interpersonal relations in the workplace and how we can improve the way we work together.

Staff health and well being

Our sickness absence rate in 2011/2012 was 6.24%. We accept that this level of absence is high when compared to other Ambulance Services and this continues to be a focus of attention for us. Musculoskeletal injuries and stress related illness are our top two reasons for absence. We continue to offer physiotherapy services through our Occupational Health Provider and manual handling education is part of our core education curriculum, supported in the workplace by our Heath and Safety Advisors. Counselling services are provided through Care First, our new Employee Assistance Provider and feedback to date has been positive about the support given.

We have invested in developing the capability and confidence of our first line managers to manage absence appropriately by providing programmes in Stress Awareness (over 60 managers attended) and in Mental Health Awareness. In April 2012, we will launch a new Health and Wellbeing Strategy which will include a programme of health promotion and healthy lifestyle initiatives. In preparation for this, 200 employees have completed a Health and Wellbeing diagnostic questionnaire which will help us prioritise our efforts. A Ride to Work scheme has been re-launched and 57 people took advantage of this. We will continue to pay attention to all matters relating to absence including a revised attendance policy, manager education and by tendering for the supply of Occupational Health Services to EMAS.

Employment Relations

A number of Agenda for Change (A4C) and Job Evaluation issues have been brought to conclusion in the year. Of particular note is settlement of pay issues related to the original transfer of staff to A4C terms.

We have undertaken a programme of retrospective CRB checks on over 1,600 front-line staff. This was an extremely successful exercise, well supported by our Trade Union representatives and staff.

Our HR team continues to support change in the organisation. We are currently managing the Transfer of Undertakings Protection of Employment (TUPE) of PTS staff to new providers and assisting managers to reconfigure support teams across the Trust. We have been recruiting and establishing high performing teams in the our new Resource Management Centre and developing engagement and leadership initiatives as part of transforming Emergency Operations Control.

We worked closely with our Trade Union representatives and staff to ensure the best level of patient care possible was provided on the National day of action (30 November 2011). The vast majority of staff agreed to work normally and many others volunteered to be contacted should any shortfalls occur. As a result of staff's commitment and goodwill, there was no impact on service provision.

Equality performance

During 2011/2012, we implemented the NHS Equality Delivery System (EDS) to ensure equality, fairness and improved access to our services and job opportunities. The EDS is a national framework designed to improve the equality performance of the NHS and embed equality into mainstream business**.** It is a tool for the NHS to use in partnership with stakeholders, to review equality performance and identify equality objectives. At the heart of the EDS is a set of 18 outcomes grouped into four goals which focus on the issues of most concern to patients, carers, communities, NHS staff and Trust Boards. During the year, we actively engaged with our local communities to raise awareness, listen to their views, and to enable grading of our equality performance against the EDS goals and also to help develop and prioritise our equality objectives for 2012 / 2013. We are now developing an Equality Assurance Strategy that will set out our equality objectives and plans for 2012 / 2013.

Corporate Governance

During the year the Governance team implemented a new web-based governance system. This has fully devolved accountability and provides full assurances to the Board in relation to internal controls. For example, the Assurance Framework, Local Risk Registers, Care Quality Commission Essential Standards of Quality & Safety, Code of Practice for health and adult social care on the prevention and control of infections and related guidance (Hygiene Code), NHS Litigation Authority Risk Management Standards for Ambulance Trusts and resultant action plans.

Governance has continued to support the Trust Board, Committee's and Sub Groups by providing compliance and progress reports and has lead the Trust's effective management of policies, procedures and Standard Operating Procedures.

The team continued to provide specialist advice and strategic input to the Foundation Trust application process through the development of an EMAS Constitution, Governance Framework and Integrated Business Plan.

The team also continued to provide claims handling support to the organisation by handling Employer Liability, Public Liability, Clinical and small claims.

The Assistant Trust Secretary continued to Chair the National Ambulance Governance Sub Group and lead the National Ambulance Benchmarking Project which allows learning and best practice to be shared amongst all UK ambulance services.

Compliments & formal complaints

During the year, we received just over 600 expressions of appreciation from patients or members of the public. Where the staff involved in any particular incident can be identified, a copy of the letter of thanks is sent to the person involved and a copy placed on their personal file.

The following table provides information on the receipt and handling of complaints:

Number relating to A&E	212
% rate in relation to journeys provided	0.00036%
Number relating to PTS	38
% rate in relation to journeys provided	0.000035%
Number acknowledged within 3 working days*	252 (98.8%)
Number receiving a formal response in 25 working days* (159 out of 245 were within agreed timescales 65%)	26 were outside the 25 day response but with permission. 86 were outside 25 days without permission
Number of complaints proved to be justified	75 (29%)
Number referred to the Parliamentary and Health Service Ombudsman (PHSO) for Independent Review	2 formal complaints that were received in the 2011/12 year. Plus, 2 that had been received the previous year but were only referred to PHSO in 2011/12. Also 2 PALS concerns were referred.

The EMAS Complaints Procedure states that “an acknowledgement must be made within three working days and a comprehensive written reply must be provided within 25 working days, unless a different timeframe has been agreed with the complainant, or it is an S.I. which will be with 60 working days.” EMAS’ policy is to work within these targets to provide a thorough and comprehensive response.

We have a dedicated team of investigation officers who maintain regular contact with complainants. This means that if we are unable to respond within the timescale, the Investigation officer will explain the circumstances and seek their agreement for the deadline to be extended. A letter of confirmation is then sent. We can confirm that EMAS complies with the ‘Principles for Remedy’ guidance published by the Health Service Ombudsman and manages complaints in accordance with the 6 ‘Principles of Good Administration.

Our Patient Advice and Liaison Service (PALS) team continued to provide a helpful service to people with concerns about their contact with EMAS. PALS concerns and formal complaints provide opportunities for the identification of trends in service delivery and we use the lessons learned as a catalyst for further improvement and change.

Communications and Community Relations

This team is located in the Chief Executive’s Directorate and helps to develop our services by promoting dialogue with patients and the public, staff, health community colleagues, the media and other stakeholders.

The ambulance service is very much in the public eye and is therefore the focus of considerable media attention, the team fielding approximately 1,600 media enquiries per annum from the 85+ news outlets located in EMAS’ area. In addition, the team is proactive in issuing press releases, averaging approximately one good news story each week, helping to bring recognition to the good work done by our staff in the service of the community.

We place great emphasis on delivering good internal communication. Our staff website is run by the communication team and is increasingly becoming the best route for staff to keep in touch with the latest news. We also have dedicated communications campaigns on key issues for staff (e.g. patient safety, infection prevention and control, safeguarding vulnerable people). In early 2012, we worked closely with our new Chief Executive to develop a more personalised approach to key internal communications. This is best illustrated by the introduction of a new weekly Chief Executive's Bulletin which has proved very popular with staff and the use of video conferencing facilities which significantly reduces the amount of time and money we spend on travel costs associated with managers' meetings. All staff are given the opportunity to sign up to Communications Direct (whereby they receive email updates on their home PC) and this has also proven to be popular with just over 1,000 staff registered as subscribers .

On the external communications and engagement front, our stakeholder newsletter *EMAS Aspect* was issued monthly electronically to almost 700 named individuals and the address list continues to grow. Our website had over 480,000 visitors over the year. In conjunction with colleagues, the team is implementing EMAS' Community Engagement Strategy. We also started to improve out use of social media tools such as Twitter and You Tube.

We work closely with Local Involvement Networks (LINks) and a particular highlight was to secure the involvement of patients and the public in the creation of the Trust's 2010 / 2011 Quality Account which included a summary document for the public – believed to be the first created by a UK ambulance trust. The team also works closely with the Foundation Trust office in attending events, helping to recruit members and managing production of the members' magazine *FT Matters*. In early 2012, we began work on re-launching a Foundation Trust consultation programme which ran from 10 April to 3 July 2012.

Finance and ICT Directorate

Finance team

The team played a key role during 2011/2012 in supporting EMAS' strategic objectives and organisational development initiatives. This included facilitating delivery of cost improvement plans and the Foundation Trust application process.

The programme to streamline and upgrade back office support effectiveness continued to be a key priority. We also benefit from the enhanced system infrastructure and resilience available to us by having routine financial transactions and payroll services dealt with by an external financial and accounting service provider NHS Shared Business services (SBS). This allows the team to focus its efforts on statutory compliance and business support.

We introduced the Oracle Business Intelligence (OBI) on-line budget statement reporting suite in conjunction with SBS. Service Line Managers and budget holders now have improved access to financial reports and supporting transaction data 'on-line' which allows the business support team to provide value added services to managers.

In December 2011, a new Chair of EMAS' Audit committee was appointed. The finance team offer support to the Committee and monitor progress against implementation of audit recommendations. During 2011/ 2012, we maintained a positive and constructive working relationship with both internal and external auditors and continue to work closely with the Local Counter Fraud Specialist. Following the market testing of internal audit and counter fraud services, we have established positive working relations with new providers.

National policy has determined that payment by results will be introduced for emergency ambulance services from April 12 2012. The finance team have worked with colleagues across EMAS to allocate costs and capture activity to support this new form of contracting of services.

Our key priorities to progress in 2012 / 2013 are to:

- Support the Trust transformation programme
- Proactively support delivery of the 2012 / 2013 cost improvement programme
- Support the Foundation Trust application process
- Support commissioning of services
- Support evaluation of out sourcing options
- Develop benchmarking to support EMAS' Performance Management Framework
- Lead modernisation of financial system processes

Information Communication Technology (ICT)

The ICT department dealt with several large scale developments and increases in activity across all services. We continued to lead the way with National developments of the Electronic Patient Record Form (e-PRF), delivered a number of key business projects aimed at delivering better patient care, greater cost effectiveness and continued to deliver against local service targets.

Innovation in service provision helps us achieve added value and an example of this is 'server virtualisation' technology. This is being used across all our applications and over 90% of our infrastructure has now been converted from physical to virtual technology. This has presented savings in server costs and reduced power consumption which supports EMAS' carbon reduction initiatives.

A project began to provide a home & remote working solution to replace the current 3G system. We envisage there will be at least two tiers of access, level one (for users who need to work at home and at an EMAS base) and level two (providing the same support as level one plus allowing access to our network whilst mobile, such as on a train or away from home). We expect the system to be rolled-out in phases with the first group of users being migrated from April 2012. This will allow flexible working for the workforce and support proposed future changes in our estates.

During the year, we launched a pilot project to evaluate the impact of a move to Microsoft Office 2010 across EMAS. We recognise the need to move to a more up-to-date product so we are able to continue receiving support from Microsoft. Newer versions of the Microsoft Office suites will also provide many functional advantages which will help the Trust develop.

To improve communication where distance is a barrier, reduce wasted time in unnecessary travel, and save costs within the organisation, roll-out of video conferencing facilities has continued at a number of our sites. We have also tested or desk to meeting room conferencing capabilities and plan to roll this out in 2012 / 2013.

Our Service desk continued to support staff and record numbers of incidents were dealt with speedily and successfully. This growth in demand was due to staff making increased use of ICT solutions to improve performance and effectiveness.

As part of our contribution to EMAS' cost improvement programme, our mobile telephony requirements were subjected to competitive tender. Through this process, an alternative provider was identified. We anticipate the new arrangement will reduce costs by 30%.

Business Intelligence Unit (BIU)

During this period, many improvements have been made in the areas of Management Information delivery; notably the development of an Integrated Board Report which is reviewed in public at each Board meeting. We have also extended the range of management reports available to support front-line service delivery. These are web based solutions giving wide access to users wherever they are. These developments have provided more meaningful Management Information allowing our Operations Team to make more informed decisions.

The BIU team played a central role in developing the National Clinical Quality indicator reporting suite in conjunction with the Department of Health. Information collected is used to support the publication of national comparative statistics for all English ambulance services. The system went live in autumn 2011.

We continue to enhance our Electronic Patient Record (ePRF) reporting solution and are now able to deliver 'automated reports' directly from the system which, in turn, allows us to use the clinical data collected to improve patient care. EMAS continues to lead the way with the delivery and usage of the Emergency Care Solution (ECS) Software as part of the Connecting for Health Programme.

Our department continues to work in close liaison with the EMAS Board to ensure they have the information needed to make decisions about the further development of services to the public.

Information Governance

Due to the increased focus on information security and confidentiality nationally, the Information Governance and Compliance Team continue to respond to ever increasing numbers of requests for information from the general public and the media. Training and awareness raising in Information Governance have also been high on the agenda this year to ensure that all staff – operational and non operational – are aware of their responsibilities with regard to confidentiality of patient information. The Trusts continues to meet its obligations under the Information Governance Toolkit thereby demonstrating its high level of compliance in this area.

Summary of personal data related incidents in 2011/2012		
Category	Nature of Incident	Total
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0 (2010/2011 – 0)
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS Premises	0 (2010/2011 – 5)
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS Premises	1 (2010/2011 – 0)

Charitable Funds

During the period under review, we continued to receive donations from members of the public who have made use of our services either in an emergency or to attend an outpatient appointment or visit a day care unit. During 2011, we introduced a on-line and a text giving facility to make it easier for members of the public to make donations.

Although a few donors make specific requests on how they would like the money to be spent, the majority ask for the funds to be used for the benefit of patients and/or staff. During the period under review, our charitable funds committee approved the spending of donations on new pieces of medical equipment and improved recreational facilities for our staff.

The fund is registered with the Charity Commission and is managed by EMAS' charitable funds committee which includes Non-Executive and executive directors and other EMAS representatives. Day to day

administration is undertaken within our finance department. Our charitable funds are subject to an internal audit and external examination.

Sustainability Report

Summary of Performance

EMAS' present estates holdings are not all in the optimum location, are aged and not suitable for adapting to achieve energy improvement measures.

Therefore a new estates strategy is being developed. Until this new strategy is complete, only basic measures have been taken to reduce energy consumption For example, replacing old fittings when they fail with energy efficient fittings (lighting units, boilers and heating controls, garage door motors and other such energy consuming devices). Where garage heating has a thermostatic control, heating is turned down to reduce energy consumption.

Overall energy consumption has increase over the past six years due to a number of factors. In 2006/2007, the Northamptonshire and Lincolnshire Ambulance Services were merged into the existing EMAS. This resulted in a substantial increase in both vehicles and buildings. In 2008/2009, a new EMAS HQ (and Control Room) building was added to our estate, adequate to meet the needs of a much larger organisation. During 2009/2010, EMAS moved in to a new building in which our Hazardous Area Response Team are now based. In addition, over the last five years, EMAS has substantially increased its fleet cleaning processes reflecting an increase in water consumption.

Summary of Future Strategy

EMAS estates strategy will affect all premises. The strategy is intended to ensure that all property is in the optimal location to improve performance and built or refurbished to the appropriate Building Research Establishment Environment Assessment Method (BREEAM) standards of efficiency. The initial report will be available during June/July 2012 and then be subject to public consultation. Subject to the outcomes of the consultation phase, a prioritised set of projects will then be developed.

During 2012, we will recruit an Environmental Manager. This will provide us with a dedicated resource to drive forward our sustainability agenda.

Green House Gas (GHG) Emissions

The calculations in this part of our report are based on a recent report covering 2006 to 2010. From 2011 onwards, only partial data has been collected therefore some of the figures for 2010 to 2012 have been extrapolated from the earlier data trends.

EMAS' GHG emissions from energy consumption and fuel have increased over the last five years with an increase of 1,134 tCO_2e in the last year. Plans will be developed during the year to reduce the GHG emissions by introducing energy saving measures in stations involving such things as movement activated lighting and other similar initiatives. These actions will reduce our GHG emissions until the new estates strategy (referred to above) brings about a more modern, energy efficient estate. However as almost 45% of carbon emissions come from fuel consumed in the movement of patients by front-line staff, there is a real challenge to be faced. Engine design and technology is improving but not at a rate that will bring about dramatic changes within the immediate future.

Waste

Our clinical waste management approach is in line with Health Technical Memorandum 07 (HTM 07) resulting in more waste being available for alternate treatment processes, as opposed to incineration.
Domestic waste is streamed to enable waste contractors to separate it into recycling streams. Our data collection in this area is inconsistent due to the number of historical contractors and available services. Waste management is being tendered this year and improved data will become available as part of the new contract.

Use of Resources

EMAS is a vehicle / transport based service and we have experienced year-on-year increases in activity which inevitably leads to increased fuel consumption. In turn, from 2006/2007, our carbon footprint (produced from fuel consumption) has increased. Some service remodelling to increase the number of rapid response cars and a change in ambulance design to a lighter bodied vehicle should bring about an improvement in fuel

consumption and associate reduction in carbon footprint; however no data is available yet to support this belief.

With the appointment of an Environment Manager in 2012, plans will be developed to address some of the challenges facing EMAS in relation to carbon emissions from our vehicles.

Climate Change Adaptation and Mitigation

We have a plan for assessing the impact of climate change and the necessary mitigations generated from that assessment. When appointed, the Environment Manager will be tasked with driving this work forward.

Biodiversity and Natural Environment

Biodiversity and Natural Environment is not an area that is currently applicable to EMAS. However, through the development of the new estates strategy, opportunities will be explored to develop projects within this area.

Sustainable Procurement

As part of normal business, the procurement team ask that suppliers make a declaration about their sustainability capabilities which is then 'scored' as part of the tender process. This assessment will raise the focus on sustainability with our suppliers.

Sustainable Construction

During 2011, we refurbished a building to create a new base for our HART team and this allowed us to achieve a 'very good' rating under BREEAM. As part of this development, all waste created as part of the building works was streamed to ensure achievement of the required standards for BREEAM.

Governance

Over the coming year, governance systems will be developed to manage sustainability programmes, these systems will become part of the Trusts existing governance reporting systems.

Remuneration Report

Executive Directors

Name	Role	Date Appointed	Date left
Prof T Thompson	Chief Executive (Interim)	5.5.2011	31.8.2011
P Milligan	Chief Executive	1.12.2011	
D Farrelly	Deputy Chief Executive	1.7.2006	
B Brewster	Director of Finance	1.1.2007	31.3.2012
K Glover	Director of Nursing	14.9.2009	
D Lee	Director of Operations	15.2.2010	22.7.2011
P Ripley	Director of Operations	8.8.2011	
Dr J Gray	Director of Clinical Services	1.11.2010	
A Spice	Commercial Director	3.1.2012	
K Gulliver	Director of Workforce (Acting)	26.9.2011	

Notes

Directors' salaries are agreed by the Remuneration Committee (with reference to similar posts in the NHS).

Directors are employed on a permanent contract which may be terminated by retirement, resignation or, in the event of unsatisfactory performance, by dismissal. The notice period for all Directors contracts is 3 months. In the event of a contract being terminated, EMAS meets all statutory and standard NHS termination payments which are dependant on the individual's age and length of service in the NHS.

N Konieczny was the Acting Trust Secretary. He left this post on 31 October 2011.

Professor Tamar Thompson was appointed Chief Executive (Interim) on 5 May 2011. She left this post on 31 August 2011.

David Farrelly held the post of Acting Chief Executive for the periods 1 April 2011 until 4 May 2011 and 1 September 2011 until 30 November 2011.

All Executive Directors are Trustees of the EMAS Charitable Fund.

Non-Executive directors

All Non-Executive Directors are members of the Remuneration Committee, Nomination Committee and Foundation Trust Programme Board. All Non Executive Directors are Trustees of the EMAS Charitable Fund.

Some of the Board's responsibilities are delegated to committees, chaired by an elected Non-Executive director (as detailed below).

Name	Date of appointment	Date left	EMAS Committees	External interests*
J Towler	1.7.2011		Remuneration Committee Nominations Committee Quality and Governance Committee Investments Committee Charitable Funds Committee (Chair)	None
G Austin	1.7.2006		Remuneration Committee (Chair) Investments Committee (Chair) Nominations Committee (Chair) Audit Committee	None
S Dawkins	11.10. 2011		Remuneration Committee Investments Committee Nominations Committee Quality and Governance Committee Audit Committee	None
P Tagg	11.10. 2011		Remuneration Committee Nominations Committee Charitable Funds Committee Quality and Governance Committee (Chair)	None
G Newton	11.10. 2011		Remuneration Committee Nominations Committee Quality and Governance Committee Charitable Funds Committee Audit Committee	None
D Toberty	7.11.2011		Remuneration Committee Nominations Committee Investments Committee Audit Committee (Chair)	None
C Faircliffe	1.7.2006	30.6.2011	Foundation Trust Programme Board (Chair) Charitable Funds Committee (Chair) Clinical Quality & Governance Committee (Ex-Officio) Audit Committee	None
R Whitehouse	1.7.2000	7.10 2011	Charitable Funds Committee Clinical Quality & Governance Committee (Ex-Officio)	None
L Jackson	1.9.2009	7.10.2011	None	None
J Williams	1.7.2006	31.10.2011	Audit Committee (Chair) Charitable Funds Committee Investments Committee	Director and Trustee of Lincolnshire & Nottinghamshire Air Ambulance Charitable Trust Chairman – Director and Trustee of Warwickshire & Northamptonshire Air Ambulance Charity
B Baker	1.7.2006	31.7.2011	Clinical Quality & Governance Committee (Chair)	General Manager, Nuffield Hospital Derby

**This only includes interests which could cause conflict with their Non-Executive role*

All Directors have confirmed that as far as they are aware, there is no relevant audit information of which EMAS' auditors are unaware and that they have taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that EMAS' auditors are aware of that information.

The following remuneration report for the year ended 31 March 2012 has been audited. This consists of the tables of senior managers' salaries and allowances and pension benefits, and the accompanying narrative.

Senior Managers' Remuneration

Remuneration Report for the year ended 31 March 2012.

Executive Directors remuneration is paid in accordance with the Department of Health Pay Framework for Very Senior Managers (VSM) in Strategic and Special Health Authorities, Primary Care and Ambulance Trusts. The Trust's Remuneration Committee has delegated responsibility for setting remuneration for the Chief Executive and all Executive Directors in accordance with the VSM Framework.

The Trust operates in accordance with the VSM Pay Framework Performance Related Pay Awards Scheme and Department of Health annual updates concerning its application. In addition, the Trust applies it's policy of annual Performance Development Reviews in order to assess individual performance. The Trust's Remuneration Committee is authorised to monitor and evaluate individual performance in accordance with the provisions of the VSM Pay Framework and the requirements of the Department of Health.

As set out above the Trust operates in accordance with the VSM Pay Framework Performance Related Pay Awards Scheme and Department of Health updates concerning its application. The Trust did not award any annual uplifts or performance bonus payments to senior managers during 2011/2012.

Salaries and Allowances

			31 March 2012 Salary Bands of £5,000 £'000	Other Remuneration Bands of £5,000 £'000	Bonus Payments Bands of £5,000 £'000	Benefits in Kind Rounded to nearest £100 £'00	31 March 2011 Salary Bands of £5,000 £'000	Other Remuneration Bands of £5,000 £'000	Bonus Payments Bands of £5,000 £'000	Benefits in Kind Rounded to nearest £100 £'00
Tamar Thompson[1]	Commenced 5 May 2011 Ceased 31 August 2011	Chief Executive Director	45 - 50	0	0	0	N/A	N/A	N/A	N/A
Phil Milligan	Commenced 1 December 2011	Chief Executive Director	45 - 50	0	0	0	N/A	N/A	N/A	N/A
Brian Brewster	Ceased 31 March 2012	Director of Finance	95 - 100	65 - 70	0	0	95 - 100	0	0	0
David Farrelly[2]		Deputy Chief Executive	105 - 110	0	0	0	85 - 90	0	0	0
Karen Glover		Director of Nursing	90 - 95	0	0	49	80 - 85	0	0	49
Diane Lee	Ceased 22 July 2011	Director of Operations	30 - 35	0	0	16	95 - 100	0	0	49
Peter Ripley	Commenced 8 August 2011	Director of Operations	40 - 45	0	0	33	N/A	N/A	N/A	N/A
James Gray		Director of Clinical Services	120 - 125	0	0	0	50 - 55	0	0	0
Kerry Gulliver	Commenced 26 September 2011	Director of Workforce (Acting)	35 - 40	0	0	15	N/A	N/A	N/A	N/A
Andrew Spice	Commenced 3 January 2012	Commercial Director	20 - 25	0	0	0	N/A	N/A	N/A	N/A
Neil Konieczny	Ceased 31 October 2011	Trust Secretary (Acting)	45 - 50	0	0	17	80 - 85	0	0	32
Karen Kanee	Commenced 1 November 2011 Ceased 29 February 2012	Trust Secretary (Acting)	15 - 20	0	0	10	N/A	N/A	N/A	N/A
Karen Sullivan	Commenced 1 March 2012	Trust Secretary	0 - 5	0	0	0	N/A	N/A	N/A	N/A
Chris Faircliffe	Ceased 30 June 2011	Chairman	5 - 10	0	0	0	20 - 25	0	0	0
Jon Towler	Commenced 1 July 2011	Chairman	25 - 30	0	0	0	N/A	N/A	N/A	N/A
Rosemary Whitehouse	Ceased 7 October 2011	Non-Executive Director	0 - 5	0	0	0	5 - 10	0	0	0
Barbara Baker	Ceased 31 July 2011	Non-Executive Director	0 - 5	0	0	0	5 - 10	0	0	0
John Williams	Ceased 31 October 2011	Non-Executive Director	0 - 5	0	0	0	5 - 10	0	0	0
Gary Austin		Non-Executive Director	5 - 10	0	0	0	5 - 10	0	0	0
Leonard Jackson	Ceased 7 October 2011	Non-Executive Director	0 - 5	0	0	0	5 - 10	0	0	0
Stuart Dawkins	Commenced 11 October 2011	Non-Executive Director	0 - 5	0	0	0	N/A	N/A	N/A	N/A
Pauline Tagg	Commenced 11 October 2011	Non-Executive Director	0 - 5	0	0	0	N/A	N/A	N/A	N/A
Gillian Newton	Commenced 11 October 2011	Non-Executive Director	0 - 5	0	0	0	N/A	N/A	N/A	N/A
Dermot Toberty	Commenced 7 November 2011	Non-Executive Director	0 - 5	0	0	0	N/A	N/A	N/A	N/A
Catherine Stuart-Jervis	Ceased 31 August 2011	Advisor to the Board	0 - 5	0	0	0	5 - 10	0	0	0

[1] The Trust obtained the services of Tamar Thompson from Webdesign Associates Ltd.

[2] David Farrelly held the post of Acting Chief Executive for the following periods:
1 April 2011 to 4 May 2011;
1 September 2011 to 30 November 2011.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2011/2012 was £142,500 (2010/2011 £132,500) This was 5.06 times (2010/2011 4.7 times) the median remuneration of the workforce, which was £28,167. Comparative information is not available for 2010/2011 median as the trust is unable to obtain the pay information from its payroll supplier, however the Trust does not consider that there has been significant changes which would materially affect this multiple as there has been no general increase in staff salary rates between the two years.
The Trust has computed the median salary following Treasury guidance with the exception of the grossing up of part time staff salaries to full time status. This approach is in line with the NHS Manual guidance.

In 2011/2012 and 2010/2011 no employees received remuneration in excess of the highest paid director.

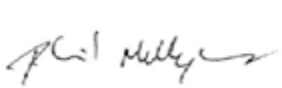
Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well ad severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension Benefits

			Real Increase in Pension at Age 60	Real Increase in Pension Lump Sum at Age 60	Total Accrued Pension at Age 60 at 31 March 2012	Lump Sum at Age 60 Related to Accrued Pension at 31 March 2012	Cash Equivalent Transfer Value at 31March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real Increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
			Bands of £2,500 £'000	Bands of £2,500 £'000	Bands of £5,000 £'000	Bands of £5,000 £'000	£'000	£'000	£'000	£'00
Phil Milligan	Commenced 1 December 2011	Chief Executive Director	0.0 - 2.5	0.0 - 2.5	50 - 55	150 - 155	1,018	900	30	0
Brian Brewster	Ceased 31 March 2012	Director of Finance	0.0 - 2.5	0.0 - 2.5	45 - 50	140 - 145	1,068	1,008	28	0
David Farrelly		Deputy Chief Executive	2.5 - 5.0	10.0 - 15.0	25 - 30	75 - 80	421	285	127	0
Karen Glover		Director of Nursing	2.5 - 5.0	7.5 - 10.0	20 - 25	65 - 70	333	233	93	0
Diane Lee	Ceased 22 July 2011	Director of Operations	0.0 - 2.5	0.0 - 2.5	30 - 35	90 - 95	576	475	26	0
Peter Ripley	Commenced 8 August 2011	Director of Operations	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	9	N/A	6	0
James Gray		Director of Clinical Services	0.0 - 2.5	2.5 - 5.0	15 - 20	55 - 60	235	160	69	0
Kerry Gulliver	Commenced 26 September 2011	Director of Workforce (Acting)	0.0 - 2.5	2.5 - 5.0	10 - 15	30 - 35	165	112	25	0
Andrew Spice	Commenced 3 January 2012	Commercial Director	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	4	N/A	1	0
Neil Konieczny	Ceased 31 October 2011	Trust Secretary (Acting)	0.0 - 2.5	0.0 - 2.5	35 - 40	105 - 110	753	696	21	0
Karen Kanse	Commenced 1 November 2011 Ceased 29 February 2012	Trust Secretary (Acting)	0.0 - 2.5	0.0 - 2.5	5 - 10	15 - 20	88	59	9	0

NHS Pensions has used Government Actuary Department (GAD) actuarial factors of 8th December 2011, and therefore the 31 March 2012 GAD factors differ to those used at 31 March 2011.
As such the real increase in the CETV is inconsistent with requirements of the NHS Manual of Accounts
As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members

Signed: 6 June 2012



Phil Milligan
Chief Executive

Statement of the Chief Executive's responsibilities

As the accountable officer of the trust

The Chief Executive Officer of the NHS has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

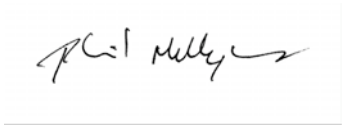
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed: 6 June 2012



Phil Milligan
Chief Executive

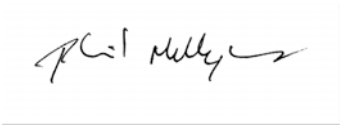
Annual Governance Statement 2011/2012

As Accountable Officer I have taken advice and assurance from a range of sources from reviews.

I am pleased to report that no significant control lapses have occurred through the year 2011/2012.

The sound progress achieved in the year will continue to provide a firm foundation to further refine and develop the control environment within the East Midlands Ambulance Service NHS Trust.

Signed: 6 June 2012



Phil Milligan
Chief Executive

A copy of our full Annual Governance Statement can be obtained by contacting:

Finance Department
East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY

Telephone 0115 884 5000

Operating and Financial Review

During the period to 31 March 2012, the Trust achieved the following financial duties:

Description of Target	Target	Actual Result
Adjusted Surplus	£1,588k	£1,402k (excluding impairment write back)
3.5% Return on Capital	3.5%	3.5%
Compliance with Capital Resource Limit	£8,014k	£7,742k

The financial position for 2011/2012 shows a retained surplus of £2,396k for the year. This figure is inclusive of impairment write backs to buildings of £994k in recognition of the revaluation exercise carried out by the District Valuer at 31 March 2012. The surplus reported is within the parameters agreed with the East Midlands Strategic Health Authority.

Revaluation gains on buildings of £1,648k are shown in the accounts. An increase in value arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure. In this case it is credited to expenditure to the extent of the decrease previously charged there. This has created an impairment reversal of £1,007k in the accounts to the benefit of the Trust. £770k relates to 2011/2012 and £237k from the previous financial year.

In December 2011, the Trust learned that in 2012/2013 it would lose a substantial proportion of its Patient Transport Services (PTS) business. Primary Care Trusts in the East Midlands engaged East Midlands Procurement and Commissioning Transformation (EMPACT) to coordinate a competitive tendering exercise regarding the provision of PTS. Unfortunately, decisions were taken by our Commissioners to award the contracts to external providers.

With an estimated loss of 15% of its income, the Trust faces significant financial challenges. In response to the loss of our PTS income, management and infrastructure costs across Support Service functions will need to be reduced by approximately £2,000k on a full year basis. The challenge for the Trust is to reduce the cost of these functions on a sustainable basis, without a reduction in the quality of the service delivered. Extra funding has made available from our Commissioners to support the Trust in restructuring the business.

Additional challenges lay ahead in 2012/2013 for the Trust, as the NHS faces a period of significant transition and financial challenge. The 2012/2013 plan is based on delivery of a 4.5% Cost Improvement Programme (CIP) which equates to approximately £6.7million. This reflects the Board view of deliverable saving in the context of the significant organisational reconfiguration challenge in 2012/2013.

Plans totalling £8m have been drawn up for 2012/2013, therefore the required baseline CIP equates to 83% delivery. It is generally acknowledged delivery of 60% to 70% is the typical achievement in a normal operating environment. That compares with delivery in the current year which is broadly in line with the level in the prior year.

Levels of CIP in the four subsequent financial years range between 3.8% and 4.5% as the Trust will move into a more conventional operational environment.

From April 2012, following a national policy change, Payment by Results (PbR) has been extended into the ambulance sector. PbR is a system for the payment of NHS providers within the NHS in England. It is a way of paying providers a standard national price or 'tariff' for each individual episode of treatment they supply.
This represents a significant change for the Trust beginning 1 April 2012.
The national roll out into the ambulance sector is under pinned by the principle of mandated national categories with local prices. The Trust's 2012/2013 A&E contract has been structured to reflect this.

The national categories are:

- Calls
- Hear and Treat
- See and Treat
- See, Treat and Convey

Local tariffs are applicable to the above.

During 2011/2012 the Trust spent the majority of its available Capital as measured by the Capital Resource Limit (97%). The Hazardous Area Response Team (HART) building was completed at a cost of £3,994k during the 2011/2012 financial year including £2,900k brought forward from last year as an asset under construction. Included in the Capital Resource Limit is an additional amount of £1,694k, received from the Department of Health to fund capital purchases relating to Hazardous Area Response Team vehicles (HART).

The Trust's performance regarding its compliance with The Better Payment Practice Code is set out within the Summarised Financial Statements.

The Audit Commission provides External Audit services to EMAS. The expenditure on External Audit services for the year was £144k.

All other non-financial performance indicators are covered elsewhere in the Annual Report.

The Accounts have been prepared in accordance with the guidance outlined in the 2011/2012 NHS Manual for Accounts and have been produced under International Financial Reporting Standards (IFRS). The accounting policies have been approved by the Audit Committee.

The Restatement note in the Summarised Financial Statements (SFS) explains the alignment project and the subsequent restatement of the 2010/2011 annual accounts. It also details the numerical changes made to the accounts.

The Trust operates income generation activities covering vehicle maintenance training and operational cover for public events e.g. football matches. These are not significant areas of income (approximately 1% of total income). All are priced to cover costs of providing the service plus a contribution to the fixed costs of the organisation.

EMAS does not make any professional indemnity insurance payments for its Directors or Officers.

Pension Liabilities (see Note 10.5 in the full audited accounts) and Annual Governance Statement are contained in the full set of audited accounts available free of charge from the Finance Department at East Midlands Ambulance Service NHS Trust, Trust Headquarters, 1 Horizon Place, Mellors Way, Nottingham Business Park, Nottingham, NG8 6PY. Telephone: 0115 844 5000. Copies of the Annual Report are available from the same address.

Summarised Financial Statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2012

	2011/2012 £000	2010/2011 £000 (restated)
Revenue		
Employee Benefits	(118,459)	(117,311)
Other Costs	(46,899)	(42,664)
Revenue from patient care activities	165,192	160,003
Other Operating revenue	4,341	1,889
Operating surplus	4,175	1,917
Finance costs:		
Investment revenue	32	28
Other gains and (losses)	1	(10)
Finance costs	(69)	(64)
Surplus for the financial year	4,139	1,871
Public dividend capital dividends payable	(1,743)	(1,777)
Retained surplus for the year	2,396	94
Other comprehensive income		
Impairments and reversals	(2)	(105)
Gains on revaluations	641	302
Total comprehensive income for the year	3,035	291

Reported NHS financial performance position Adjusted retained surplus

Retained surplus for the year	2,396
Impairments	(994)
Reported NHS financial performance position Adjusted retained surplus	1,402

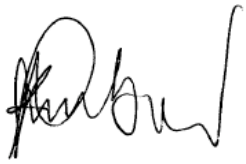
STATEMENT OF FINANCIAL POSITION AS AT 31 March 2012

	31 March 2012 £000	31 March & 1st April 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets			
Property, plant and equipment (PPE)	60,848	55,972	56,654
Intangible assets	31	54	86
Total non-current assets	60,879	56,026	56,740
Current assets			
Inventories	1,308	901	844
Trade and other receivables	7,564	8,141	7,081
Cash and cash equivalents	11,652	7,757	791
	20,524	16,799	8,716
Non-current assets held for sale	0	0	0
Total current assets	20,524	16,799	8,716
Total assets	81,403	72,825	65,456
Current liabilities			
Trade and other payables	(16,079)	(13,376)	(10,259)
Provisions	(2,189)	(914)	(990)
Borrowings	(17)	(17)	(17)
Net current assets / (liabilities)	2,239	2,492	(2,550)
Total assets less current liabilities	63,118	58,518	54,190
Non-current liabilities			
Provisions	(802)	(914)	(983)
Borrowings	(51)	(68)	(85)
Other liabilities	0	0	0
Total assets employed	62,265	57,536	53,122
Financed by taxpayers' equity:			
Public dividend capital	62,228	60,534	56,411
Retained earnings	(8,299)	(10,713)	(10,843)
Revaluation reserve	8,336	7,715	7,554
Total Taxpayers' Equity	62,265	57,536	53,122

The financial statements on pages 1 to 48 were approved by the Board on 6 June 2012 and signed on its behalf by:

Signature

Phil Milligan
Chief Executive



Ian Turnbull
Acting Director of Finance

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Balance at 31 March 2010	56,411	(10,843)	7,554	0	53,122
Changes in taxpayers' equity for 2010/11					
Retained surplus for the year	0	94	0	0	94
Transfers between reserves	0	36	(36)	0	0
Impairments and reversals	0	0	(105)	0	(105)
Net gain on revaluation of property, plant, equipment	0	0	302	0	302
New PDC received	4,123	0	0	0	4,123
Balance at 31 March 2011	60,534	(10,713)	7,715	0	57,536
	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2011/12					
Restated Balance at 1 April 2011	60,534	(10,713)	7,715	0	57,536
Retained surplus for the year	0	2,396	0	0	2,396
Transfers between reserves	0	18	(18)	0	0
Impairments and reversals	0	0	(2)	0	(2)
Net gain on revaluation of property, plant, equipment	0	0	641	0	641
New PDC received	1,694	0	0	0	1,694
Balance at 31 March 2012	62,228	(8,299)	8,336	0	62,265

STATEMENT OF CASH FLOWS FOR THE YEAR

31 March

	2011/201 £00	2010/201 £00
Cash flows from operating		
Operating	4,17	1,91
Depreciation and	4,52	4,75
Impairments and	(994	34
Donated Assets received credited to revenue but non-	0	(25
Interest	(69	(64
Dividends	(1,634	(1,835
(Increase) in	(407	(57
Decrease/(Increase) in trade and other	46	(1,002
Increase in trade and other	1,77	3,79
Provisions	(387	(477
Increase in	1,55	33
Net cash inflow from operating	9,00	7,68
Cash flows from investing		
Interest	3	2
Payments for property, plant and	(6,861	(4,996
Proceeds from disposal of assets held for sale	4	14
Net cash (outflow) from investing	(6,783	(4,827
Net cash Inflow before	2,21	2,86
Cash flows from financing		
Public dividend capital	1,69	4,12
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and	(17	(17
Net cash inflow from	1,67	4,10
Net increase in cash and cash	3,89	6,96
Cash and cash equivalents (and bank overdrafts) at the beginning of the	7,75	79
Cash and cash equivalents (and bank overdrafts) at the year	11,65	7,75

1. Capital Programme Year Ended 31 March 2012

	2011/2012 £'000	2010/2011 £'000
Purchased Assets		
Replacement Vehicles	5,555	363
Medical Equipment	118	0
IT Equipment	496	342
Estates	1,618	713
Assets Under Construction	0	2,903
Donated Assets		
Vehicles	0	25
Less:- Book Value of assets disposed of	(45)	(151)
Less:- Donations towards acquisition of non current assets	0	(25)
Charge against Capital Resource Limit	7,742	4,170
Capital Resource Limit	8,014	10,159
Underspend against the Capital Resource Limit	272	5,989

2. Better Payments Practice Code

The Better Payments Practice Code is a measure of the promptness of payment made to our suppliers. The NHS Executive requires that Trusts pay their non-NHS and NHS trade creditors in accordance with the CBI prompt payment code and government accounting rules. The target is to pay non-NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Results achieved this year have been as follows:

	Number (Total)	£'000 (Total)
Total Non-NHS invoices paid 2011/2012	30,174	42,790
Total Non-NHS invoices paid within target	29,404	41,213
% of Non-NHS invoices paid within target	97.45%	96.31%
Total NHS invoices paid 2011/2012	913	3,041
Total NHS invoices paid within target	865	2,784
% of NHS invoices paid within target	94.74%	91.55%

3. Staff Sickness Absence

	2011/2012	2010/2011
Total Days Lost	48,907	44,383
Total Staff Years	3,125	3,170
Average working Days Lost	16	14

Restatement Exercise

The Department of Health is required to prepare its 2011-2012 statutory accounts in accordance with Treasury directions.

For 2011-2012, accounts are prepared on an aligned basis in accordance with Treasury's Clear line of Sight (CLOS) programme. This seeks to:

Align budgets, Estimates and accounts in a way that allows Treasury to control what is needed to deliver the fiscal rules, incentivises value for money and reduces burdens on government departments;

Combine and/or align the timing of publication of government financial reporting documents in order to avoid duplication and make them more coherent.

To permit the preparation of the 2011-2012 accounts, it is necessary for the Department and NHS to restate 2010/2011 results on an aligned basis.

The key features of the restatement that affected the Trust are:

An increased emphasis on the importance intra-NHS agreement of balances and transactions (AoB) particularly with respect to those new entrants to the boundary that may not have participated fully in earlier AoB exercises. Hence:

Balances at 31 March 2010 and 31 March 2011 must be agreed;

Income and expenditure transactions for 2010-2011 need not be agreed, but must be reported accurately

The Employee Benefits" note has been revised to permit staff recharges to be recorded gross (i.e. separately identifying intra-NHS income for staff recharges) where this is required to match a Foundation Trust's counter-party's treatment of the transaction.

In the Restated accounts for 2010-2011 both income and expenditure has been increased by £275k to reflect this revision. (See Statement of Comprehensive Income – SoCE).

Unrelated to the alignment agenda, a significant change in accounting policies in respect of the receipt of donations has been made and has been incorporated in the 2011-2012 Treasury Financial Reporting Manual (FReM), so restatement is also required in respect of this.

Following the required restatement of the 2010-2011 accounts, the Donated Asset Reserve (£221k as at 1 April 2010) was eliminated and transferred to Retained Earnings within the Statement of Financial Position (SoFP).

As the Donated Asset Reserve had been eliminated, the original release from the Donated Asset Reserve (£51k),originally transacted in the 2010-2011 accounts was reversed leading to a £51k decrease in income in the restated accounts. During the 2010-2011 financial year a donated asset (£25k) was received. This had previously been credited to the Donated Asset Reserve but is now required to be credited to the SoCE.

Note 1.13 Donated assets explains the accounting treatment for 2011-2012.

The table below summarises the movements:-

	£000
Original 2010/2011 Accounts: Other Operating Revenue	1,640
Restatement Adjustments:	
Staff Recharges	275
2010/2011 Donated Assets Reserve Release	(51)
Donated Asset Receipt	25
Restated Total	1,889
Original 2010/2011 Accounts: Operating Expenses	159,700
Staff Recharges	275
Restated Total	159,975
Original 2010/2011 Accounts: Operating Surplus	1,943
2010/2011 Donated Assets Reserve Release	(51)
Donated Asset Receipt	25
Restated Total	1,917

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

I have examined the summary financial statement for the year ended 31 March 2012 which comprises Statement of Comprehensive Income, Statement of Financial Position, Statement in Change in Taxpayers' Equity, Statement of Cash Flows, accompanying notes 1 to 3 and restatement exercise note.

This report is made solely to the Board of Directors of East Midlands Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of East Midlands Ambulance Service NHS Trust for the year ended 31 March 2012.

Ian Sadd
District Auditor

Audit Commission
Unit 10, Whitwick Business Centre
Whitwick Business Park, Stenson Road
Coalville
LE67 4JP

8 June 2012

Glossary of financial terms

Remuneration

Monetary payment made for services rendered to an employer. Remuneration includes the following: base salary, bonuses, allowances, the benefit of a company car and all other payments receivable by the Applicant.

External Financing Limit

The amount of additional funding the Trust is required to repay or borrow from the Department of Health.

Better Payment Practice Code

A measure of the promptness of payment to our suppliers. The target is to pay suppliers within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Private Finance Initiative

A government initiative where the public sector contracts to purchase services, with defined outputs, on a long-term basis from the private sector, including the construction and maintenance of the necessary infrastructure.

Agenda for Change

The NHS pay system which supports service modernisation

Efficiency

In the public sector this involves making the best use of the resources available

Value for Money

Is a measurement of quality that compares the resources used to procure goods or services with the benefit obtained from those goods or services

Income generation

Income generation activities relate to the provision of services, supplies or products for financial gain to parties 'outside the NHS'. 'Outside the NHS' means parties other than fellow NHS organisations, NHS staff and NHS patients.

Annual Report
2011/2012

East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY

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To receive this information in large print, audio or in another language, please call us on 0845 299 4112.

communications@emas.nhs.uk

APPENDIX A

Questionnaire

SYSTEM INFORMATION:
Interviewer number
Interviewer name
Date:
Time interview started:

Introduction

Good morning/afternoon/evening. My name is ..... and I work for the market research company Accent, which is carrying out research for the healthcare regulator Monitor. Monitor's main duty is to protect and promote the interests of patients. The purpose of this questionnaire is to find out more about how patients use walk-in centres.

The questionnaire should take about 10-15 minutes.

Any answer you give will be treated in confidence in accordance with the Code of Conduct of the Market Research Society.

Before we start the main questions, I need to ask you a few quick questions about yourself to check that you are in scope for the research.

Scoping questions

Q1. **INTERVIEWER CODE LOCATION**

Name of centre	Region	Possible to Register (for routing only)
Battle Hill Health Centre	North East	Yes
The Skelton Medical Centre	North East	Yes
Bury Walk-in Centre	North West	Yes
NHS Walk-in Centre Widnes	North West	**No**
Liverpool City Centre NHS Walk-in Centre	North West	**No**
Ashton GP-led Health Centre	North West	Yes
Doncaster 8 to 8 Health Centre	Yorkshire and Humber	Yes
Story Street Medical Practice and Walk-in Centre	Yorkshire and Humber	Yes
Derby Open Access Centre	East Midlands	Yes
Putnoe Medical Centre	East of England	Yes
Shropshire Walk-in Health Centre	West Midlands	Yes
Hanley Health and Wellbeing Centre	West Midlands	Yes
Reading Walk-in Health Centre	South Central	Yes
Brighton Station Health Centre	South East Coast	Yes
Cardrew Health Centre	South West	Yes
Yeovil Health Centre	South West	Yes
Finchley NHS Walk-in Centre	London	**No**
New Cross GP Walk-in Centre	London	Yes
Urgent Care Centre, Guys' Hospital	London	No

The Practice Loxford, Loxford Polyclinic London Yes

Q2. **ASK ALL:** Have you come here today to attend the walk-in centre (or a GP practice located together with the walk in centre) or a different clinic/service located on these premises?

1. Walk-in service/GP Practice
2. Other clinic/service (eg Sexual Health Clinic, Out of hours GP service) **THANK AND CLOSE**

Q3. Are you at this walk-in centre today because of your own needs or someone else's? **READ OUT**

Yourself
Your child
Your partner
Your mother/father
Other (please specify)
Don't know/Prefer not to say [IF TICK THIS IN TEXT FILLS INCLUDE THE WORD 'your friend'] DO NOT READ OUT

Q4. **INTERVIEWER: RECORD GENDER OF PATIENT**

Male
Female

Q5. May I just ask which of the following age bands #IF Q3=1# do you/#IF Q3>1 does #Q3# fall into? **READ OUT**

ASK IF GUARDIAN WILL GIVE PERMISSION FOR CHILD UNDER 16 TO PARTICIPATE OR IF GUARDIAN WILL ANSWER QUESTIONS ON THE CHILD'S BEHALF. IF NO THANK AND CLOSE

1. baby (0-2 years): adult take part
2. child (3-10): adult take part
3. teenager (11-15) adult take part
4. teenager (11-15) : child take part with guardian's permission

.

5. 16-24
6. 25-34
7. 35-44
8. 45-54
9. 55-64
10. 65+

11 Don't know/Prefer not to say DO NOT READ OUT
12. Child under 16: adult refuses to take part THANK AND CLOSE. CODE REFUSAL ON THE REFUSAL SHEET

Q6. **[IF** Q5**=1-3] OTHERWISE GO TO** Q7

May I ask, what is your relationship to the young person?

READ OUT

Parent or guardian
Brother / sister
Other family member
Other (specify)
Don't know/Prefer not to say DO NOT READ OUT

Main Questionnaire

Thank you, I can confirm #IF Q3=1 you are /#IF Q3>1 # Q3 is # in scope for the survey. The questionnaire will take between 10 and 15 minutes to complete. You do not have to answer questions you do not wish to and you can terminate the interview at any point.

Registration at the walk-in centre

Q7. #IF Q3=1# Have you/#IF Q3>1# Has # Q3# just been seen today by a GP, nurse, or other healthcare professional? **DO NOT READ OUT**

1. Yes
2. No, Turned away as centre too busy
3. No, Turned away as arrived too late to be seen today
4. No, Decided to leave as the predicted wait time is too long
5. Other (specify)

Q7a **[ASK IF** Q7**=1]:** Who attended to #IF Q3=1# you /#IF Q3>1# your Q3's# condition today? READ OUT. **MULTICODE**

A GP
A nurse
Another healthcare professional (eg physiotherapist)
Care assistant
Don't know/Prefer not to say DO NOT READ OUT

Q8. #IF Q3=1# Do you/#IF Q3>1# Does # Q3# live near this walk-in centre? **INTERVIEWER: THIS REFERS TO THE USUAL PLACE OF RESIDENCE**

Yes
No
Don't know/Prefer not to say DO NOT READ OUT

Q9. **IF** Q3 **=5-9**
#IF Q3=1# Do you/#IF Q3>1# Does # Q3# work near this walk-in centre? **INTERVIEWER: THIS REFERS TO THE USUAL PLACE OF WORK**
IF Q5 **= 1 OR 10 DO NOT ASK**
IF Q5 **= 2-4 ASK**
#IF Q3=1# Do you # Q3>1 Does your # Q3# go to school or college near this walk-in centre? **INTERVIEWER: THIS REFERS TO THE USUAL PLACE OF EDUCATION**

Yes
No
Don't know/Prefer not to say DO NOT READ OUT

Q10. **(IF** Q8**=2 or** Q9**=2 ASK)**
#IF Q3=1# Are you/#IF Q3>1# Is your #Q3# in this local area temporarily, for example, on holiday or business?

No
Yes – UK resident on holidays **GO TO** Q16
Yes – UK resident on business **GO TO** Q16
Yes- Non-UK resident visiting from overseas **GO TO** Q24
Yes – other (please specify) **GO TO** Q16

Q11. **IF** Q8**=CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP**
Is this walk-in centre #IF Q3=1# your/#IF Q3>1# your # Q3#'s registered GP practice?

INTERVIEWER READ OUT IF NECESSARY: By 'registered' we mean that #IF Q3=1# you have/#IF Q3>1# your Q3 has# completed a form called a GMS1, giving details such as your name and address , your date of birth, your NHS number and other information, such as the name and address of your previous GP. Some GP surgeries will also ask to see proof of your identity.

Yes
No **GO TO** Q16
Don't know/Prefer not say **DO NOT READ OUT GO TO** Q16

Q12. REMOVE Q12. ASK Q12B
IF Q1**=CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP**
Q12B Why did #IF Q3=1# you/#IF Q3>1# your # Q3# choose to register with this walk-in centre? M**ULTICODE. SHOWCARD A. READ OUT**

Convenience of location
It's close to home
It's close to work/place of education
Ease of getting to the centre
Ease of parking at the centre

Convenience of getting an appointment
Not having to phone ahead to book an appointment
Short expected waiting times
The time of day or week that appointments are offered

Quality and range of services
The range of services that are offered to registered patients
Clinical expertise of the staff at the centre
Cleanliness and comfort of waiting rooms and facilities
Friendliness and attentiveness of staff

Privacy or other practical reasons
Unlikely to see anyone I/we know
Not able to register with a different GP practice
Dissatisfied with the service where registered previously
Visited the centre as a walk-in patient and was satisfied with the service

Other
Other (please specify)
Don't know/prefer not to say **DO NOT READ OUT**

Q13. **[IF MORE THAN ONE RESPONSE AT Q12b BRING RESPONSES FORWARD AND ASK]:**
What was the **most important** reason for choosing to register with this walk-in centre? **SINGLE CODE. READ OUT SHOWCARD A**

Convenience of location
It's close to home
It's close to work/place of education
Ease of getting to the centre
Ease of parking at the centre

Convenience of appointments
Not having to phone ahead to book an appointment
Short expected waiting times
The time of day or week that appointments are offered

Quality and range of services

The range of services that are offered to registered patients
Clinical expertise of the staff at the centre
Cleanliness and comfort of waiting rooms and facilities
Friendliness and attentiveness of staff

Privacy or other practical reasons
Unlikely to see anyone I/we know
Not able to register with a different GP practice
Dissatisfied with the service where registered previously
Visited the centre as a walk-in patient and was satisfied with the service

Other
Other (please specify)
Don't know/prefer not to say DO NOT READ OUT

Q14. **IF** Q1**=CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP** Before #IF Q3=1# you /#IF Q3>1# your Q3 # registered at this walk-in centre, were #IF Q3=1# you /#IF Q3>1# they Q3 # registered with another GP practice in the local area?
Yes - was registered locally
No - was registered in another area
No - was not registered previously
Don't know /prefer not to say **DO NOT READ OUT**

Q15. **IF** Q1**=CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP** Before choosing to register at this walk-in centre, did #IF Q3=1# you /#IF Q3>1# they Q3 # research and consider registering at any other GP practice in the local area? **[INTERVIEWER PROMPT: BY RESEARCH WE MEAN FOR EXAMPLE TALKING TO FRIENDS OR LOOKING ON THE INTERNET TO UNDERSTAND WHICH GP PRACTICES ARE IN THE AREA AND WHAT THEY OFFER]**
Yes
No
Don't know/Prefer not say (**DO NOT READ OUT)**
GO TO Q28

Q16. IF Q11=2 or 3
#IF Q3=1# Are you /#IF Q3>1# Is your Q3 # registered with a different GP practice?
IF Q1 NE CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP or IF Q11 NE 1
#IF Q3=1# Are you /#IF Q3>1# Is your Q3 # registered with a GP practice?
Yes – locally
Yes – in another area
No **GO TO** Q20
Don't know / prefer not to say **GO TO** Q20

Q17. What is the name and location of the GP practice where #IF Q3=1# you are /#IF Q3>1# your Q3 is # registered?
[RECORD AS MUCH DETAIL AS POSSIBLE: EG NAME AND LOCATION/POSTCODE/ ANY LOCAL LANDMARKS NEARBY EG SHOPS]
Name/Location (specify)
Would need to conduct further research or ask someone
Don't know/Prefer not to say **DO NOT READ OUT**

Q18. **IF** Q11**=2 AND** Q16**=3 AND IF** Q1**=CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP. READ OUT.**
Why have #IF Q3=1# you /#IF Q3>1# Why has your Q3 # chosen **not to** register with this walk-in centre? **MULTICODE**
Just moved to area
Only in the area temporarily **(Q10 > 1)**
Not eligible to register at this walk-in centre
Intend to register shortly
No need to register as can still use the walk-in service
Would register, but it is too difficult or time consuming
Want to stay registered at my own GP because still want to use their service
Other (specify)

[If Q16=2 GO TO Q22**]**

Q19. **[IF** Q1**=1 ASK]** How often #IF Q3=1# do you /#IF Q3>1# does your Q3 # visit the GP practice where #IF Q3=1# you /#IF Q3>1# they# are registered? **DO NOT READ OUT**
More than once a month
About once a month
Less than once a month but more than twice a year
About twice a year
Less than once a year
Never
Don't know/Prefer not to say DO NOT READ OUT

Q20. **[IF Q1<> CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP, and IF Q16=**3], OR [IF **Q1 = CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP, and IF Q11=2 and Q16=**3] ASK: MULTICODE
Why have #IF Q3=1# you /#IF Q3>1# your Q3 # chosen not to register at any GP practice?
Not eligible to register
Don't know how to
Too difficult / time consuming
Prefer not to give personal details
No need to register as can use this service without registering
Other (please specify)
Don't know / prefer not to say [**DO NOT READ OUT**]

Q21. If #IF Q3=1# you /#IF Q3>1# your Q3 # had to register to use the services at the walk-in centre, would #IF Q3=1# you /#IF Q3>1# your Q3 # still use the walk-in centre?
Yes
No
Don't know / prefer not to say [**DO NOT READ OUT**]
GO TO Q24

Reason for choosing this walk-in centre

[IF Q11=1 ASK] I've asked you some questions about whether #IF Q3=1# you are/#IF Q3>1# your Q3 is registered with this walk-in centre. Now I want to ask you some questions about #IF Q3=1# your /#IF Q3>1# your Q3's # visit here today.

Not registered with centre

[IF Q16=1-2 ASK] I've asked you some questions about whether #IF Q3=1# you are /#IF Q3>1# your Q3 is registered with a different GP practice. Now I want to ask you some questions about #IF Q3=1# your /#IF Q3>1# your Q3's # visit here today.

[IF Q11=3 or Q16=3 OR **IF** Q1 **NE CODES OF CENTRES WHERE IT IS POSSIBLE TO REGISTER WITH A GP** ASK] I've asked you some questions about whether #IF Q3=1# you are /#IF Q3>1# your Q3 is registered with a GP practice. Now I want to ask you some questions about #IF Q3=1# your /#IF Q3>1# your Q3's # visit here today.

Q22. **[IF** Q16**=1 OR 2 ASK]** Did #IF Q3=1# you /#IF Q3>1# your Q3 # try to contact or book an appointment with #IF Q3=1# your /#IF Q3>1# their Q3 # GP practice before #IF Q3=1# you /#IF Q3>1# they# came to this walk-in centre today? READ OUT. SHOWCARD B

1. No
2. Yes – Called but couldn't get through
3. Yes – Tried to book but no appointment was available
4. Yes – Tried to book but the appointments available were not at a convenient time
5. Yes – Tried to book but the waiting time for appointments was too long
6. Yes – They said come to this walk-in centre
7. Yes – Saw own GP previously about this
8. Other (specify)

Q22A [IF Q22=1] Why did #IF Q3=1# you /#IF Q3>1# your Q3 # decide not to contact #IF Q3=1# your /#IF Q3>1# your Q3's # GP practice before coming here today? **READ OUT**. **MULTICODE**

Didn't think about it
Don't want to bother own GP
Wouldn't be able to get an appointment that was convenient
Other (please specify)

Q23. **[IF** Q22**=7]** Why did #IF Q3=1# you /#IF Q3>1# your Q3 # choose to come to this walk-in centre today? SINGLE CODE

Wanted a second opinion
Wanted treatment or medication that own GP won't prescribe
Were dissatisfied with the service at own GP practice
Other (please specify)
GO TO Q24

Q24. ASK ALL: Did #IF Q3=1# you /#IF Q3>1# your Q3 # contact any other health care provider before #IF Q3=1# you /#IF Q3>1# your Q3 # came to this walk-in centre today? **SINGLE CODE**

No **IF** Q22 **= 6 GO TO** Q29**, IF Q22=7 then Q29, OTHERWISE GO TO** Q26
Yes – A&E [INTERVIEWER READ OUT IF NECESSARY: ACCIDENT & EMERGENCY/CASUALTY DEPARTMENT]
Yes – local pharmacy
Yes – Call an NHS helpline [INTERVIEWER PROMPT IF NEEDED: EG NHS DIRECT OR THE '111' PHONE LINE]
Other (please specify)
IF Q22=7 then Q29

Q25. #IF Q3=1# Were you /#IF Q3>1# Was your Q3 # directed to this walk-in centre today by the #Q3#?

No IF Q22=6 GO TO Q29, OTHERWISE **GO TO** Q26
Yes **GO TO** Q29

Q26. **REMOVE Q26 [IF Q24=1 Or** Q25**=1 ASK]** Why did #IF Q3=1# you /#IF Q3>1# your Q3 # choose to visit this walk-in centre today? **MULTIPLE CODE. DO NOT READ OUT**

ASK Q26B [IF Q24**=1 Or** Q25**=1 ASK]** Why did #IF Q3=1# you /#IF Q3>1# your Q3 # choose to visit this walk-in centre today? **MULTICODE. SHOWCARD C. READ OUT. INTERVIEWER ENCOURAGE RESPONDENT TO CHOOSE ALL THAT APPLY**

Convenience of location
1. .It's close to home
2. It's close to work/place of education
3.Ease of getting to the centre
4.Parking at the centre

Convenience of appointments
5. Not having to phone ahead to book an appointment
6. Short expected waiting times
7. The time of day or week that appointments are offered

Quality and range of services
8. The range of services that are offered at the centre
9. Clinical expertise of the staff at the centre
10. Cleanliness and comfort of waiting rooms and facilities
11. Friendliness and attentiveness of staff

Privacy reasons
12. Unlikely to see anyone I/we know
13. Prefer not to give personal details

Overseas/temporary location
14. Newly arrived in the area/country
15. Only in the area on a temporary basis

Other practical reasons
16. Not having to register with a GP practice
17. Needed to see someone urgently
19. Just stumbled across it/walked by
20.Could not get an appointment with a GP

Other
21 Other (specify

Q27. [**IF MORE THAN ONE RESPONSE AT Q26b BRING RESPONSES FORWARD AND ASK**]:
What was the **most important** reason for choosing this walk-in centre today? **SINGLE CODE SHOW CARD C**

Convenience of location
1. It's close to home
2 .It's close to work/place of education
3. Ease of getting to the centre
4. Parking at the centre

Convenience of appointments
5. Not having to phone ahead to book an appointment
6. Short expected waiting times
7. The time of day or week that appointments are offered

Quality and range of services
8. The range of services that are offered at the centre
9. Clinical expertise of the staff at the centre
10. Cleanliness and comfort of waiting rooms and facilities
11. Friendliness and attentiveness of staff

Privacy reasons

12. Unlikely to see anyone I/we know
13. Prefer not to give personal details

Overseas/temporary location
14. Newly arrived in the area/country
15. Only in the area on a temporary basis

Other practical reasons
16. Not having to register with a GP practice
17. Needed to see someone urgently
18 Didn't know where else to go
19. Just stumbled across it/walked by
20.Could not get an appointment with a GP

Other
21 Other (specify

GO TO Q29

Q28. **IF Q11=1** Why did #IF Q3=1# you# /#IF Q3>1# your #Q3# choose to visit this walk-in centre today?

For the same reasons as choosing to register here
Other (please specify)

Journey to GP walk-in centre

Q29. Where did #IF Q3=1# you /#IF Q3>1# your Q3 # travel from today? DO NOT READ OUT

Home
Work
Place of study
Friend's home
Hotel
Other (please specify)

Q30. How long did it take #IF Q3=1# you /#IF Q3>1# your Q3 # to travel to the walk-in centre from # Q3#? **DO NOT READ OUT**

Less than 10 minutes
Between 10 and 30 minutes
Between 31 minutes and 1 hour
More than 1 hour
Don't know/Prefer not to say DO NOT READ OUT

Q31. How did #IF Q3=1# you /#IF Q3>1# your Q3 # travel to the walk-in centre from #Q29#? **MULTICODE DO NOT READ OUT**
By car
By public transport
Walked
Cycled
Other

Purpose of visit to the walk in centre

Q32. **SHOW SHOWCARD D**. What health condition led to #IF Q3=1# your /#IF Q3>1# your Q3's# visit to this walk-in centre today? MULTICODE

Injury
Sprain or strain
Cut , bruise or abrasion
Burn or scald
Injury to the back or shoulder
Insect and animal bites
Suspected fracture / broken bone
Something in ear or eye

Illness
Cough, cold, sore throat
Nausea / diarrhoea
Stomach ache
Skin conditions eg eczema, rashes, psoriasis, boil etc
Ear / eye infection
Pain in chest or stomach
Breathing or asthma problems
Dizziness
Female issues eg thrush
Pain passing urine / urinary tract infection
Headache

Other
Health advice eg weight loss, stop smoking
Blood pressure check / other health check
Emergency contraception
Dressing care
Removal of stitches
Blood test
A prescription

Other [please specify]
Don't know/Prefer not to say DO NOT READ OUT

Q33. How would #IF Q3=1# you /#IF Q3>1# your Q3 # describe the condition that led to #IF Q3=1# your /#IF Q3>1# your Q3's# visit?
Urgent and requiring immediate attention
Not urgent
Other (specify)

Q34. Did #IF Q3=1# you /#IF Q3>1# your Q3 # (or someone on #IF Q3=1# your /#IF Q3>1# their # behalf) try to book an appointment at this walk in centre before your visit today?
Yes - booked an appointment prior to coming to the centre
No - tried to book an appointment but was unable to
No - did not try to book an appointment
Don't know/Prefer not to say DO NOT READ OUT

Q34b [IF Q34=3 or 4, ASK] If you had to phone ahead on the day to book an appointment, would #IF Q3=1# you /#IF Q3>1# your Q3 # have used this centre today?
Yes
No
Don't know / prefer not to say {DO NOT READ OUT]

Q35. What time of day did #IF Q3=1# you /#IF Q3>1# your Q3 # arrive at the walk-in centre today? **TYPE IN USING 24 HOUR CLOCK**

Q36. blank question

Q37. **[ASK IF** Q7**=1 AND Q34 =1]:** Did #IF Q3=1# your /#IF Q3>1# your Q3's# appointment take place on time?

Yes **GO TO** Q41
No
Don't know/Prefer not to say **DO NOT READ OUT GO TO** Q41

Q38. **[ASK IF** Q37**=2]:** How long was the delay? **DO NOT READ OUT**

Less than 10 minutes
Between 10 and 30 minutes
Between 31 minutes and an hour
More than 1 hour
Don't know/Prefer not to say DO NOT READ OUT

Q39. **[ASK IF** Q7**=1 AND** Q34**=2-4]:** ASK if Q7a=1-4: How long did #IF Q3=1#you /#IF Q3>1# your Q3# have to wait before being seen today by # Q7A#? **DO NOT READ OUT. [check text fill works]**
[ASK FOR EACH TICKED AT Q7a]

Less than 10 minutes
Between 10 and 30 minutes
Between 31 minutes and an hour
More than 1 hour but less than 4 hours
More than 4 hours
Don't know/Prefer not to say DO NOT READ OUT **GO TO** Q41

Q40. **[ASK IF** Q7**=1 AND (**Q34**=2-4 OR** Q37**=2]:** ASK if Q7a=1-4: How did #IF Q3=1# you /#IF Q3>1# your Q3# feel about this length of wait?

Waiting time was acceptable
Waiting time was unacceptable
Don't know/Prefer not to say DO NOT READ OUT

Q41. Following your visit to this walk-in centre, #IF Q3=1# do you /#IF Q3>1# does your Q3 # intend to use the services of another health care provider for the same reason as #IF Q3=1# you /#IF Q3>1# your Q3 # came here?

Yes
No **GO TO** Q45
Don't know/Prefer not to say DO NOT READ OUT **GO TO** Q45

Q42. What health care services #IF Q3=1# do you /#IF Q3>1# does your Q3 # intend to use following #IF Q3=1# your /#IF Q3>1# your Q3's# visit to this walk-in centre? DO NOT READ OUT

Will go to own GP practice [**list option only if 'yes' to Q16**]
Will go to A&E [[INTERVIEWER READ OUT IF NECESSARY: ACCIDENT & EMERGENCY/CASUALTY DEPARTMENT]
Will go to a different walk-in service
Will go to a pharmacy
Other (please specify)

Q43. [**ASK IF** Q42**=3**] Which walk-in service #IF Q3=1# do you /#IF Q3>1# does your Q3 # intend to go to?
[RECORD AS MUCH DETAIL AS POSSIBLE: EG NAME AND LOCATION/POSTCODE/ ANY LOCAL LANDMARKS NEARBY EG SHOPS]

Name/Location (specify)
Would need to conduct further research or ask someone
Don't know/Prefer not to say **DO NOT READ OUT**

Q44. What is the main reason why #IF Q3=1# you intend /#IF Q3>1# your Q3 intends# to use that other health care service?

The walk-in-centre said go and see own GP **[SHOW ONLY IF** Q42**=1 AND** Q16**=1 OR 2]**
The walk-in centre said to go to A&E [INTERVIEWER READ OUT IF NECESSARY: ACCIDENT & EMERGENCY/CASUALTY DEPARTMENT] [**SHOW ONLY IF** Q42**=2]**
The walk-in centre said go to the pharmacy [should only if Q42=4]
Need to see a specialist or have further tests
Want a second opinion
Other (please specify)

What respondent would have done if the walk-in centre wasn't available

Q45. There are no plans to close this walk-in service, but we want to understand what other healthcare options #IF Q3=1# you /#IF Q3>1# your Q3 # would have today if this walk-in centre was not available.

With this in mind if this walk-in centre was not available, where would #IF Q3=1# you /#IF Q3>1# your Q3 # have gone instead today? [DO **NOT READ OUT] MULTICODE**

1. Own GP practice [**list only if** Q16**=1 or 2]**
2. Different GP practice **[list only if Q11=1]**
3. A GP practice **[list only if Q11 NE 1 OR Q16=3]**
4. A&E [INTERVIEWER READ OUT IF NECESSARY: ACCIDENT & EMERGENCY/CASUALTY DEPARTMENT]
5. Called an ambulance
6. Called an NHS helpline [INTERVIEWER PROMPT IF NEEDED: EG NHS DIRECT OR THE '111' PHONE LINE]
7. A pharmacist
8. A different walk-in centre
9. Stay at home / self treat
10. Don't know / prefer not to say/ not sure DO NOT READ OUT
11. Other (please specify)

Q46. [**ASK IF** Q45=1, **2, 3, 4 OR 8**]
What is the name of the # Q3# #IF Q3=1# you /#IF Q3>1# your Q3 # would go to instead?
[**[RECORD AS MUCH DETAIL AS POSSIBLE: EG NAME AND LOCATION/POSTCODE/ ANY LOCAL LANDMARKS NEARBY EG SHOPS**
Name/Location (specify)
Would need to conduct further research or ask someone
Don't know/Prefer not to say **DO NOT READ OUT**

Q47. Would it make any difference to #IF Q3=1# you /#IF Q3>1# your Q3 # if #IF Q3=1# you /#IF Q3>1# they Q3 # had to do this today? CLARIFY IF NEEDED: THE DIFFERENCE IN TERMS OF THE TIME OR COST OF GOING SOMEWHERE ELSE INSTEAD OF THE WALK-IN CENTRE
Yes
No
Don't know/Prefer not to say **DO NOT READ OUT**

Q48. **[ASK IF** Q47**=1]** What would be the difference for #IF Q3=1# you /#IF Q3>1# your Q3 #? **Multicode DO NOT READ OUT**
Would have had to take more time off work or study
Would have had to travel further
Would need a babysitter
Would have to wait much longer to see someone

Would have had to pay for parking
Other (specify)
Don't know / prefer not to say DO NOT READ OUT

Q49. If all of the following options were available to #IF Q3=1# you /#IF Q3>1# your Q3 #, at a time that was convenient, which **one** option would #IF Q3=1# you /#IF Q3>1# your Q3 # have chosen if this walk-in centre was not available? **READ OUT. SINGLE CODE. SHOWCARD E**

Visit a GP
Visit A&E
Call an ambulance
Call an NHS helpline
Visit a pharmacist
Visit another walk-in service
Stay at home / try to self-treat
Other (please specify)
Don't know/Prefer not to say DO NOT READ OUT

Q50. Remove question.

Frequency of visiting walk-in centre and other health care services

---

Q51. How often #IF Q3=1# have you /#IF Q3>1# has your Q3 # visited this walk-in centre over the past twelve months? **DO NOT READ OUT**
Never – this was the first visit
Only once previously
About 2 or 3 times
Between 3 and 12 times
More than 12 times
Don't know/Prefer not to say DO NOT READ OUT

Q52. Do you think #IF Q3=1# you /#IF Q3>1# your Q3 # will visit this walk-in centre again?
Yes
No
Maybe
Don't know/Prefer not to say DO NOT READ OUT

Q53. REMOVE QUESTION

Q54. REMOVE QUESTION

Background Information

Q55. Which of the following best describes #IF Q3=1# your /#IF Q3>1# your Q3's # working status? **READ OUT. SHOWCARD F**
Working full time (30+ hrs)
Working part-time (9-29 hrs)
Unemployed/ Not working
Retired
Looking after house/children
Not working due to illness or disability
In full time education
Other
Don't know/Prefer not to say DO NOT READ OUT
Refused

Q56. What is the job title of the chief wage earner of #IF Q3=1# your /#IF Q3>1# your Q3's# household or, if you are the chief wage earner, your own job title?

IF SELF-EMPLOYED: ask if MANUAL/NON-MANUAL, SKILLED/QUALIFIED OR NOT, NUMBER OF EMPLOYEES – then look up self employed table
IF MANAGER/EXEC: ask for industry sector, NUMBER OF EMPLOYEES in company AND MANAGEMENT STATUS
IF RANK/GRADE (CIVIL SERVANT, NURSING, MILITARY, NAVY, POLICE ETC.) RECORD rank/grade SPECIFICALLY
IF PENSIONERS: ASK IF STATE (GRADE "E") OR PRIVATE/occupational PENSION (GRADE ON PREVIOUS OCCUPATION)
IF UNEMPLOYED: IF MORE THAN 6 MONTHS ago (GRADE "E"), IF LESS than 6 months ago (GRADE ON PREVIOUS OCCUPATION)

WRITE IN AND CODE
SEG.....

1. A
2. B
3. C1
4. C2
5. DE
6. Don't know/Prefer not to say DO NOT READ OUT

Q57. Which of the following groups do you consider #IF Q3=1# you belong /#IF Q3>1# your Q3 belongs# to? **READ OUT SHOWCARD G**

WHITE
1. British
2. Irish
3. Any other white background

MIXED
4. White and Black Caribbean
5. White and Black African
6. White and Asian
7. Any other mixed background

ASIAN OR ASIAN BRITISH
8. Indian
9. Pakistani
10, Bangladeshi
11. Any other Asian background

BLACK OR BLACK BRITISH
12. Caribbean
13. African
14 Any other black background

CHINESE OR OTHER ETHNIC GROUP
15 Chinese
16 Any other background
17 Don't know/Prefer not to say DO NOT READ OUT
18 Refused

Q58. What is #IF Q3=1# your /#IF Q3>1# your Q3's# postcode? **INTERVIEWER: IF ASKED, THIS IS FOR ANALYSIS PURPOSES ONLY**

Postcode (specify)
Non-UK resident
Don't know/Prefer not to say **DO NOT READ OUT**

Q58a Is there anything else you would like to tell Monitor about how you feel about this centre or walk-in centres more generally?

Yes (please specify)
No

Q59. We really appreciate the time that you have given us today. Would you be willing to be contacted again for clarification purposes or be invited to take part in other research for Monitor?

Yes, for both clarification and further research
Yes, for clarification only
Yes, for further research only
No

Thank you. This research was conducted under the terms of the MRS code of conduct and is completely confidential. If you would like to confirm my credentials or those of Accent please call the MRS free on 0500 396999.

HAND OVER THE THANK YOU SLIP.

Please can I take a note of your name and where we can contact you for quality control purposes?

Respondent name:

Telephone:

Interviewer Confirmation

I confirm that this interview was conducted under the terms of the MRS code of conduct and is completely confidential

Yes No

SYSTEM INFORMATION
Time interview completed:

APPENDIX B

Poster

Survey in Progress

In August 2013, this centre is taking part in a national survey of patients' views on walk-in centre services.

The survey will only take 10-15 minutes to complete.

We would greatly appreciate your views.

Please ask at Reception for further details

Monitor

Sector regulator of NHS-funded health care services

Accent

Independent market research company conducting the survey on Monitor's behalf

Thank you for your time today

APPENDIX C

Letter of Authority

Chiswick Gate
598-608 Chiswick High Road
Chiswick
London
W4 5RT

Telephone: +44 (0)20 8742 2211
Facsimile: +44 (0)20 8742 1991
Email: info@accent-mr.com
www.accent-mr.com

2636 LoA.doc
31st July 2013

Dear Sir/Madam

Patients' Use of NHS Walk-In Centres

Accent has been commissioned by Monitor to undertake research about NHS walk-in centres. The research is being conducted on behalf of Monitor and is therefore being conducted independently of the company or organisation that manages this walk-in centre.

Monitor is the sector regulator of NHS-funded health care services. Under the Health and Social Care Act 2012, Monitor's main duty is to protect and promote the interests of people who use them.

The purpose of the research is to understand how patients use the walk-in centres. The results will be used by Monitor as part of its review of the provision of walk-in centre services in England.

An Accent interviewer will be interviewing at this centre during August 2013. They will have an ID card with them at all times to identify them as a bona fide interviewer. We would greatly appreciate it if you could spend 10-15 minutes of your time answering some questions which will help us to understand your thoughts on this walk-in centre.

If you wish to verify or confirm any details of this survey, please do not hesitate to contact Rahima Miah (Accent Field Controller) or Teresa McGarry (Accent Project Manager) on 020 8742 2211. Alternatively, if you wish to confirm the validity of the survey or get more information about the survey aims and objectives then please call Nina Shore (Economic Advisor) or Sondra Roberto (Inquiries Lead) at Monitor on 020 3747 0000.

You can also find out more about Monitor and its review of walk-in centre services on its website (See:http://www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-40).

Yours faithfully

Rahima Miah
Field Controller

Monitor

Making the health sector work for patients

Walk-in centre review: final report and recommendations

www.monitor.gov.uk

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Find out more: www.monitor.gov.uk

Contents

Executive summary

In the decade from 2000-2010, the NHS opened more than 230 walk-in centres across England. The aim was to improve patients' access to primary care, modernise the NHS to be more responsive to patients' busy lifestyles, and offer patients more choice.

The centres delivered primary care differently from the traditional way in which general practitioners (GPs) provide primary care services to patients who register with their practice. The walk-in centres allowed patients to access care from a GP or a nurse with no need to register or to pre-book an appointment. The centres were open for longer hours than the typical GP practice, including after normal working hours and on weekends.

Walk-in centres proved to be popular with the public. Attendances at many centres have exceeded expected levels.

However, from the start, the centres have stirred debate. Proponents say that walk-in centres are important in providing easy access to primary care, particularly when some patients have difficulties getting timely or convenient appointments with a GP practice or accessing primary care more generally. Others believe that walk-in centres create demand for care for self-limiting, minor conditions. They say that the resources used to provide walk-in centres would be better spent on other priorities.

Since the start of 2010, local commissioners have closed more than 50 walk-in centres across England. About one-third of these closures were part of service reconfigurations that replaced a walk-in centre with an urgent care centre co-located with an A&E department or with primary care staff within an A&E department.

In many localities where walk-in centres still operate, commissioners are reviewing contractual arrangements and are considering closing the centres or making changes to services or locations.

Following reports of walk-in centre closures, Monitor decided to review the provision of walk-in centre services in England. As the sector regulator for health services in England, our primary duty is to protect and promote the interests of patients. We aim to enable providers and commissioners of NHS-funded care to deliver the best possible outcomes for patients today and tomorrow by creating the right incentives, providing information they need, and enforcing rules where necessary. The questions about walk-in centres that we sought to understand are:

- Why are walk-in centres closing?
- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?

- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

How we conducted our review

In May 2013, Monitor launched this review with a call for submissions seeking information and views about walk-in centre provision in England. We received 65 responses from patients, walk-in centre providers, GPs, commissioners and other stakeholders in the sector. In addition to the call for submissions, we undertook a broad range of research, including a survey of almost 2,000 patients using 20 walk-in centres across England. We also gathered evidence from walk-in centre providers and commissioning bodies and spoke to more than 25 stakeholders about their experiences and views of walk-in centres.

In November 2013, we published a preliminary report setting out our initial findings and the results of our patient survey. In our preliminary report, we invited stakeholders to respond to a number of specific questions related to our findings and to submit any additional information and views about walk-in centre provision. We received 36 responses, and we gathered more feedback from stakeholders, which we took into account in preparing this final report. The submissions are published on our website.[1]

This document represents the final stage of our walk-in centre review. The factual background and key findings are largely unchanged from the preliminary report. We have noted where we have made changes or additions based on stakeholders' responses to our preliminary report. Also in this final report, we have:

- updated the section describing the factors for commissioners to consider when deciding whether to continue to procure walk-in centre services with examples of best practice and links to relevant guidance (Section 8);
- added our recommendations for commissioners that aim to address, in the short-term, some of the findings of our review (Section 9); and
- highlighted the long-term work going on in the sector that is also likely to address some of the findings of our review, emphasising the need for this work to be well co-ordinated (Section 10).

Our findings

We found that the provision of walk-in centre services varies greatly by location. The range of services on offer, the settings where the centres are located, the skill mix of clinicians, opening hours, the degree to which they are integrated with other

[1] http://www.monitor.gov.uk/WIC

providers, the types of patients attending – all of these factors can vary from centre to centre, reflecting local health economies and populations. Likewise, the reasons for a particular closure and its impact on patients largely depend on local circumstances.

Despite the variation, our review revealed some common themes in the key areas that we examined.

As to why walk-in centres are closing, commissioners who have closed centres often cited concerns that the centres were generating unwarranted demand for services; that they led to duplication because some patients used them in addition to other services for the same problems; and that they caused confusion among patients about where to go for care. Commissioners also commonly said they felt they were "paying twice" for patients who attend walk-in centres. This was because most patients attending a walk-in centre are registered with a GP practice elsewhere that is already being paid to provide their primary care under the current list-based remuneration mechanism for primary care.

We also identified some common issues in the other key areas that we explored: the potential impact on patients of walk-in centre closures; whether commissioning practices are working in patients' interests; and whether payment mechanisms for walk-in centres and GP services are generating benefits for patients. Our examination of these areas has led us to the following findings:

- **In some cases, walk-in centre closures may adversely affect patients' access to primary care for some patients**

  Our research indicates that closures may adversely affect some patients by:

  - making it more difficult for them to access primary care services where there are problems with access to local GP practices; and
  - limiting the ability of primary care to reach particular groups of people who find it difficult to engage with the traditional model of GP services or whose uptake and interaction with primary care has traditionally been poor.

- **The division of commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision**

  Walk-in centres play a role in both primary and urgent care provision. The split in commissioning responsibilities between NHS England and clinical commissioning groups (CCGs), with NHS England broadly responsible for primary care and CCGs for urgent care, has led to confusion about which commissioning body is chiefly responsible for overseeing walk-in centre provision. This is particularly true where a walk-in centre offers both a

registered-list GP practice and walk-in services for non-registered patients. The absence of clarity can lead to some drawbacks for patients, including a lack of clear accountability for decision-making and a lack of transparency as to which commissioners are making key decisions. In addition, the split in responsibilities has created a risk that commissioners' decisions about walk-in centres do not take a local system-wide view of patients' needs and the potential impact of changes to walk-in centre services across primary and secondary care services in the local health system.

- **Walk-in centres would work better for patients if payment mechanisms were reformed**

  Current payment mechanisms for GP practices and walk-in centres discourage commissioners from offering walk-in centres, even where these may represent a high quality, cost-effective model for delivering services. In addition, the payment mechanisms do not strengthen incentives for GP practices to improve the quality and efficiency of their services so that their patients are more likely to choose the GP's services rather than a walk-in centre.

Increasing demand for services and finite resources create significant challenges for the NHS. In taking decisions about whether to continue to procure walk-in centre services, commissioners will want to assess the benefits of walk-in centres and of other models of care in areas including ease of access, quality of care, efficiency and affordability. It is for local commissioners to decide what is best for patients in their areas, having engaged with relevant stakeholders, including people in their communities.

Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services

Taking the challenges described above into account, and recognising commissioners' independence, in Section 8 of this report we set out some factors for commissioners to consider when deciding whether to continue to procure walk-in centre services. We have highlighted those factors that are most likely to be relevant to commissioners making decisions about walk-in centres, including:

- assessing patients' needs in the local area and understanding what role the walk-in centre may play in meeting them;
- deciding what services to procure and from whom when a contract for a walk-in centre is due to expire;
- considering whether services can be delivered in a more integrated way;
- managing conflicts of interest; and

- ensuring transparency in decision making.

We have also included some relevant examples of best practice and links to further resources for commissioners. Assessing walk-in centres in this way should ensure that local patients' needs are met as well as they can be.

Recommendations and future work

While Section 8 describes the factors commissioners will need to consider when deciding whether to continue to procure walk-in centre services generally, Section 9 sets out recommendations for commissioners to address some of the specific findings of our review. We recommend that:

- commissioners take steps now to clarify and bring transparency to commissioning responsibilities by publishing certain information about the contracts for each walk-in centre in their area, including which commissioning bodies are managing them and which are responsible for decisions about whether to continue to procure them;
- NHS England and CCGs work together to make decisions about walk-in centres, both with and without a registered list, to ensure that they take into account the effect on patients across primary and secondary care of any changes in services;
- local Healthwatch organisations and health and wellbeing boards should play a role in the decision process;
- commissioners work with any GP practices that have a high number of their patients using a walk-in centre to identify and correct any access or other problems; and
- commissioners follow up their decisions related to walk-in centres with a review to ensure that any changes are working in patients' interests.

Our recommendations aim to support commissioners' decision-making processes related to walk-in centres in the short-term. However, long-term solutions are needed to address the difficulties that some patients have in accessing primary care, and the difficulties some GP practices have in responding to increasing demand. Likewise, it will be necessary to ensure that the division in responsibilities for commissioning is working in patients' interests across NHS services and that payment mechanisms are creating the right incentives to benefit patients.

In Section 10, we describe some of the work currently taking place across the sector that is likely to address these issues in the long-term, including:

- NHS England, the commissioner of primary medical services and specialist services, is leading the development of a strategic framework to strengthen primary care.
- NHS England also has set out its vision for urgent care, which features an enhanced NHS 111 service to help people get the right advice or service to meet their needs. It also envisions providing a more standardised, less confusing, offer of urgent care services outside of hospital so that people without emergency needs will no longer seek treatment at A&E departments.
- In addition to supporting NHS England in its work to improve general practice and urgent care, Monitor has proposed doing further research into demand for and supply of GP services to gain a better understanding of the variations in access and quality across England and how these may be addressed.

It is important that all of the organisations working to promote change – NHS England, Monitor, the Department of Health, the Care Quality Commission, and others – co-ordinate their work so that NHS services, including walk-in centres, work better for patients.

1. Introduction

1.1. What are walk-in centres?

There is no standard definition of an NHS walk-in centre.[2] We define an NHS walk-in centre as a site that provides routine and urgent primary care for minor ailments and injuries with no requirement for patients to pre-book an appointment or to be registered at the centre or with any GP practice.

Our definition includes "GP-led health centres". These treat minor illness and injury with no requirement for patients to pre-book an appointment or be registered at the centre, but which also offer patients the option to register with the GP practice at the centre if they wish. We describe the different types of walk-in centres that fall within our definition in more detail in Section 2.

While all walk-in centres provide basic advice and treatment for minor conditions, the full range of services on offer vary greatly by location. In Section 4, we discuss in more detail the services that walk-in centres provide and alternatives for those services that may be available to patients.

1.2. Why did Monitor review walk-in centres?

Our decision to review walk-in centre provision was grounded in our main duty as health care sector regulator: to protect and promote the interests of patients by promoting the provision of health care services that is effective, efficient and economic and that maintains and improves the quality of services.

We have a range of functions to enable us to carry out our duty. This review was based on our functions of ensuring that the commissioning of services, choice and competition are working in the best interests of patients.[3]

[2] For purposes of setting out commissioning responsibilities, regulations define a walk-in centre as "a centre at which information and treatment for minor conditions is provided to the public under arrangement made by a relevant body." National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

[3] To carry out these functions, Monitor has the power to: enforce the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013; enforce the provider licence; enforce provisions of the Competition Act 1998; make market investigation references to the Competition Commission; review mergers between NHS trusts; and provide advice on merger benefits to the Office of Fair Trading for mergers involving foundation trusts. From April 2014, the functions of the Competition Commission and the Office of Fair Trading will transfer to the Competition & Markets Authority.

We launched this review, following reports of walk-in centre closures, to understand the nature of walk-in centre provision in England[4] as well as to understand:

- Why are walk-in centres closing?
- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?
- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

Some issues related to walk-in centre provision fell outside the scope of our review. We did not investigate, for example, how the quality of care at walk-in centres compares to other primary care services. We also did not assess the underlying costs of providing care in walk-in centres compared to the costs in other settings.[5] Commissioners are best placed to consider these issues locally when evaluating which models of care are best to meet the needs of their patients.

Further, some of the issues we identified in our review of walk-in centres relate more broadly to the provision of GP services. We published a discussion document in February 2014 summarising the issues raised in our call for evidence on GP services, which set out to understand how well arrangements for commissioning and providing GP services are working for patients. The document also proposes further work by Monitor in this area.[6]

1.3. Our key pieces of research

- **Call for submissions:** we issued a call for submissions and received 65 responses from service users, commissioners, walk-in centre providers (both independent and public), GPs, nurses, and several local and national organisations. We also invited stakeholders to respond to our subsequent preliminary report, published in November 2013. We received 36 submissions, which are published on our website.[7]

[4] See *Review by Monitor of the provision of walk-in centre services in England*, Scope of review, 31 May 2013, www.monitor.gov.uk/sites/default/files/publications/ToPublishReviewWalkinCentreServicesMay2013.pdf.
[5] Comparing costs to deliver services in different settings is complex and subject to the reliability of underlying data. Monitor is working to improve costing as part of its role in setting prices for NHS-funded services. See www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-10.
[6] Available at www.monitor.gov.uk/node/5942.
[7] http://www.monitor.gov.uk/WIC

- **Patient survey:** to better understand who uses walk-in centres and why, we commissioned a survey of 1,886 patients at 20 centres across England. The patient survey report was published alongside the preliminary report.[8]
- **Stakeholder meetings:** we met with more than 25 stakeholders, including walk-in centre providers, commissioners, local health and wellbeing board members, Healthwatch representatives, local authority councillors, and academics who have studied walk-in centres.
- **Information and data from providers and commissioners:** in addition to gathering publicly available information, we sought information and data from walk-in centre providers and commissioning bodies.

1.4. Topics covered in this report

Section 2:	The history and policies behind walk-in centres
Section 3:	The policy context today
Section 4:	Overview of walk-in centre provision today: locations, services, providers, and pricing
Section 5:	Demand for walk-in centre services
Section 6:	Reasons for the trend to close walk-in centres
Section 7:	Our analysis and findings related to the key areas that we examined
Section 8:	Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services
Section 9:	Our recommendations
Section 10:	Long-term work to make services work better for patients

[8] See Accent, *Patients' use of walk-in centres*, Report, October 2013 [Monitor's patient survey report], available at www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-40.

2. Walk-in centres were introduced to improve access to primary care, modernise the NHS, and offer patients more choice

Between 2000 and 2010, the government launched initiatives to establish NHS walk-in centres throughout England as part of efforts to achieve three major health care policy goals:

1. **Improving access to primary care**

   The government wanted to improve access to primary care because of concerns that people sometimes found it difficult to access health care quickly from general practice. The requirement to register with a GP practice close to home, in particular, was thought to present barriers to access for certain groups, including commuters, the homeless, tourists and travellers.[9] Later in the decade, the Department of Health's public consultations raised concerns that:

   "*many people are seeking the opportunity to access routine primary care from a GP in the evenings or at weekends. And a quarter of patients still report that they cannot book advance appointments at their GP practice. It is also significant that young working males and black and ethnic minority communities are more likely to report difficulties in accessing GP services."*[10]

   The walk-in centre model was introduced to lower the barriers to accessing primary care.

2. **Modernising the NHS to make it more responsive to patients' lifestyles**

   The government wanted to modernise the NHS to meet the needs of people with busy schedules, such as parents and workers who have difficulty taking time off work to visit their GP.[11] Walk-in centres were to offer conveniently located services with extended hours including weekends, and fast access to an appointment. Many centres were expected to keep waiting-times to within 15-30 minutes for a triage assessment or a full consultation.[12]

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[9] C. Salisbury, M. Chalder, et al, *The National Evaluation of NHS Walk-in Centres*, Final Report, July 2002, p.1.
[10] Department of Health, *NHS Next Stage Review Interim report*, October 2007, p.25.
[11] See press release, 1999/0226, *Up to £30 million to develop 20 NHS fast access walk-in centres*, 13 April 1999.
[12] L. Mountford, R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, The King's Fund, 2001; Department of Health, *Contract for Primary Medical Care Services* [for use with health centres as per EAPMC criteria], 11 July 2008, Schedule 2, p.13, available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086657.

3. Offering more choice to patients

> The government has sought to expand choice in both primary and secondary care to give patients more control over their care and to strengthen incentives for providers to improve services in order to attract patients. Walk-in centres, particularly those introduced later in the decade, were intended to give people greater choice from a range of primary care services.[13]

While walk-in centres were established primarily to provide and improve access to primary care, our conversations with stakeholders and other evidence suggests that many in the sector view the main purpose of walk-in centres as reducing pressures on A&E departments.[14]

Most walk-in centres in England were established through the three national initiatives described below. The centres reflected local commissioners' decisions about where, how, and what services were to be provided.[15]

2.1. 1999-2004: Nurse-led walk-in centres

In April 1999, Prime Minister Tony Blair announced plans to establish a number of nurse-led walk-in centres that would provide information and treatment for minor conditions.[16] Services were to be provided without the need for a pre-booked appointment for extended hours (typically 7am to 10pm), 365 days a year. The centres were to be sited in easily accessible locations, such as town centres or adjacent to A&E departments.[17]

An additional goal of the nurse-led centres was to maximise the role of nurses in primary care. Beginning with pilot sites, the Department of Health eventually established about 72 nurse-led walk-in centres throughout England.[18] This included a final wave of centres established in 2004 that were mostly co-located with A&E departments as way to reduce pressure on A&E services.[19] The centres had to be managed by an NHS body (such as an NHS trust) or GP co-operatives and were expected to build on, rather than duplicate, existing services, and to have links with

[13] Department of Health, *NHS Next Stage Review: Our vision for primary and community care*, June 2008, p.28.
[14] See, eg, NHS Office of the Strategic Health Authorities, *Emergency Services Review, Good practice in delivering emergency care: a guide for local health communities*, July 2009, p.13 (urgent care centres, walk-in centres, and minor injury units "are intended to provide alternatives to Emergency Department attendance").
[15] In addition to walk-in centres that started as part of these national initiatives, our research suggests that there are a small proportion (we estimate less than 10% of all centres) that started as part of local initiatives or evolved from existing local services.
[16] See press release, 1999/0226, *Up to £30 million to develop 20 NHS fast access walk-in centres*, 13 April 1999.
[17] NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/116, 11 May 1999.
[18] *The rise of the walk-in centre*, Nursing Times,18 August 2008. Other sources gave a slightly different number of nurse-led centres that opened as part of the national initiative.
[19] Salisbury et al, *The impact of NHS walk-in centres on A&E services*, February 2006.

local GP practices.[20] Some centres had access to a GP for patients who needed one.[21]

GPs and other health professionals initially voiced concerns that the walk-in centres would adversely affect continuity of care or that the centres would increase demand.[22] However, in later years, some GPs began referring their patients to the centres for services such as blood pressure checks and dressings.[23]

Although walk-in centres were new to the NHS, minor injuries units had already been established in several towns in the UK to serve patients with urgent care needs on a walk-in basis. And walk-in centres were already operating in a number of other countries, including the US, Canada, Australia and South Africa.[24]

2.2. 2005-2007: Commuter walk-in centres

Building on the policies behind the first walk-in centre initiative, the government established six GP-led walk-in centres between 2005 and 2007 aimed at commuters in London, Manchester, Leeds and Newcastle.[25]

The commuter centres were introduced as part of the Independent Sector Treatment Centres programme launched in 2002. The programme sought to increase independent sector involvement in the NHS to increase capacity and reduce waiting-times as well as to offer patients greater choice of services to stimulate improvements in quality through competition.[26]

At the time, walk-in centres were viewed as part of a broader vision for primary care, as set out in Table 1.

[20] NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/116, 11 May 1999.
[21] L. Mountford, R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, The King's Fund, 2001.
[22] A walk-in? Now you're talkin', *Health Service Journal*, 4 May 2000.
[23] The rise of the walk-in centre, *Nursing Times*,18 August 2008.
[24] C. Salisbury, J. Munro, Walk-in centres in primary care: a review of the international literature, *British Journal of General Practice*, January 2002; pp.53-59.
[25] Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, June 2004, paragraph 5.8. The government pledged to open more so-called "commuter centres" in 2006, but these openings did not occur.
[26] Department of Health, *Independent Sector Treatment Centres*, Report to the Secretary of State for Health, 16 February 2006.

Table 1: The government's vision in 2004 for primary care

THE NHS IN 2000	THE NHS IN 2008
Patient has to make an appointment with a registered GP for advice, diagnosis and referral	Patient chooses whether to make an appointment with a GP or practice nurse, visit an NHS Walk-in Centre or Pharmacy Service Centre, or contact NHS Direct for advice and diagnosis
Patient may wait several days for an appointment with their GP	Patients see a primary care practitioner within 24 hours when they need to or a GP within 48 hours
GP makes decision about how, when and where patient is treated	Patient chooses how, when and where they are treated – from a range of providers funded by the NHS and accredited by the Healthcare Commission

Source: Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, June 2004, p.33.

The commuter centres were to be open from 7am to 7pm, 365 days a year and were to offer treatment for minor illness and injuries, prescriptions and pharmacy services, and other services such as physiotherapy and blood pressure checks.[27] Six centres were contracted from independent providers using five-year contracts at a total cost of about £9 million a year.[28] However, by December 2011, all six commuter centres had been closed upon contract expiration, mainly because they saw fewer than expected patients,[29] were poorly located, or were not thought to represent value for money.[30]

2.3. 2007-2010: The Next Stage Review and the emergence of GP-led health centres

In October 2007, as part of his *Next Stage Review*, health minister Lord Darzi announced new investment to develop 150 GP-led health centres that offered both:

- a list-based GP practice at which patients could register if they chose; and
- a GP-led service open to any member of the public, including those registered at GP practices elsewhere or those not registered with any GP practice. The

[27] Department of Health, *New surgeries offer commuters fast-track to treatment*, Press release, 4 November 2004.
[28] Bureau Investigates, *Get the data: Commuter walk-in centre closures*, May 2011.
[29] www.ncbi.nlm.nih.gov/pubmed/2087525.
[30] http://alternativeprimarycare.wordpress.com/2011/06/16/the-light-nhs-leeds-walk-in-centre-to-close/.

service was to allow any member of the public to access GP services through pre-bookable appointments or walk-in appointments that did not require pre-booking.[31]

Under the Equitable Access to Primary Medical Care (EAPMC) programme, each Primary Care Trust (PCT) was expected to commission at least one GP-led health centre in their area.[32,33]

The centres were to be open between 8am and 8pm, 7 days a week, and were to be situated in easily accessible locations. They were intended to be responsive to local needs and, to foster integrated care, they were to be co-located where possible with other community-based services such as diagnostic, therapeutic (for example, physiotherapy), pharmacy and social care services.[34]

The GP-led health centres – commonly referred to as "Darzi centres" – were commissioned between 2008 and 2010. PCTs procured the centres primarily through competitive tender for Alternative Provider Medical Services (APMS) contracts, which allowed bids to provide the services from the independent sector, GP-formed companies, traditional GP practices, social enterprises and NHS trusts.[35] The Department of Health raised PCTs' baseline funding to pay for the centres.[36]

The centres were controversial from the start. For example, the British Medical Association (BMA) stated in a submission to our review that it "*supported establishing these centres where there was a proven need for the services they offered*" but it did not support the blanket approach requiring every PCT to open a centre. The BMA also stated: "*the resources invested in walk-in centres would be better targeted at existing GP services, which have been stretched for many years.*"[37] Several stakeholders also told us that some PCT commissioners felt they were being forced to procure a service that they did not need.[38] In some cases,

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[31] Department of Health, *NHS Next Stage Review Interim report*, October 2007, p.25.
[32] We identified 150 GP-led health centres that opened under the EAPMC programme (including those that have now closed). Our research suggests that a few PCTs out of 150 did not commission any centres at all, while a few commissioned more than one. The EAPMC also provided funding for 113 new standard GP practices (with no walk-in requirement) in the most under-doctored (and often the most deprived) areas of the country. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm.
[33] Department of Health, *NHS Next Stage Review Interim report*, October 2007; Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report*, June 2008.
[34] Department of Health, *Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs*, Version 3, August 2008.
[35] See J. Ellins, C. Ham, & H. Parker, *Choice and Competition in Primary Care: Much Ado About Nothing?*, University of Birmingham Health Services Management Centre, November 2008.
[36] Department of Health, *Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs*, Version 3, August 2008, p.9.
[37] BMA submission to Monitor review, June 2013.
[38] Reflecting last year on how the GP-led health centres were established, Lord Darzi wrote that while he still believes the centres are "a good idea," "the initiative's credibility was badly damaged by its top-

PCTs closed existing walk-in centres in 2008 or 2009 to replace them with GP-led health centres.[39]

On the other hand, we were told that some commissioners welcomed the walk-in centres and the opportunity to design the services around local needs.

However, soon after (or in some instances even before) the centres opened, some PCTs began to renegotiate contracts to change the services provided by the centres, moving away from initial policy guidance, such as by reducing opening hours or dropping the option of patient registration (see Section 6 for a description of changes to walk-in centre provision).

We refer throughout this document to the walk-in centres established as a result of the EAPMC programme as "GP-led health centres." These have both a registered list GP practice and a walk-in service that is available to patients who are registered or not registered with the practice.

down nature" and did not always reflect local needs. A. Darzi and P. Howitt, Integrated care cannot be designed in Whitehall, *International Journal of Integrated Care*, 18 May 2012.

[39] See, for example, www.bristolpost.co.uk/Anger-closure-south-Bristol-walk-health-centre/story-11314060-detail/story.html.

3. Since 2010, policy objectives have evolved to focus on improving access to 24/7 care and better managing demand

The policy context and the economic climate have changed since walk-in centres were established. In 2010, the government's whitepaper, *Equity and excellence: Liberating the NHS*, provided a blueprint for the Health and Social Care Act 2012 (the 2012 Act). Among other reforms, the 2012 Act abolished PCTs and transferred commissioning responsibilities to NHS England and to clinical commissioning groups (CCGs) (made up of providers of primary medical services, including GPs). *Equity and excellence* also reaffirmed the government's commitment to offer patients greater choice of service providers.[40]

Financial pressures are a key focus of policymakers, commissioners, and providers today. The Quality, Innovation, Productivity and Prevention (QIPP) programme was launched to achieve £20 billion in savings to be reinvested in the NHS. In October 2013, Monitor published a report on the challenge of closing a predicted £30 billion funding gap by 2021.[41]

There also are efforts underway to better manage demand for services. NHS England has set out a vision for redesigned urgent care and emergency services that includes:

- offering better support for people to self-care;
- enhancing NHS 111[42] to help people who need urgent care find the right service at the right time;
- providing responsive urgent care services outside of hospital so that people with non-emergency needs no longer seek treatment at A&E departments;
- introducing two levels of emergency departments to replace the inconsistent levels of service available at different departments; and
- connecting urgent and emergency care services together in emergency care networks.[43]

Work is now underway to develop plans to implement this vision.

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[40] *Equity and Excellence: Liberating the NHS*, July 2010, pp.16-18.
[41] Monitor, *Closing the NHS funding gap: how to get better value health care for patients*, 2013, available at www.monitor.gov.uk/closingthegap.
[42] For information about NHS 111, see Annex 1.
[43] *Transforming urgent and emergency care services in England, Urgent and Emergency Care Review, End of Phase 1 Report*, NHS England, November 2013, available at www.england.nhs.uk/2013/11/13/keogh-urgent-emergency/.

The National Audit Office also published a report in November 2013 looking at the causes behind increased emergency admissions, how well emergency admissions are managed and what might be done to better manage demand.[44]

Improving access to primary care continues to be a major policy goal. In early October 2013, the Prime Minister announced a proposal to implement seven-day 8am-8pm GP access to "help thousands who struggle to find GP appointments that fit in with their family and work life."[45] Under the proposal, at least nine GP groups will operate pilots to provide extended and flexible access, including email, Skype and phone consultations, as well as online registration and choice of practice. The groups will apply to a £50 million fund for support for the pilots.

Alongside these efforts, NHS England is developing a national strategic framework for commissioning of GP services that addresses key challenges facing the sector: an ageing population; growing co-morbidities and increasing patient expectations; increasing pressure on NHS financial resources; growing dissatisfaction with access to services and persistent inequalities in access and quality of primary care; and growing workforce pressures.[46]

The Department of Health's recent consultation on its Mandate to NHS England also stated: *"we want to improve people's access to primary care through new forms of provision including rapid walk-in access".*[47]

[44] National Audit Office, *Emergency admissions to hospital: managing the demand*, 31 October 2013, available at www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/.
[45] https://www.gov.uk/government/news/seven-day-8am-8pm-gp-access-for-hard-working-people.
[46] NHS England, *Improving General Practice – A Call to Action, Slide Pack*, August 2013.
[47] Department of Health, *Refreshing the Mandate to NHS England: 2014-2015*, Consultation, p.9.

4. Walk-in centres today: service features vary by locality

While walk-in centres were largely established under national initiatives, local commissioners often tailored the centres to reflect local needs and priorities. As a result, many key features of walk-in centres, such as where they are sited, opening hours, skill-mix of staff, the range of services provided, and the degree of co-location with other health and social care services vary by walk-in centre.

The names of walk-in centres also vary and are not necessarily indicative of the services provided. Labels include NHS walk-in centre or simply walk-in centre, GP-led health centre, equitable access centre, open access centre, 8 to 8 centre, same day centre, health centre, medical centre, and primary care centre.

There is no central repository containing data and information about all walk-in centres in England.[48] In this section, we provide an overview of walk-in centres that is based on our compilation of publicly available information, data and information received from commissioners and providers, and conversations with stakeholders.

We also provide an overview of services that might be considered an alternative to walk-in centre services. While facilities labelled as urgent care centres and minor injuries units often look very similar to a walk-in centre, the nature of services can be different to walk-in centre services and many offer a suitable alternative only for certain health care needs (see Section 4.3).

4.1. Numbers and locations of walk-in centres in England

Our research identified 185 walk-in centres operating throughout England.[49] A list of these is provided in Annex 2. This number includes 135 walk-in centres that are GP-led[50] and 50 that are nurse-led.

Walk-in centres exist in most areas of England (see Figure 1), and are present in all of the (former) Strategic Health Authority (SHA) areas of England.[51] We found that

[48] The Department of Health collects some data about walk-in centres operated by NHS trusts and NHS foundations trusts (Department of Health, National Schedule of Reference Costs 2011-12 for NHS trusts and NHS foundation trusts, available at https://www.gov.uk/government/publications/nhs-reference-costs-financial-year-2011-to-2012); however, trust-run centres represent a small fraction of the total number of walk-in centres. Likewise, NHS England A&E statistics include attendance figures for some NHS trust-run and independently-run walk-in centres but not the full universe of walk-in centres (NHS England, Weekly A&E SitReps, available at www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/).

[49] This figure reflects centres that were in operation in England at the time of our review that fit our definition of a walk-in centre, as described in Section 1.1. Our list of walk-in centres was developed using information from the Care Quality Commission, the Health and Social Care Information Centre, submissions from providers and commissioners, CCG information request responses, and our own web research and conversations with stakeholders.

[50] Of the 135 GP-led walk-in centres that we identified, 124 are GP-led health centres (known as "Darzi" centres) that opened under the Equitable Access to Primary Medical Care programme. The other 11 GP-led walk-in centres appear to have developed from local initiatives.

centres are more prevalent in the North East and North West, London and West Midlands compared to other areas of England (see Table 2). We identified 81 CCGs out of a total of 211 that do not have a walk-in centre in their geographical boundaries. Nineteen CCGs told us that they have no walk-in centres, no urgent care centres and no minor injuries units located within their geographical boundaries.[52]

[51] Although SHAs no longer exist, they are a convenient way of dividing England into smaller regional areas. SHAs were also responsible for overseeing health care services in each region when the latest wave of walk-in centres was established. The SHA areas adopted are those that were formed in 2006. The 10 SHA areas are: North East, North West, Yorkshire & Humber, East Midlands, East of England, West Midlands, South Central, South East Coast, South West, and London.

[52] The number of CCGs without these services in their areas is most likely an underestimate as approximately half of the 211 CCGs in England responded to our request for information. See Section 4.3 and Annex 1 for a description of these other services.

Figure 1: Walk-in centres in England

Source: Monitor analysis

Table 2: Number of walk-in centres by (former) SHA areas

Strategic Health Authority	Number of walk-in centres	Population mid-2012 ('000)	Number of walk-in centres per million residents
North East	19	2,602	7.3
London	42	8,308	5.1
West Midlands	25	5,643	4.4
North West	31	7,084	4.4
Yorkshire and the Humber	15	5,317	2.8
South East Coast	11	4,514	2.4
South West	12	5,340	2.2
East Midlands	10	4,568	2.2
East of England	12	5,907	2.0
South Central	8	4,211	1.9
Total	**185**	**53,494**	

Sources: Monitor analysis; ONS Population Estimates mid-2012

Walk-in centres are often located within areas of relative deprivation. Our research suggests that 28% of walk-in centres are located within the 10% most deprived areas, whereas 1% of walk-in centres are located within the 10% least deprived areas (see Table 3).[53]

[53] This has been calculated using the Index of Multiple Deprivation (IMD), a combination of 7 indices that measure aspects of deprivation including income, employment, health and crime. Indices are calculated by Lower Layer Super Output Areas (LSOAs), of which there are 32,482 in England. Source data and more information about the IMD are available here: https://www.gov.uk/government/organisations/department-for-communities-and-local-government/series/english-indices-of-deprivation.

Table 3: Deprivation levels of walk-in centre locations

Percentile of deprivation	Number of walk-in centres	Proportion of total walk-in centres
10th	2	1%
20th	9	5%
30th	6	3%
40th	10	5%
50th	12	6%
60th	12	6%
70th	26	14%
80th	23	12%
90th	34	18%
100th	51	28%

Least deprived areas

Most deprived areas

Sources: Monitor analysis; The English Indices of Deprivation 2010

At a local level, our research indicates that walk-in centres are generally sited in one of five types of locations:

- in urban city/town centres such as in a central shopping area or close to a train station;[54]
- within suburban locations, for example, close to or within large residential estates;[55]
- within or on the fringes of commercial/industrial areas, sometimes close to residential estates;[56]

[54] There are many examples of walk-in centres in urban/town centres including Reading Walk-in Centre, Liverpool City Walk-in Centre, Brighton Station Health Centre, Worcester Walk-in Health Centre, Soho Walk-in Centre, Walsall Walk-in-Health Centre, Birmingham NHS Walk-in Centre and Swindon Walk-in Centre.

[55] Examples of walk-in centres located within residential areas include Battle Hill Health Centre, Dudley Borough Walk-in Centre, The Practice Loxford (Loxford Polyclinic), and Putnoe Medical Centre.

[56] For example, Barkantine Practice, Cardrew Health Centre and Quayside Medical Centre.

- in community hospitals or other community health care hubs;[57] and
- at acute hospital sites, with or without an A&E.[58]

4.2. Overview of services provided

Most walk-in centres are open seven days per week for extended hours, such as from 8am to 8pm, or 7am to 10pm.[59] Services provided vary and may depend on whether a walk-in centre is nurse-led or GP-led; however, walk-in centres commonly provide advice and treatment for minor illnesses and injuries including:

- coughs, colds and flu-like symptoms;
- skin conditions or skin infections;
- stomach upset or pain;
- breathing problems (such as asthma);
- back pain;
- urinary tract infections;
- ear, eye and throat infections;
- cuts, strains and sprains; and
- insect and animal bites.

Beyond advice and treatment for these and other minor conditions, the services provided depend on the centre and local commissioning priorities.

Nurse-led walk-in centres

Nurse-led centres often provide health promotion and advice and some provide information such as opening hours and contact numbers for other local health services. Several offer assessment, diagnosis and initial therapy for deep vein thrombosis (DVT) upon referral from GPs. Some centres provide blood tests, emergency contraception or travel vaccinations. Nurses or other staff who are qualified prescribers can issue prescriptions, and the centres may be authorised to offer certain medications within set guidelines.

[57] For example, Solihull Healthcare & Walk-in Centre and Finchley Walk-in Centre.
[58] For example, Royal Devon & Exeter Walk-in Centre.
[59] A number now operate with reduced opening hours. (See Section 6 for a description of changes to walk-in centre provision.)

Some centres provide wound care such as the removal of sutures and dressings; others do not. Some centres have access to x-ray services, although these may be offered for limited hours and may be operated by a separate provider.

Generally, nurse-led centres provide a single episode of care – they do not provide ongoing care for patients with chronic conditions although they may treat patients with symptoms of such conditions. However, some providers of nurse-led centres said they are looking to develop joint pathways for certain services. For example, 5 Boroughs Partnership NHS Foundation Trust, with three walk-in centres in the Knowsley area near Liverpool, is working with commissioners and other providers to develop pathways for people with chronic conditions to go direct from a walk-in centre to specialist care, including one for patients with chronic obstructive pulmonary disease.

GP-led health centres

GP-led health centres can offer many of the same services as nurse-led centres, however, services available may depend on whether the patient is registered with the practice or not. The original EAPMC template contract for the GP-led health centres[60] required them to offer, at a minimum, "essential services" for registered patients. These are services that a traditional GP practice would offer and include care for patients "who are, or believe themselves to be":

(a) ill, with conditions from which recovery is generally expected;

(b) terminally ill; or

(c) suffering from chronic disease.[61]

In addition, PCTs could choose to contract for a host of additional or enhanced services[62] for registered patients, which could include a range of nationally-defined or locally-defined services, such as cervical screening, contraceptive services, vaccinations and immunisations, minor surgery, weight loss or smoking cessation clinics, anticoagulation monitoring and others.

[60] The Department of Health issued a contract template for PCTs to use, and (other than with respect to terms mandated under the APMS Directions) tailor locally when procuring the GP-led health centres. We refer to this as the "EAPMC template." We examined the template dated 7 January 2009 that is available in Department of Health online archives at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086657.

[61] The definition of essential services comes from the National Health Service (General Medical Services Contracts) Regulations 2004, which govern General Medical Services (GMS) contracts for GP services.

[62] The additional services that could be on offer are defined in the EAPMC contract template. For a definition of enhanced services, see: www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices.aspx.

For non-registered patients, PCTs could exclude some essential services, so long as the centres offered them advice or care for a defined set of minor conditions. PCTs could choose which additional, enhanced or specialist services (if any) the GP-led health centre was required to offer to non-registered patients.

Our review of several GP-led health centre contracts suggests that some PCTs contracted their centres to offer non-registered patients close to the full range of services provided for registered patients. Some went even further to try to target certain high need populations. For example, the Walsall GP-led heath centre in West Midlands was commissioned to provide special services for homeless patients, violent patients, nursing home patients, alcohol misusers, and people with learning disabilities as well as "street-doctoring" and sexual health services.[63]

Providers told us that, in practice, the main difference between services offered to registered and non-registered patients is the ongoing nature of care for registered patients. Non-registered patients do not, for example, receive regular treatment for chronic conditions, but may be encouraged to see their GP practice or to register with the centre's GP practice for further care.

GP-led health centres were intended to offer both bookable and non-bookable (walk-in) appointments to both registered and non-registered patients. We found that some centres have a greater proportion of bookable appointments, while others more often provide walk-in appointments. Some services at some centres are available only by booking an appointment in advance.

Although walk-in centres are typically described as "nurse-led" or "GP-led," in practice, a walk-in patient is likely to see a nurse-practitioner at either type of centre, and at some centres will have access to a GP if needed.

4.3. Alternative service options to walk-in centres

Based on the types of services available at different walk-in centres, a number of alternatives to walk-in centres may be available within a locality for people needing advice or treatment for minor illness or injury. These include:

- urgent care centres;
- minor injuries units;
- A&E departments;
- NHS Direct and NHS 111 services;
- GP services (in hours);

[63] The PCT closed the registered list practice at Walsall in December 2011; however, the walk-in element and full range of services are still available for unregistered patients.

- out-of-hours GP services;
- community pharmacy services; and
- self-care and self-management.

These alternatives are described in detail in Annex 1.

Like walk-in centres, the service features for each of these alternatives can also vary widely by locality. However, broadly, walk-in centres typically differ from other services in the following service features:

- whether services are only available to patients with urgent care needs;
- whether services are available on a walk-in basis;
- whether services are available to unregistered patients;
- the time and day of week that services are available;
- where services are located within a local area; and
- who is responsible for leading delivery of services (for example, a nurse, a GP, or consultant).

An overview of how the services vary is provided in Table 4. The table illustrates a number of distinctions between walk-in centres and alternative services. Urgent care centres and minor injuries units, for example, while offering services with extended hours and on a walk-in basis, will sometimes turn away patients with non-urgent needs (instead sign-posting them to their registered GP practice) (See Annex 1 for further discussion).

Likewise, services such as the new 111 initiative and out-of-hours GPs are not accessible on a walk-in basis (they are telephone-based); they also refer patients back to their registered GP practice if their needs are assessed to be non-urgent. GP services (in hours) typically offer more restricted opening hours compared to walk-in centres; also services generally are not available on a walk-in basis and patients must first register before using services.

Table 4: Features of different health care providers offering routine and urgent primary care

Service options	Routine primary care	Urgent primary care	Services accessible on a walk-in basis	Opening hours[1]	Service lead
Walk-in centre	✓	✓	✓	Extended	Nurse or GP
Urgent care centre	?[2]	✓	✓	Extended or 24/7	GP
Minor injuries unit	X[3]	✓	✓	Extended or 24/7	Emergency Nurse
A&E department	X[4]	✓	✓	24/7	Consultant
NHS Direct / 111 services	X	✓	X	24/7	Nurse / GP / non-clinical adviser
Out-of-hours (OOH) GP services	X[5]	✓	X	OOH	GP
GP services (in hours)	✓	✓	?[6]	Core[7]	GP
Community pharmacy	✓	✓	✓	Extended[8]	Pharmacist
Self-care and self-management	✓	X	X	24/7	-

Notes: (1) Opening times are defined as either: Core, OOH, Extended, or 24/7. Core is 8:00 to 18:30 weekdays (not including bank holidays); OOH is 18:30 to 8:00 weekdays, 24 hours on weekends and bank holidays; Extended will vary by location, eg, 8:00 to 20:00 or 7.00 to 22.00 every day of the week (including bank holidays). (2) Not all urgent care centres treat routine primary care cases, eg, some centres will direct non-urgent cases to other services (such as patients' registered GP practice). (3) Minor injuries units only treat minor injuries and will often re-direct patients with routine care needs to other services. (4) A&E departments are not intended for patients with routine needs, however these patients are often accepted if they present. (5) Services are accessible by telephone; after a clinical assessment, the caller will be directed to a service that best suits their needs (eg, an OOH GP appointment may be booked for patients with urgent needs). (6) Some GP practices offer walk-in appointments for their registered patients. (7) Some GP practices offer extended hours one or two evenings a week or on the weekend; similarly other practices may offer more restricted hours (eg, they may also be closed one or two afternoons during the week). (8) Some pharmacies may have more restricted opening hours, eg, some high street community pharmacies.

4.4. Providers of walk-in centres

There are many different providers of walk-in centres in England. Large independent sector companies (such as Care UK and Virgin Care) operate about 17% of walk-in centres; acute and community NHS trusts and foundation trusts operate 25%; and 58% are operated by other providers including GP-formed limited companies (such as Malling Health, The Practice, Danum Medical Services), mid-to-small size GP partnerships (such as GTD Primary Care, Brisdoc), partnerships between GP practices and NHS Trusts (such as Freeman Clinics), social enterprises (Local Care Direct) and individual GP practices.

Walk-in centre providers tend to also offer other NHS services such as out-of-hours services or GP practices.

Table 5: Providers with the largest number of walk-in centres

Provider	Number of walk-in centres	Proportion of total walk-in centres
Care UK[(1)]	14	7.6%
Virgin Care[(2)]	13	7.0%
Malling Health	8	4.3%
The Practice	6	3.2%
Liverpool Community Health NHS Trust[(3)]	4	2.2%
The Hurley Group[(4)]	4	2.2%
Central London Community Healthcare NHS Trust	4	2.2%
Primecare	4	2.2%
South Tyneside NHS Foundation Trust	4	2.2%
5 Boroughs Partnership NHS Foundation Trust	3	1.6%
Bondcare Medical Services	3	1.6%
Bridgewater Community Healthcare NHS Trust	3	1.6%
Danum Medical Services	3	1.6%
DMC Healthcare	3	1.6%
GTD Primary Care	3	1.6%
Local Care Direct	3	1.6%
One Medicare	3	1.6%
Wirral Community NHS Trust	3	1.6%
Total	**88**	**47.6%**

Source: Monitor analysis.
Notes: (1) includes walk-in centres formerly operated by Harmoni; (2) includes those formerly operated by Assura in partnership with local GPs; (3) The Liverpool Community Health NHS Trust operates an additional walk-in centre for children only; (4) The Hurley Group provides three GP-led health centres plus one branch site which also offers a walk-in service.

4.5. Links and relationships with other providers

Delivering care in an integrated way means that patients have a person-centred, well-co-ordinated experience when accessing different providers or services to get the care they need.[64] As noted in Section 2, the government intended walk-in centres to be well-integrated with other services and providers, but the extent of their actual links and relationships varies. Some walk-in centres appear to be well integrated, while others operate mostly in isolation, according to stakeholders. Several walk-in centre providers told us that they seek to build stronger relationships with other health and social care providers. Other providers emphasised that walk-in centres can be quickly adapted to provide rapid response services, such as for flu outbreaks, or to deliver evolving urgent care strategies.

We observed how walk-in centres link with other providers or services across several areas:

Co-location

Reflecting the original intent that walk-in centres foster integrated care, many are co-located with other health or social care services. Some have a pharmacy on site;[65] some are co-located with diagnostics, such as x-ray services.[66] Some are housed in a facility with a range of other services such as other GP practices, GP out-of-hours, and dental services. Walk-in centres may also operate or may be co-located with a variety of community clinics, such as sexual health or family planning. Co-location in some instances has led to stronger links between providers, such as shared working among staff.[67]

Relationships with GPs

Walk-in centres typically have contact with GP practices because often they are contractually required, subject to a patient's permission, to send a report of an attendance to the patient's GP practice.

In addition, walk-in centre providers say that some GP practices advise patients to attend walk-in centres when they have no same-day appointments available.[68] Some

[64] See National Collaboration for Integrated Care and Support, *Integrated care and support: Our shared commitment*, May 2013.
[65] Some walk-in centres are located within the pharmacy itself (for example, Birmingham NHS Walk-in Centre, Yeovil Health Centre, and Bristol City Walk-in Centre are located within a Boots chemist); others have a pharmacy onsite (for example, St Andrew's Health Centre).
[66] For example, Garston Walk-in Centre operated by Liverpool Community Health NHS Trust and Battle Hill Health Centre operated by Freeman Clinics.
[67] See, eg, Lattimer et al, *The impact of changing workforce patterns in emergency and urgent out-of-hours care on patients experience, staff practice and health system performance*, March 2010, p.92 (shared working of staff from walk-in centre and co-located out-of-hours).
[68] See also BMG Research and Communications and Engagement Team, NHS Central Midlands CSU, *Understanding people's use and experience of the Birmingham and Solihull walk-in and urgent*

walk-in centre providers suggested that this might work better for patients if the centres could work with GP practices to enable GPs to use phone triage to direct appropriate patients to walk-in centres (those with one-time minor conditions) instead of using a "first-come, first-served" approach to scheduling same-day appointments. This would prevent patients who need care for chronic or complex conditions from being directed to a walk-in centre. GP practices may also direct their patients to walk-in centres for certain services, such as blood tests or DVT services.

Two walk-in centre providers told us that they have entered into subcontracts with local GP practices to provide phone answering services or out-of-hours services during afternoon closing hours or for holiday cover.

Relationships with A&E departments

Walk-in centres send patients needing emergency care on to A&E departments, although evidence indicates that the proportion of walk-in patients sent to A&E is low.[69] Some A&E departments will direct patients with minor conditions to a walk-in centre during times of pressure; however, several stakeholders told us that A&E departments can be reluctant to redirect patients and do not refer as many patients as they could to walk-in centres or other primary care services.[70]

Some walk-in centres, such as Solihull Healthcare and Walk-in Centre, have agreed with ambulance services to receive their non-emergency patients, or patients with minor injuries that can be treated in primary care, directly into the walk-in centre. In another example of walk-in centres building relationships with emergency services, Malling Health has agreed to station a GP and a nurse from one of its walk-in centres at a nearby A&E department to provide triage and treatment for less serious conditions.

Referrals to secondary care and joint pathways

Evidence suggests that most walk-in centres have limited ability to refer patients on to secondary care services (unless patients are registered with a GP-led health centre practice).[71] Patients needing a referral to secondary care are typically told to see their GP for a referral, as GPs are the traditional gatekeeper. However, some commissioners have developed referral pathways (such as for DVT services) for both nurse-led and GP-led walk-in centres. For example, clinicians at the Reading Walk-in Centre are able to refer patients on to secondary care services.

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care centres, 2012, p.51 (GPs sometimes signpost patients to the walk-in centre); see Section 7.1 of this document for further discussion of issues related to access to GP practices.

[69] Sources indicate that referrals can be up to 5%.

[70] See also NHS Nottinghamshire County, *Walk-in Centres Review Business Case*, NHS Nottinghamshire County Board Meeting, 24 March 2011, p.14, available at: www.nnotts.nhs.uk/board/default.aspx?recid=2083.

[71] GP-led health centres are able to refer their registered patients in the same way that a GP practice can, and the EAPMC template called for the centres to offer registered patients Choose and Book for specialist services.

Access to patients' records

Commissioners and health professionals sometimes raise concerns that walk-in centres do not provide continuity of care, particularly because they do not have access to patients' general practice medical records. This may be changing, as it appears that most walk-in centres are able to access patients' nationally-held summary care records, which show medications, allergies and adverse reactions.[72] In addition, the Department of Health intends to give patients access to their records online by 2015 – this could facilitate access for walk-in centres if patients agree to make the records available to them.[73]

In some areas, walk-in centres and other providers share access to urgent care records. For example, St Andrews GP-led health centre in London shares a database with a local out-of-hours provider and other area walk-in centres. The providers also have shared access to a database of all children subject to a child protection plan to make this information visible to clinicians.

But shared access to patients' full medical records continues to present a challenge to the NHS, in part because providers may use different technology platforms.[74] Even where walk-in centres use the same system as other GP practices or urgent care providers (such as SystmOne), stakeholders told us that the centres do not always have the required access permissions from the providers holding the records.

Some stakeholders said, however, that continuity of care is not a large concern for patients attending walk-in centres because many feel they have an urgent one-time need and simply want to see a doctor or nurse.[75] Younger people, in particular, are less likely to have a preferred GP.[76]

4.6. Pricing for walk-in centre services

Walk-in services generally are paid for on a per-attendance basis or through a block contract (a contract for a fixed value that does not vary with the volume of activity).

Evidence suggests that nurse-led centres are often paid on a block contract basis and that services were commissioned through various contractual arrangements,

[72] See www.nhscarerecords.nhs.uk/. So far about half the population of England have a summary care record; www.nhscarerecords.nhs.uk/havescr. Patients have the ability to opt out.
[73] See www.pulsetoday.co.uk/patients-given-access-to-full-gp-record-by-2015/13131402.article#.UmLrA3Nrrlc.
[74] Some GPs are switching to a common system to enable shared access to patients' records. See, eg, *West London GPs start switch to SystmOne*, EHI ehealth insider, 1 August 2013. www.ehi.co.uk/news/EHI/8798/west-london-gps-start-switch-to-systmone.
[75] See also The King's Fund and Nuffield Trust, *Securing the future of general practice: new models of primary care*, July 2012. ("Sometimes speed of access will trump the desire to see the same person or team, and this can be mitigated by a shared record.")
[76] See 2012-13 GP Patient Survey, question 8.

such as through the NHS Standard Contract for Community Services or through an APMS contract.[77]

Most GP-led health centres were commissioned under APMS[78] contracts, procured through a competitive tender process. The typical duration of contracts was five years.

Because the contracts for GP-led health centres included two elements of service, a registered-list GP practice and a service available for any member of the public, including those not registered with the practice, the EAPMC template developed by the Department of Health recommended that PCT commissioners divide the payment structure accordingly:

- **For registered patients**, PCTs could pay a set price per patient for each contract year to cover essential and any included additional services for each patient on the practice's registered list, and could top that up with a national tariff-based payment for national enhanced services (NES) or directed enhanced services (DES) and a locally-negotiated payment for local enhanced services (LES). (See Section 4.2 for a definition of these types of services).

  This is similar to the way that traditional GP practices are paid under the general medical services (GMS) contract – by capitated payment based on the number of patients on their registered list, and by an add-on payment for enhanced services. One difference, though, is that for the GP-led health centres, providers could submit a bid price, per-patient, whereas for traditional GP practices the per-patient price is set by national negotiations (for GMS contracts) or local contract negotiations with GPs (for personal medical services contracts).[79]

[77] As noted in Section 2.1, nurse-led walk-in centres were introduced as a pilot programme in which GPs, GP co-operatives, or other NHS bodies (such as trusts), could operate the centres through primary care groups, which were precursors to PCTs. See NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/16, 11 May 1999. Following the pilot, the Department of Health funded the opening of additional centres. Some of these centres were operated by PCTs, which then transferred them to other providers, such as NHS trusts, social enterprises, or community foundation trusts, through the Transforming Community Services programme. We found other examples of nurse-led walk-in centres co-located with GP practices that were contracted under local initiatives with APMS contracts.

[78] APMS contracts are Alternative Provider Medical Services contracts for primary medical services. They place minimum requirements on APMS contractors which broadly reflect those for Personal Medical Services agreements (which along with GMS contracts are the traditional categories of contracts for providing primary medical care services) but otherwise allow the remainder of the contract to be negotiated between the commissioner and the contractor or, more commonly, stipulated by the commissioner during the course of a tender process. NHS England, *Managing Regulatory and Contract Variations*, June 2013. www.england.nhs.uk/wp-content/uploads/2013/07/mng-reg-con-vari.pdf.

[79] Another slight difference is in how additional services are handled. Under the GMS contract, additional services are included in the per-patient price, but GP practices may opt out of them in

As an alternative to this more traditional payment structure for registered list patients, PCTs could combine essential, additional, NES and DES together in the per-patient price, with only LES priced separately. The price for the combined services could be paid for based on a bidder's price, or according to a weighted capitation price formula. LES were to be priced separately.

- **For unregistered patients**, the Department of Health recommended that PCTs use a price per attendance, with providers to bid on the price.

Our analysis of several GP-led health centre contracts and our conversations with stakeholders suggest that most providers are paid according to one of the Department's recommended approaches and a minority are paid using a block payment structure instead.

In addition to these payments, some GP-led health centres were paid a minimum income guarantee for the first two years while the practices were building their list size.[80]

The GP-led health centres can also receive performance-based Quality Outcomes Framework (QOF) payments, like traditional GP practices.[81]

Moreover, at GP-led health centres, providers often are not paid on a per-attendance basis for walk-in attendances by registered patients (as those payments are deemed to be covered under the capitated payment for the registered list).[82]

Some commissioners also have used marginal payments for walk-in attendances. In these instances, providers are paid a marginal rate for walk-in attendances exceeding the contractual targets, in some cases gradually declining to no payment.

The EAPMC contract template called for GP-led health centres to have up to 25% of their total payment for services provided tied to their performance against key performance indicators (KPIs). We have seen some local modifications of the amount tied to KPIs. The KPIs are quality measures designed around indicators regarding access, quality (which may be based on the centre's QOF score), service delivery, value-for-money and patient experience. Commissioners have tailored KPI measures to meet local priorities. Evidence suggests that some, but not all, commissioners have separate sets of KPIs applying to registered patients and to non-registered patients.

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exchange for a slight income reduction. See National Health Service (General Medical Services Contracts) Regulations 2004, Regulation 17.

[80] See EAPMC contract template, Schedule 3.

[81] For a description of the QOF, see: www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx.

[82] We understand that there are some GP-led health centres that do not allow their registered patients to access services on a walk-in basis, but require them to pre-book appointments.

The GP-led health centre contracts include some demand management tools for both the registered list and unregistered list elements. The EAPMC template and several contracts we examined require providers to obtain consent from commissioners before registering new patients or seeing walk-in unregistered patients who come close to or slightly exceed target numbers of patients set in the contract.[83]

As demand in many cases has exceeded contractual targets, particularly for walk-in services, providers told us that they have gone to commissioners to seek additional payment. This has happened under both block and per-attendance contracts. Our evidence suggests that in some cases, commissioners have agreed to provide more funding; in others they have not. Where they have not, it appears that some providers do not turn patients away, but some do.

[83] See EAPMC contract template, Schedule 2, Part 2, Section 2.3 and Part 5, Section 2.2.

5. Demand for walk-in centre services is strong

Providers and commissioners say demand for services at many walk-in centres is rising year-on-year. In this section, we look at who is using walk-in centres and how often.

5.1. Who uses walk-in centres?

The types of people using walk-in centres will vary by locale; however, evidence on the use of walk-in centres suggests that:

- younger people are the predominant users, with people between 16 and 45 attending at higher rates than other age groups;[84]
- there are slightly higher proportions of women attending, compared to men at most centres (some centres in our survey show higher proportions of men attending, for example at the Putnoe Medical Centre);[85]
- people from lower socio-economic groups tend to be the most common users of walk-in centres;[86]
- the majority of patients attend on their own behalf, although people often attend on behalf of their child particularly at some centres;[87] and
- populations served often depend on locations. City centre sites often cater to working people. Sites on residential estates often serve young families. Some centres see high numbers of university students, who tend not to be registered with a GP in the area in which they are attending university.

We also found that the needs of most patients attending a walk-in centre are being met at the centre. For example, our patient survey found that 84% of patients did not intend to use the services of another health care provider following their visit to the walk-in centre.[88] A small minority of patients (1% or 13 patients) had already seen

[84] The age breakdown of patients from our patient survey shows those in the 25 to 34 year age bracket (23%) and the 16 to 24 age bracket (16%) were the most commonly attending patients. Monitor patient survey report, p.23.
[85] In our patient survey, for example, almost three-fifths of patients were female (59%) and just over two in five were male (41%). Monitor patient survey report, pp.21-22. This is consistent with information submitted by walk-in centre providers.
[86] Our patient survey suggested that 36% of patients attending walk-in centres were from social grade DE, with a further 19% from C2 and 30% from C1 (see pp.24-25 of the Monitor patient survey report, including definitions of each grade).
[87] Our patient survey indicated that up to 23% of people attended on behalf of their child at some walk-in centres. Monitor patient survey report, pp.21-22.
[88] Two percent of patients said they did not know whether they would use another service, while 14% of patients indicated they would use the services of another health care provider following their visit to the walk-in centre. Of the 14%, 7% indicated they would see their GP; 2% indicated they would visit a pharmacy; 1% indicated that they would go either to A&E or another walk-in centre. About 3% said they would use “other” services. Monitor patient survey report, pp.46-47.

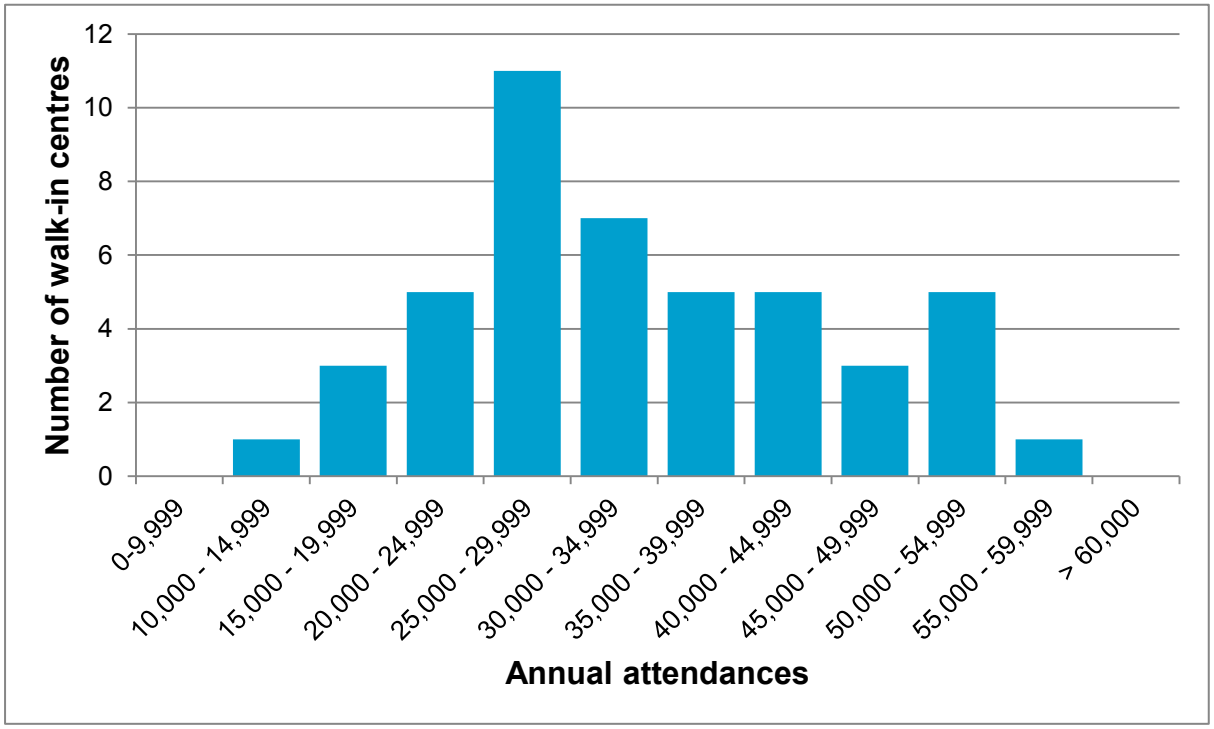
their GP before coming to the walk-in centre. Five of these 13 patients had wanted a second opinion and a further four patients had wanted treatment or medication that their own GP would not prescribe.[89]

Evidence also suggests that the majority of people would have gone to a GP practice or an A&E department if the walk-in centre was not available. Very few people indicated that they would stay at home and attempt self-care.[90]

5.2. Numbers of walk-in attendances

Evidence supplied by providers indicates that walk-in attendances can range from 12,000 to 60,000 attendances per year, depending on the centre. Figure 2 shows the range of attendances at 46 walk-in centres. Over 70% (33 walk-in centres) provide between 20,000 and 45,000 walk-in appointments per year, with 24% (11 walk-in centres) providing between 25,000 and 30,000 walk-in appointments per year.

Figure 2: Current annual walk-in attendances in a sample of 46 centres



Source: Data submitted to Monitor by providers of walk-in centres
Notes: Figures reflect walk-in attendances at 46 walk-in centres in England over the last 12 months or financial year. Estimates do not include pre-booked appointments.

[89] Monitor patient survey report, pp.72-73.
[90] In our patient survey, when patients were asked spontaneously what option they would choose in place of the walk-in centre they had attended if it were not available, 34% indicated they would go to a GP practice (for example, their own GP practice or a different practice, depending on where the patient was registered), 21% said that they would go to A&E, and 16% indicated that they would go to a different walk-in centre. Only 8% indicated that they would stay at home or attempt self-care. Even fewer people indicated that they would visit a pharmacist (5%) or call an NHS helpline (4%). Monitor patient survey report, pp.74-75. This result is consistent with survey results we received from several walk-in centre providers, which typically indicate that around 20-40% of patients say they would attend a GP practice and 20-30% of patients say they would visit an A&E department if the walk-in centre was not available.

Walk-in attendances at some walk-in centres exceeded the levels originally anticipated when they were initially opened.[91] Attendances anticipated (or targeted) in commissioning contracts were typically in the range of 12,000 to 24,000 attendances, rising to 35,000-60,000 in years four and five for some contracts.

Providers report that when walk-in centres first opened, in some cases excess demand strained resources, staffing, and facilities. Press reports also suggest that some centres were forced to close for temporary periods while capacity was extended or reconfigured to meet the volumes of patients attending.[92]

NHS England reports that attendances at walk-in centres and minor injury centres have increased by around 12% per year since data was first recorded in 2003.[93]

Increased demand for walk-in services is part of a larger trend of increased demand for other NHS services. The average number of GP practice consultations per patient rose from 3.9 to 5.5 per year between 1995 and 2008.[94] Attendances at major and single specialty A&E departments have also increased, by about 18 per cent between 2003 and 2011 (or 2% per year).[95]

Patterns of walk-in attendances by time of day and week vary by walk-in centre. Most report Mondays or Saturdays as their busiest days. Some walk-in centres report, on average, higher attendances during weekday regular business hours,[96] and others report peak times during GP closure hours in the evenings and on weekends and bank holidays.[97]

Figure 3 shows average attendance patterns over the week for six walk-in centres.[98] It shows that on weekdays, centres are typically busy from 9am, with surges in

[91] See, eg, www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/; www.thestar.co.uk/what-s-on/out-about/walk-away-from-walk-in-centre-1-2965911; www.thetelegraphandargus.co.uk/news/8763859.___Walk_in_medical_centre_a_success___/.

[92] For example, Trafford Health Centre closed temporarily so that capacity could be reconfigured to handle the large number of patients attending. See: www.traffordpct.nhs.uk/Latest_News/NHS_walk_in_service.aspx and www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/.

[93] NHS England, Evidence Base from the Urgent and Emergency Care Review, 17 June 2013, p.18 [NHS England, Evidence Base] www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf; see also John Appleby, *Pressures on accident and emergency service*s, The Kings Fund, 4 June 2013. www.slideshare.net/kingsfund/john-applebyqmrjune13; www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing.

[94] Health and Social Care Information Centre, *Trends in consultation rates in general practice 1995/1996-2008/2009: Analysis of the Q research database*, 2009.

[95] NHS England, Evidence Base from the Urgent and Emergency Care Review, 17 June 2013, p.18.

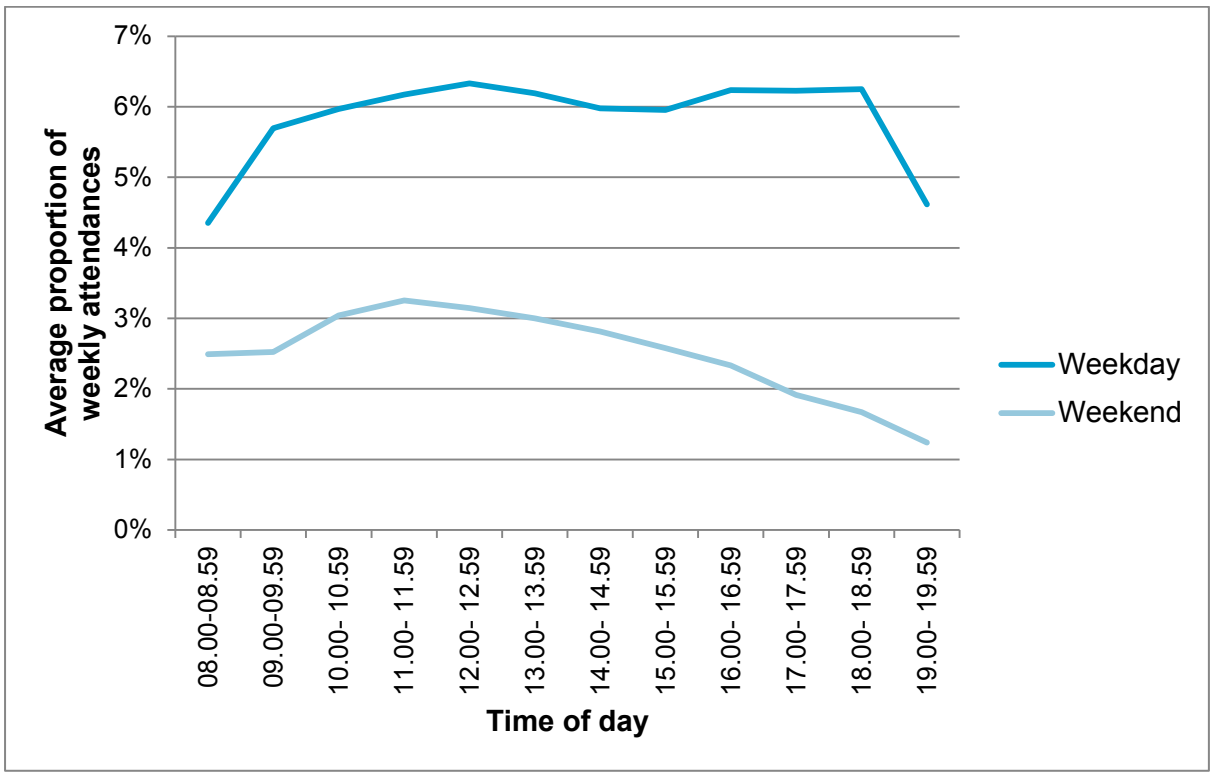
[96] See, eg, Barking & Dagenham consultation documents: 70% of attendances during GP opening hours.

[97] See, eg, NHS East London and the City, Pre-Consultation Business Case, January 2012 (peak times weekdays from 4pm-8pm); NHS Southhampton City PCT consultation (64% used walk-in centre during evenings or weekends).

[98] We received (descriptive and quantitative) data on attendance patterns for almost 40 walk-in centres. A lack of data compatibility meant that we had to restrict our graphical presentation to only

activity between 11am and 1pm and between 3pm and 7pm. A higher proportion of attendances are earlier in the day during weekends than during weekdays.

Figure 3: Walk-in attendances by time of day and week in a sample of six centres



Source: Data submitted to Monitor by providers of walk-in centres

5.3. Registration with GP-led health centres

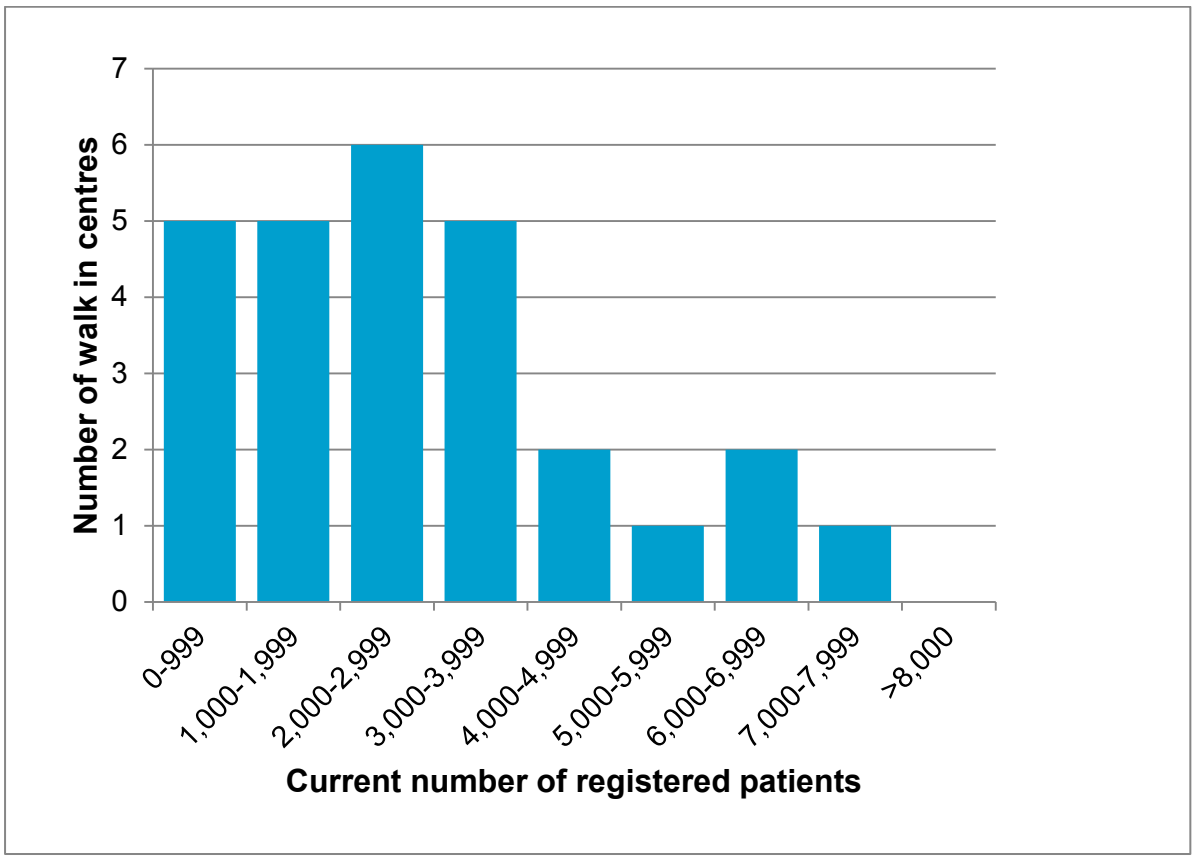
As noted, GP-led health centres offer a registered-list GP practice as well as walk-in services open to any member of the public. The take-up of registration at the GP practices of GP-led health centres has been more modest compared to the numbers of walk-in attendances seen. Most centres started without any registered patients.

With many now in or approaching their fifth year of operation, our research shows that registered list sizes for these practices tend to be between 1,000 and 3,000 patients, although we observed several centres with a registered list of between 5,000 and 6,000 patients. This compares to an average list size for a GP practice of

six walk-in centres. The data is broadly consistent with the attendance patterns described by providers for other walk-in centres.

6,891 in 2012.[99] Figure 4 shows the distribution of current list sizes for 27 GP-led health centres for which we have data.

Figure 4: Current number of registered patients in a sample of 27 GP-led health centres



Source: Data submitted to Monitor by providers of walk-in centres.
Notes: figures shown are only for GP-led health centres that started with no patients on their lists.

Data on registered list size over time indicates that, for most walk-in centres, registered patient numbers have grown at a steady rate. Provider data indicates that growth in list sizes ranges from between 200 to 2,000 patients per year depending on the location of the walk-in centre. Across all GP practices, average list size grew by about 1,000 patients in total over the 10 years from 2002-2012.[100]

As noted in Section 4.6, list size tended to be contractually limited, requiring providers to seek the commissioner's consent to go beyond the targets.

The practice boundaries for registered patients at GP-led health centres were set through negotiations between the provider and the PCT, often with input from local

[99] See Health and Social Care Information Centre, *NHS Staff – 2002-2012*, General Practice, Selected Practice Statistics.
[100] Average list size grew from 5,833 in 2002 to 6,891 in 2012. Average list size varies between 5,993 in the North West and 8,760 in South Central England. See Health and Social Care Information Centre, *NHS Staff – 2002-2012, General Practice*, Selected Practice Statistics.

GPs. The practice boundaries usually overlapped with some other GP practices. (The centres generally have no practice boundaries for walk-in patients who are not registered at the centre's GP practice, and they can and do treat walk-in patients who are registered with a different practice.)

Our patient survey indicates that of all patients in our survey who chose to register with a GP-led health centre, about half were previously registered with a different GP practice locally;[101] a further 25% were registered previously in another area and the final 25% had not been registered with a GP practice before. Patients who had not been registered with a GP practice before were more likely to be female; between 25 and 34 years of age; working full-time; and/or from a lower socio-economic group.[102]

[101] A few walk-in centres had a very high proportion of patients stating that they had previously been registered with another GP locally, including Battle Hill Health Centre (79%), Shropshire Walk-in Health Centre (76%) and The Skelton Medical Centre (76%).
[102] See Monitor patient survey report, pp.54-56.

6. There is a trend to close walk-in centres

Of the 238 walk-in centres that we estimate originally opened, we found that commissioners closed 51 between 2010 and 2013, the time frame for our research. Of these closures, about one-third were part of reconfigurations to replace the walk-in centres with urgent care centres co-located with A&E departments at hospital sites,[103] or with models that integrated primary care staff within an A&E department.

Of the 51 centres that closed, 20 were nurse-led centres, six were commuter centres, and 25 were GP-led health centres. One-third of the GP-led health centres that closed ceased to provide walk-in services for non-registered patients, but continue to operate as a GP practice.

See Annex 3 for our list of walk-in centre closures; see Figure 5 (below) for a map of open and closed walk-in centres in England.

Our review focused on closures after 2009 because most GP-led health centres (the majority of walk-in centres) were opened in 2009 and were unlikely to have closed before 2010. Our initial research also indicated that the trend to close walk-in centres began after 2009. However, we found a handful of examples in which, prior to 2010, PCTs closed nurse-led walk-in centres to replace them with GP-led health centres. There may have been other walk-in centre closures before 2010 that were not captured in our research.

[103] Some of these were already located on a hospital site, but as separate walk-in centres.

Figure 5: Open and closed walk-in centres in England

Closed walk-in centre
Open walk-in centre

Source: Monitor analysis

We are aware of a further 23 walk-in centres that have had their services reduced or modified in some way. These modifications include:

- discontinuing the registered list element of a GP-led health centre;
- reducing the hours or days the walk-in centre is open;
- reducing the volume of activity commissioners will pay for;
- reducing the range of services;
- moving from being GP-led to nurse-led; and
- restricting the service to patients with urgent conditions.

We reviewed PCT and CCG documentation underlying a number of closures and changes in walk-in centre services as well as submissions to our review from commissioners. We also spoke to commissioners involved in decisions to close centres. Our aim has been to understand the reasons why commissioners have closed walk-in centres or made changes to the services; in this report, we are not seeking to challenge or endorse particular decisions.

In deciding not to continue walk-in centre services, commissioners have given the following reasons (often not one, but several, of these reasons are behind decisions to close a walk-in centre):

- **Funding pressures**

  Many centres have seen greater numbers of walk-in patients than commissioners initially anticipated (see Section 5). In some cases, this has led to higher payments to walk-in centre providers than expected.[104] Commissioners have cited annual costs for a walk-in centre as being between £450,000 and £1.5 million.

  > *"We are spending far too much money on treating people in walk-in centres and in A&E with primary care type conditions which could be managed by the GP practice."*
  > Barking and Dagenham CCG, *Urgent care – the case for change* (issued as part of the CCG's decision to close a walk-in centre)

  Alongside these unpredicted costs, commissioning budgets as a whole have been under growing pressure. Some commissioners told us that they felt they could no longer fund the convenience that walk-in centres offer and others

[104] See, eg, The Bureau of Investigative Journalism, *NHS forced to close walk-in health centres because they are 'too popular'*, 23 June 2011, www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/. We also are aware of cases in which the provider chose to withdraw from a walk-in centre contract because it had become financially unviable. See for example, walk-in services at the Laurels Healthy Living Centre, www.haringeyindependent.co.uk/news/8927389.Health_trust_will_not_restore_walk_in_service/.

have closed walk-in centres as part of efforts to achieve savings and contain costs.[105]

- **Failure to reduce A&E attendances**

  Some stakeholders viewed reducing A&E attendances as a key purpose of walk-in centres. (See Section 2 for a discussion of the policies behind walk-in centres). One commonly-cited reason for closures is that the centres have not reduced A&E attendances.[106] The focus of many commissioners is on improving the availability and configuration of urgent care services in the hope of reducing pressure on A&E departments. As a result, a number of commissioners have closed or plan to close walk-in centres to reconfigure services alongside or within A&E departments, with the intention of reducing A&E attendances.[107]

- **"Paying twice" or duplicating services**

  A commonly-cited concern among commissioners is that they are "paying twice" for walk-in centre services because most patients attending are registered with a GP practice elsewhere, and those GP practices are already paid to provide those patients with primary care services through the capitated payment structure. Commissioners argue that walk-in centres duplicate services already provided because patients attend the centres for the same reasons that they would see their GP, often during GP core hours. They believe that patients should see their GP as a "first port of call."[108] (See Section 7.3 for further discussion on concerns about paying twice).

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[105] See, eg, NHS Salford, Trust Board Meeting paper, *Urgent Care, Report of Strategic Commissioning / Interim Deputy Chief Executive*, 31 August 2010, p.4 and Appendix 3.

[106] For example, the Stockport walk-in centre opened in October 2009, and the PCT had hoped that the centre would help reduce the number of patients attending Stepping Hill's A&E for non-emergency treatment. But reports suggest that attendances at A&E had increased by about 5% and commissioners felt they could not justify the amount spent on the walk-in centre. See www.pulsetoday.co.uk/darzi-centre-closes-due-to-duplication-in-services/11042967.article and http://alternativeprimarycare.wordpress.com/2010/10/27/walk-in-centre-to-close-stockport-pct/; See also NHS Salford, Urgent Care Engagement, 30 September 2010.

[107] Several commissioners cited a King's Fund study recommending that commissioners should evaluate walk-in centres "rigorously" and, where possible, "co-locate and integrate" them with emergency departments. The King's Fund, *Urgent and Emergency Care: A review for NHS South of England*, March 2013. We spoke to several commissioners who have experience with a model of integrating walk-in or urgent care services or primary care services with A&E departments. They discussed challenges in the model meeting its goal to reduce A&E attendances in part because of a reluctance of some A&E departments to redirect patients to primary care services. They told us that this may stem from A&E triage clinicians being more risk-adverse or from concerns about loss of revenue to A&E departments. The Primary Care Foundation has pointed to similar challenges with the model.

[108] See, eg, NHS Barking and Dagenham CCG, *Walk-in centres in Barking and Dagenham*, consultation on proposals to close walk-in service, 2013.

- **Walk-in centres create demand**

  The convenience and accessibility of walk-in centres, as well as the relatively minor clinical nature of conditions they treat, has led some commissioners to take the view that walk-in centres create demand unnecessarily.[109] Some commissioners and even some walk-in centre providers said walk-in centres cater mostly to the "worried well" who could otherwise self-manage or go to a pharmacy, rather than serving patients who previously had unmet needs.

- **Concerns over confusion and duplicative use of services**

  In some communities, commissioners closed walk-in centres in part due to concerns that the various points of access to urgent care, and the variation in types of services provided, has created confusion among patients about where to seek appropriate treatment. In some cases, commissioners said, this confusion may result in mistrust of the system and fragmented care, in which the patient is referred onwards to another service such as their GP practice or A&E. Some commissioners said it also may introduce clinical risk if patients requiring emergency services attend a walk-in centre instead. [110]

  In addition, commissioners have cited concerns that walk-in centres result in duplicative use of services based on evidence that some patients use walk-in centres and other services for the same problem, for example, in seeking a second opinion.[111] (See Section 5.1 for the proportion of patients in our survey who used or intended to use more than one service for the same problem.)

- **"Inequity" of access**

  A few commissioners said that their walk-in centres created inequity of access because they were mostly used by people who lived close by, rather than by groups from areas of high deprivation or those with significant health needs.[112] (See Section 5.1 for a discussion of the types of patients using walk-in centres.)

Finally, we found a few examples in which commissioners cited high numbers of attendances by out-of-area patients or insufficient use of walk-in centres as reasons for closure.

Although in many areas commissioners favour closing or changing walk-in centre services, several commissioners we spoke to said that their walk-in centres play an

[109] See Pulse, *Darzi centres are fuelling PCT deficits*, 21 Jan 2011, www.pulsetoday.co.uk/darzi-centres-are-fuelling-pct-deficits/11051000.article#.UnnZZXNR7lc.
[110] See, eg, NHS Bolton CCG, Public Board Meeting paper, *Walk-in Centre Implementation – Urgent and emergency care for the future*, 4 May 2012.
[111] See, eg, NHS Bolton CCG, Public Board Meeting paper; NHS Barking and Dagenham CCG, Walk-in centres in Barking and Dagenham, consultation on proposals to close walk-in service, 2013.
[112] See, eg, NHS Nottinghamshire County, *Walk-in centres review* (public consultation document).

important role in meeting health needs and provide value for money. We were told that some have extended walk-in centre hours, or are looking to expand services and establish stronger links between walk-in centres and other providers. In some places, community members, often with support from local politicians, have lobbied successfully to keep a walk-in centre open.[113]

Many commissioners are currently reviewing walk-in centre provision or will begin reviews shortly. The reviews are being driven in part by the five-year contracts for the GP-led health centres, procured in 2009 or 2010 and set to expire in 2014 or 2015. In addition to this, many CCGs are reviewing walk-in services as part of wider reviews of urgent care services.

[113] For example, the strong views of the local community is said to have influenced the commissioner in its pre-engagement phase regarding its decisions on the future of the Bitterne walk-in centre in Southhampton; NHS Southhampton City, *Consultation on the future of the walk-in service provided at Bitterne Health Centre, Public Consultation Feedback Report*, February 2011.

7. Analysis and preliminary findings

As the preceding sections indicate, walk-in centre provision and the issues surrounding decisions about whether to continue to procure these services depend largely on local circumstances. However, we were able to draw out some common themes from our review of evidence from various locales that relate to the key factors we examined in our review:

- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?
- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

This section describes our analysis and findings on these questions.

7.1. In some cases, walk-in centre closures may adversely affect patients' access to primary care for some patients

Walk-in centres were intended to improve access to primary care both in and out of normal GP practice hours. Government policies establishing walk-in centres sought to offer patients a service model believed to be more flexible and better suited to the needs of those most likely to find access difficult (see Section 2).

We find from our review that walk-in centre closures may have the potential to affect some patients adversely by:

- making it more difficult for people to access primary care services where there are problems with access to local GP practices; and
- limiting the ability of primary care to reach particular groups of people who find it difficult to engage with the traditional model of GP services or whose uptake and interaction with primary care has traditionally been poor.

Our findings and analysis, described below, suggest that local commissioners must carefully consider the extent to which patients' needs for access to primary care (or for other needs that walk-in centres may be meeting) are present in their communities when taking decisions about walk-in centres.

7.1.1. Access to GP services

Access to GP services is still frequently cited as a problem. The 2013 call to action by NHS England to improve general practice, for example, identifies growing dissatisfaction with access to GP services as a key challenge for the sector.[114]

Evidence also indicates that patients' experience of GP services, particularly when related to ease of access, affects their uptake and interaction with primary care, which in turn can affect quality of care and clinical outcomes. Ease of access to GP services can affect quality of care and outcomes through its impact on a patient's attendance rates, continuity of care, communication and engagement with clinical staff, compliance and adherence with treatment, and out-of-hours access.[115]

The results of NHS England's 2013 national GP patient survey showed that across different CCGs the percentage of people that were:

- able to get an appointment when they wanted - ranged from 71% to 92%;
- able to easily contact their GP surgery by telephone - varied from 49% to 89%; and
- satisfied with the opening hours of their GP - ranged from 71% to 85%.[116]

We found that people routinely cite difficulties, and perceived difficulties, in getting an appointment with their GP practice or being seen at a convenient time as a reason for attending walk-in centres. In our patient survey, the majority of patients attending the walk-in centres (62%) were registered with a GP practice elsewhere. Of those patients:

- 22% said that they had tried to contact their GP practice before attending the walk-in centre, but either found that no appointment was available (14%), or not available at a convenient time (4%) or within a suitable waiting time (3%), or they simply could not get through (1%);
- 24% said they did not try to contact their GP practice because of perceptions that they would not be able to get an appointment that was convenient; and
- 6% had been directed to the walk-in centre by their GP.[117]

[114] NHS England, *Improving general practice – a call to action*, 2013, www.england.nhs.uk/ourwork/com-dev/igp-cta/.
[115] The King's Fund, *Data briefing: improving GP services in England: exploring the association between quality of care and the experience of patients*, November 2012, www.kingsfund.org.uk/publications/improving-gp-services-england.
[116] www.gp-patient.co.uk/results/latest_weighted/ccg/.
[117] See Monitor patient survey report, pp.72-73.

For patients who had chosen to register with a GP-led health centre (34% of those surveyed), 19% said they registered because of "not having to phone ahead to book an appointment'"[118] and 18% indicated "time of day or week that appointments are offered" as the reason for registering.[119]

Other surveys of people attending walk-in centres show similar results.[120] For example, more than two thirds of patients surveyed at eight walk-in and urgent care centres across Birmingham and Solihull indicated they had attended because of an access-related issue, such as they could not get an appointment with their GP or would have had to wait to be seen.[121] Patients in that survey also expressed concern over the opening hours of their GP practices, wanting them to be open earlier in the mornings, later in the evenings and on weekends.

> *"I am absolutely horrified to hear that there are plans to close the walk-in centres as I believe they are a vital health resource in our community. I have personal experience of the [local walk-in centre] having used it two or three times with various family members with excellent results to deal with the medical issue and returning home. I feel it provides an essential service for those people who cannot get in to see their doctor but need medical attention for whatever reason."*
> Angela, submission to Monitor

There is wide variation in how well GP practices manage demand for appointments.[122] For example, the Primary Care Foundation's survey of 150 GP practices found that some had fewer than 10% of their appointments available for same-day appointments, while others had well over 70%.[123] In addition, while many practices appear to offer appointments during core or extended hours, some

[118] Not having to phone ahead to book an appointment was particularly important for patients choosing to register at Cardrew Health Centre, Reading Walk-in Centre, and Shropshire Walk-in Health Centre.
[119] Time of day or week that appointments are offered was particularly important for patients choosing to register at Reading Walk-in Centre. Monitor patient survey report, p.57.
[120] We reviewed patient surveys conducted by providers for about 12 walk-in centres and the following studies: Healthwatch Barking & Dagenham, *A response from the public: consultation on proposals for urgent care services and the Broad Street walk-in service*, 21 May 2013; Barking and Dagenham LINk, *Patient survey of walk-in services, Upney Lane Walk-in Centre and Broad Street Walk-in Centres*, December 2012; Arain Mubashir, Jon Nicholl and Mike Campbell, *Patients' experience and satisfaction with GP led walk-in centres in the UK*; a cross sectional study, BMC Health Services Research, 2013, 13:142.
[121] The survey was conducted on behalf of NHS Central Midlands CSU in 2012; a total of 1,106 patients were interviewed. BMG Research and Communications and Engagement Team, NHS Central Midlands CSU, *Understanding people's use and experience of the Birmingham and Solihull walk-in and urgent care centres*, 2012.
[122] See Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, 2009.
[123] See Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, 2009, p.17. The Foundation recommends that one-third of appointments be reserved for same-day access.

practices close for some afternoons each week or for stretches in the middle of the day.[124]

Patients and other community members also have raised concerns about access to GP services when commissioners have proposed closing a walk-in centre. In response, many commissioners pledged to improve access to existing local GP practices to mitigate the impact.

In some cases, commissioners analysed walk-in centre data to determine which local GP practices had high numbers of their registered patients attending the walk-in centre. One commissioning body found "broad correlation between satisfaction with GP access and use of the [two local] walk-in centres, with some of the most represented practices having received low MORI patient satisfaction survey scores."[125]

In another example, commissioners found that a local practice was having difficulties matching resources to peak demand times and was leaving phone calls unanswered because staff members were too busy with other tasks.[126] Another commissioner told us that his CCG found that a practice was not making arrangements to cover periods when the practice was closed for holidays or training amounting to several weeks each year. Commissioners worked with these practices to improve services.

However, in some cases, city or borough council leaders have expressed concerns about walk-in centres closing before GP access problems were adequately addressed.[127] In Manchester, for example, the City Council Health and Wellbeing Overview and Scrutiny Committee contested NHS Manchester's decision to close three community-based walk-in centres due to concerns that commissioners had not demonstrated that all GP practices in the city were providing "genuine same day access to GP appointments."[128]

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[124] NHS Nottinghamshire walk-in centre review documents, Appendix 17, available at www.nnotts.nhs.uk/board/default.aspx?recid=2083; NHS Choices spot research; The GMS contract requires GP practices to be open during core hours, 8:30am – 6pm, however, we understand that GP practices may close for surgery appointments during those hours so long as phone lines are open.

[125] NHS East London and the City, Pre-consultation business case, Appendix C, Patient profiles, attendance and clinical outputs, January 2012, p.9. The MORI scores refer to the GP Patient Survey by Ipsos MORI.

[126] NHS Nottinghamshire walk-in centre review documents, Appendix 17, available at www.nnotts.nhs.uk/board/default.aspx?recid=2083.

[127] See for example, Letter from The London Borough of Barking and Dagenham to Barking and Dagenham CCG, 21 May 2013, available at www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/consultation-report-and-associated-documents.htm

[128] The city council committee twice referred their concerns to the Independent Reconfiguration Panel (IRP) of the Secretary of State for Health. See IRP letters to Secretary of State for Health, 22 Nov. 2011 and 26 Oct. 2012. In its first letter of advice, the IRP determined that the centres should remain open until assurances of same-day access to GP services were provided. In the second, almost one year later, the IRP urged the parties to settle differences and move forward with the proposals to close the centres and develop urgent care centres co-located with A&E departments.

Several GPs told us that it is difficult, within the bounds of current primary care funding, for some smaller practices to offer extended hours or to invest in improvements that would lead to better access for patients. Practices are looking at new organisational models to meet demand and improve services.

Some commissioners have discounted the possibility of an adverse impact of walk-in centre closures on patients' access because they found unused capacity in the system, such as local GP practices with open lists or reports of same-day appointments being unused. However, while open lists or appointments may be factors to consider, other features of GP practices might make access difficult, such as demand that is beyond the capabilities of phone-answering systems or a lack of extended hours.[129]

Some commissioners have said that the cohort of patients using walk-in centres are attending for minor conditions that could be handled instead by a pharmacist or through self care.[130] But, while self-care or a pharmacy may be suitable for certain medical needs, the public often can lack awareness or confidence in these options.[131]

We spoke to commissioners who said they saw no increases in demand for GP services in the wake of walk-in centre closures, although we found no post-closure studies evaluating the impact on patients' access to primary care and whether patients' needs are being met elsewhere or not. However, walk-in centre closures are occurring at a time of increasing demand for GP services overall.[132]

Some commissioners have reported a lack of complaints as an indication of no or minimal impact on patients. A lack of complaints from patients is unlikely to be sufficient evidence of no or little impact on patients. Patients can be reluctant to complain about a lack of access to service, for example, due to a lack of awareness

[129] See, for example, Section 8.1 of this document describing types of needs related to access that patients may have.
[130] Some stakeholders said they perceive a cultural change among service users. For example, they suggested that some patients, particularly those of younger generations, have higher expectations of services including wanting more immediate advice, care, or reassurance for self-limiting minor conditions, whereas in the past patients were more willing to self-care or "wait-and-see".
[131] NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013, www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf.
[132] The King's Fund and Nuffield Trust, *Securing the future of general practice: new models of primary care*, 2013, p.9, www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice-_full_report_0.pdf.

about who to complain to or because they fear it will affect the quality of service they might receive in future.[133]

7.1.2. Reaching people who find it difficult to access primary care

As well as filling a gap where easy and convenient access to GP services may be lacking, some walk-in centres appear to be successfully reaching people who ordinarily would find access to GP services difficult and for whom uptake and interaction with primary care has generally been poor. This is perhaps unsurprising given that some walk-in centres, particularly GP-led health centres, were explicitly contracted to offer health promotion and disease prevention services for "hard-to-reach" or "equality target groups".[134] Overall, we found that walk-in centre closures may risk increasing health inequality if suitable alternatives are not put in place.

We found few studies evaluating whether walk-in centres have improved access to primary care for certain groups. An early evaluation of the first nurse-led walk-in centres found that the centres improved access primarily for younger, more affluent people, including young and middle-aged men who had been relatively low users of general practice.[135] The authors concluded that walk-in centres may not improve access to health care for those who may need it most.

> *"We treat around 100 homeless patients and many others who are not registered with any other practice, we see substance misusers that other practices don't want to see, and during times of peak demand such as Christmas, or the recent failed NHS 111 launch, we are able to quickly increase capacity to ease pressure on appointments generally."*
> Malcolm Sampson, Director, Worcester Walk-in Centre

However, our research suggests that the characteristics of patients using walk-in centres have changed somewhat since the centres were first introduced, at least in some locations. While younger adult groups are still the predominant users of walk-in centres, women and those from lower socio-economic groups often account for a higher percentage of users than men and those of affluent status (see Section 5.1).

[133] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 1: Analysis of evidence and lessons learned*, chaired by Robert Francis QC, February 2013, Chapter 3, p.245; Patients' Association, *Primary Care: Patients and GPs – Partners in Care?*, September 2012, p.6.
[134] See EAPMC contract template. "Hard to reach" or "equality target" groups were defined to include: those who do not understand English; those who cannot hear, see or have other disabilities; working single parents; asylum seekers or refugees; those who have no permanent address; black or minority ethnic communities; adolescents; elderly and/or housebound people; those who have mental illness; those who misuse alcohol or illicit drugs; and those who belong to a lower socio-economic class or who are unemployed.
[135] Salisbury, C., et al, *The National Evaluation of NHS Walk-in Centres*, Final Report, July 2002.

In addition, we found examples of walk-in centres serving:

- People who can find it difficult to schedule and keep GP appointments, such as homeless patients, traveller communities, substance misusers and ex-offenders. GP-led health centre providers told us that over time, some of these patients could be persuaded to register at the practice ensuring more consistent care, particularly for chronic conditions.

- Asylum seekers, refugees, and other groups facing language and cultural barriers. Stakeholders told us that these groups typically find it difficult to access GP services, or would use A&E for their primary care needs instead, because of a lack of understanding or experience of the NHS or the process of registering with a GP practice. Some providers of GP-led health centres told us that, in areas with high migrant populations, they sought to reach out to these groups and educate them about the NHS and the benefits of registration to ensure continuity of care.

- Workers and students. Accessing traditional GP practices often requires people to take time off work,[136] yet this can be difficult or simply not possible for some.[137] The extended and weekend opening hours of walk-in centres, as well as the locations of some in city or town centres, allow those finding it difficult to take time off work to attend to primary care needs, including seeking preventative services and routine checks for chronic conditions. Walk-in centres located near universities tend to serve high numbers of students who are living away from home and are often unregistered in the locales where they are studying. Our patient survey indicates that about 6% of patients attending walk-in centres work or study near the centre but do not live near it, rising to between 19% and 31% for some centres.[138]

- Minority ethnic groups. Our patient survey indicates that some walk-in centres serve high proportions of minority ethnic groups relative to the local population.[139] Also, of those choosing to register at GP-led health centres, patients who previously had not been registered with a GP practice are more likely to be from black and minority ethnic groups.[140] The Birmingham and Solihull survey found that the eight centres they studied are “particularly

[136] In a recent survey by the Patients’ Association, I in 5 (21.7%) of working age respondents said that they had to take time off to attend an appointment with their GP. Submission to Monitor from Patients’ Association, Call for Evidence for GP services, July 2013.
[137] The 2012-13 GP Patient Survey indicates that, of those in part or full-time work, 32% could not take time away from work to see a GP.
[138] For example, the Urgent Care Centre at Guys’ Hospital and Liverpool City Walk-in Centre. See Monitor patient survey report, p.27.
[139] For example, 23% of patients surveyed at Derby Open Access Centre were Pakistani (which compares to 1% of local population), Monitor patient survey report, p.23.
[140] Of patients who were not previously registered with a GP practice, 38% were from black and minority ethnic groups. Monitor patient survey report, p.59.

popular with black and Asian communities, with a disproportionate percentage of these groups using them."[141]

- Patients not registered with a GP practice. While only 3% of all patients attending walk-in centres in our survey are not registered with a GP practice,[142] this number rises to up to 12% at some centres.[143] Other sources report that up to 28% or even up to 50% of patients attending some centres are not registered with a GP practice.[144,145]

At a June meeting of the National Inclusion Health Board, the Department of Health reported improvements in registering homeless people and travellers with a GP practice, but noted that "homeless people, asylum seekers, and other transient groups are still frequently being refused registration by GP practices. Information suggests registration is a particular barrier for migrants or those with perceived 'irregular' immigration status." The Department also reported that "current models of primary care usually require patients to conform to patterns of access which assume certain characteristics and resources. For those with additional needs or whose circumstances make it difficult to meet these expectations, engagement in traditional models of care can be problematic and can lead to exclusion from any mainstream services."[146]

Our evidence suggests that while walk-in centres mostly serve people with minor conditions, some centres are providing an important route into primary care for high-risk groups. Lower socio-economic status is associated with poorer health outcomes and less healthy behaviours, and lifestyle risk factors in the young in particular have been identified as a key challenge for the NHS.[147] Both of these groups are being served by walk-in centres.

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[141] BMG Research's Birmingham study for NHS Central Midlands CSU, p.28. The study found that the ethnicity of patients at five centres was roughly proportionate with residents within a 3-mile radius of the centres, but the other three centres had much higher proportions of non-white patients than their local populations. Results of all centres combined showed a disproportionately high number of non-white groups using the centres compared to the ethnic make-up of Birmingham and Solihull counties. Appendix 1 of Birmingham study.

[142] Not including non-UK residents who are temporary visitors to England or those who stated that they did not know or were unsure or refused to say. Monitor patient survey report, p.54.

[143] For example, New Cross GP Walk-in Centre, the Urgent Care Centre at Guys' Hospital, Brighton Station Health Centre, Putnoe Medical Centre, and Reading Walk-in Centre.

[144] For example, NHS North East London and the City, Pre-Consultation Business Case (28%); Mountford, L. and R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, Kings Fund, 2001, Executive Summary (up to 45%).

[145] This compares to a figure of 1% for the population as a whole. NHS England, *Improving general practice – a call to action*, slide pack, August 2013, p.6, www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf.

[146] *Sixth National Inclusion Health Board Meeting Notes*, 4 June 2013. The Department of Health statements were based on an internal report that has not been published.

[147] NHS England, *The NHS belongs to the people: A call to action*, July 2013, p.14, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf.

Walk-in centres that were carefully thought out in terms of their locations and services on offer appear to have been most successful at reaching these groups.

Overall, the evidence we collected suggests that walk-in centre closures, or possibly relocations/reconfigurations, can risk increasing health inequality if suitable alternatives are not put in place. Commissioners are conducting Equality Impact Assessments in some cases before closing or reconfiguring walk-in centre services, but it is not clear whether they are adequate to determine the needs of certain populations and what is being done to mitigate the impacts of changes.

The potential impact on patients' access to primary care highlights the need for commissioners to do a careful needs assessment as a first step in any decision about whether to continue to procure walk-in centre services (see Section 8 for more about needs assessments in commissioning decisions).

7.2. The split in commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision

The split in commissioning responsibilities between NHS England and CCGs has created confusion about which body is responsible for deciding whether to continue to procure walk-in centre services. In addition, this split has created a risk that NHS England and CCG commissioners are not sufficiently joined up to make decisions about walk-in centres that will deliver the most benefits for patients.

Responsibility for commissioning walk-in centres

Since April 2013, CCGs generally have responsibility for commissioning urgent care, while NHS England is responsible for commissioning primary care.[148] But the division is not so clear-cut and the commissioning of walk-in centres, which provide both routine and urgent primary care, straddles the boundary.

Based on this rough division of responsibilities, CCGs have taken responsibility for managing the nurse-led walk-in centre contracts and deciding whether to continue to procure walk-in centre services, as these centres are considered to provide urgent care. For GP-led health centres, the Department of Health has said that NHS England should manage and monitor the contracts until a decision needs to be made about whether to continue services. At that time, CCGs are to decide whether to

[148] NHS England is responsible for commissioning primary medical services, primary dental services, primary ophthalmic services and pharmaceutical services under Parts 4 to 7 of the National Health Service Act 2006, while CCGs are responsible for commissioning other services under sections 3 and 3A of the Act (which covers secondary care, but also community health services, ambulance and urgent care services). In addition, since April 2013, local authorities are responsible for commissioning public health services.

continue to procure the walk-in element of the contracts for non-registered patients and NHS England will decide whether to continue the registered list practice. [149]

We found that, in practice, walk-in centre contracts are being handled differently in different locations. In some cases, CCGs are leading reviews about whether to continue to procure walk-in centre services, while in other cases NHS England local area teams are leading reviews. It is not always clear how the separate bodies are working together in these decisions, and some commissioners said they were unsure about what would what happen if there was disagreement between the two commissioning bodies about what to do.

In some areas, we found commissioners adhering strictly to the Department of Health's guidance about splitting responsibilities by trying to split the GP-led health centre contracts into two: one being a contract for a registered list practice and one a contract for walk-in services for non-registered patients. However, the Department also noted in its direction that "it would not be practicable to separate out the 'open access' element of the contract from the registered patient element."[150]

The picture is further complicated by other divisions of responsibility between NHS England and CCGs, and the involvement of other entities. For example:

- While CCGs are responsible for commissioning urgent care, NHS England is responsible for commissioning urgent care from GP practices, to the extent that such care falls within the GP contract.[151]
- NHS England is responsible for commissioning primary care and monitoring quality, while CCGs have a complementary duty to improve quality of care. CCGs do this in part by monitoring whether GP practices, including GP-led health centre practices, have achieved QOF indicators.
- CCGs are responsible for commissioning out-of-hours services and other primary care services that are not included in GP contracts.[152] This means

> *"…there has been confusion in some areas over responsibility for future commissioning of walk-in centres. Local commissioners require greater clarity around the respective roles of CCGs and the local NHS England Area Team and would welcome further guidance as to how commissioning of the services is to be divided."*
> BMA submission to Monitor

[149] Letter from Dame Barbara Hakin, Department of Health, 3 February 2011, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215793/dh_123926.pdf.
[150] Letter from Dame Barbara Hakin, Department of Health, 3 February 2011.
[151] NHS Commissioning Board (NHS England), *Commissioning fact sheet for clinical commissioning groups*, October 2012.
[152] NHS England has delegated responsibility for commissioning out-of-hours primary care services to CCGs (except for the small number of GP practices that did not opt-out of responsibility for out-of-hours care). CCGs also have responsibility to decide whether or not to commission any services that

that CCGs are able to procure new services from their member GP practices, including services currently being provided by walk-in centres.

- Local authorities are responsible for commissioning public health services, such as smoking cessation and weight loss clinics, which are offered at some walk-in centres.

- It is unclear, with respect to GP-led health centres that are currently being managed by NHS England, whether funds now being used for walk-in services for non-registered patients will be allocated to CCGs to continue those services if CCGs decide they wish to do so.

- Urgent care review boards and health and wellbeing boards, made up of local stakeholders, also are involved in reviewing walk-in centre provision in some areas as part of their review of wider services.

The various divisions in responsibilities appear to have created confusion. Several stakeholders told us of concerns about the lack of clarity around commissioning.

Joined-up commissioning

The split and, in some cases, overlapping responsibilities related to walk-in centres may make it difficult for commissioners to achieve the system-wide approach they need to take when considering changes to the provision of walk-in centre services. Any change in the provision of walk-in centre services has the potential to affect patients' needs and demand for services across primary care and urgent/emergency care. In particular, a needs assessment related to walk-in services must look at the availability and quality of other services across the system, including whether the community has good provision and access to high quality GP practice services.

Our conversations with some stakeholders raised concerns that because the walk-in element is considered to be part of urgent care, commissioners may not be fully considering the relationship between the walk-in services and other primary care services. We found that, in some locations, NHS England local area teams appear to be focused only on decisions about what to do with the registered list element of GP-led health centres, while CCGs appear to be focused on decisions about the walk-in centres with no registered list or the walk-in element of GP-led health centres.

For example, in commissioning decisions concerning walk-in services for non-registered patients at both nurse-led and GP-led health centres, it is not clear that NHS England local area teams, which have responsibility for commissioning primary care, are involved in working with CCGs to establish:

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go beyond the scope of the GP contract when contracts for local enhanced services originally commissioned by PCTs come to an end. NHS England, *Primary medical care functions delegated to clinical commissioning groups: Guidance*, 26 April 2013.

- whether demand for walk-in centres may be related to difficulties in accessing some local GP practices and how GP access or capacity can be improved;
- the potential impact of a closure on current provision by GP practices and other primary care services, such as pharmacy;
- whether NHS 111 is operating locally in a way that helps patients get the right care in the right place while making the most efficient use of resources, including appropriate use of any local walk-in centres;
- whether different models, such as walk-in services provided by GP practices, may be the best way to meet the specific routine or urgent primary care needs identified within the local population;
- how local urgent care strategies are aligned with primary care strategies.

There also is some evidence that the timing of the commissioning reforms and the split in responsibilities have led to delays in reviewing walk-in centre contracts that are set to expire in 2014.

Possible drawbacks for patients

The lack of clarity around commissioning responsibilities and the division of responsibilities has potential drawbacks for patients, including:

- lack of clear accountability for decision-making;
- lack of transparency as to who key decision-makers are; and
- potential for decisions to not take a system-wide view of patients' needs and impact of changes.

In our preliminary report, we sought views from stakeholders about whether one commissioning body – either NHS England or CCGs – should take lead responsibility for making decisions about walk-in centres, including GP-led health centres. Most stakeholders who responded to this question said that CCGs should be responsible as they are closer to local health economies than NHS England local area teams, which cover a larger geographic territory. However, providers consistently raised concerns about potential conflicts of interest among CCG members taking decisions about walk-in centres (see Section 8.4).

At this time, we do not recommend that one commissioning body take lead responsibility for all walk-in centres; rather, we seek to make commissioning responsibilities clearer and the decision process more transparent.

We also encourage CCGs and NHS England to work together to consider whether to continue to procure walk-in centre services, for both non-registered patients and those registered at GP-led health centres. See Section 9 for our recommendations.

7.3. Walk-in centres would work better for patients if payment mechanisms are reformed

Even where the walk-in centre model works well to improve patients' access to primary care and provides high-quality, efficient services, current payment mechanisms:

- discourage commissioners from using the walk-in centre model; and
- do not strengthen incentives for GP practices' to improve quality and efficiency of their services so that their patients are more likely to choose to their services instead of using a walk-in centre.

7.3.1. Payment mechanisms are discouraging commissioners from offering walk-in centre services

As discussed in Section 6, the payment mechanisms for GP practices and walk-in centres has led some commissioners to view attendances at walk-in centres as "paying twice" for patients who are registered at a GP practice.

Some commissioners have tried to address their concerns by requiring a GP-led health centre to encourage frequent attendees to register with the centre's practice or to use their own registered GP. For example, a commissioner in Reading required an arrangement in which the GP-led health centre would not be paid for patients registered elsewhere who visited more than six times, other than in exceptional circumstances.

However, some commissioners told us that they have not been able adequately to address their concerns about paying twice through local contract arrangements. Other stakeholders, including a few commissioners and some walk-in centre providers, were sceptical of concerns about "double-payment," noting that the same concern could be raised with respect to patients attending urgent care centres or A&E departments for primary care needs.

We found that concerns about "double payment" are not new. At the time of the EAPMC initiative, the Department of Health issued a set of FAQs for local commissioners regarding procurement of the GP-led health centres. One question was: "*Isn't there a risk of paying twice for the same patient if these health centres are able to see local patients who are already registered with a local practice?*" The Department answered: "*The White Paper 'Our Health Our Care Our Say' committed the Department to review the funding arrangements for walk-in services. This review is currently underway is expected to make recommendations shortly.*"[153] Other than a statement in the cited white paper, we could find no additional evidence of the referenced review or recommendations.

[153] Equitable Access to Primary Medical Care, Local Procurements of GP Practices and GP-led Health Centres FAQs.

Our research suggests that concern about "double-payment" is a key factor driving decisions to close walk-in centres as commissioners seek to address funding pressures. There is a risk that this factor distracts commissioners from an analysis of the merits of the walk-in centre model itself in meeting patients' needs and in providing value-for-money in comparison to other services. Commissioners might find it more practical to support and enable the easy-access walk-in centre model if payment structures were different.

7.3.2. Payment mechanisms do not strengthen incentives for GP practices to improve quality and efficiency so that their patients are more likely to choose their services instead of using a walk-in centre

Choice and competition are tools that commissioners can use to create stronger incentives for providers to improve quality and efficiency of services, thereby benefiting patients. Commissioners can do this by allowing providers to compete to provide services or by allowing patients to choose between competing providers. For example, offering walk-in centres to patients as a choice for certain primary care needs could encourage GP practices to improve their services so that their patients would choose them instead of using a walk-in centre. However, the payment mechanisms currently in place do not always reinforce the right incentives for choice and competition among walk-in centres and other providers of primary care to generate benefits for patients.

This is because GP practices receive the majority of their income through payments that are based on the number of patients registered on their lists; their income is not directly affected when their patients choose to attend a walk-in centre (or another service offering primary care) instead of using their practice. Thus, where their patients have a choice to use a walk-in centre, GP practices have little incentive to improve their services so that their patients will choose to see them instead of attending the walk-in centre.

For example, several walk-in centre providers and commissioners told us that some GP practices point their patients to a walk-in centre when they are unable to offer a same-day or otherwise convenient appointment slot.[154] This suggests that some practices are using the centres to meet the needs of some patients for whom they are paid to provide primary care, rather than responding to what these patients want by, for example, accommodating more same-day or convenient-time appointments for these patients. The payment mechanism creates little incentive for GP practices to respond in this way because they are still paid the same amount to provide primary care for those patients, even when they direct them to a walk-in centre.

[154] We also received some results of patient surveys taken by walk-in centre providers showing that between 4% and 25% of patients attending the walk-in centre indicated that they heard about the centre through their GP practice, although it is not clear what portion of these patients were referred by GP practices for particular services offered by the walk-in centre, such as blood tests or a DVT service (see Section 4.5).

If payment mechanisms created stronger incentives for GP practices to encourage their patients to choose their services instead of using a walk-in centre, this competition for patients could drive GP practices and walk-in centres to continually improve their own services. Such improvements might include delivering services in a more innovative way, such as with telephone or online consultations, improving quality of customer service features like telephone systems or receptionist skills, better prioritising the needs of patients when they ring for appointments, and/or extending hours or offering walk-in appointments. GP practices and walk-in centres could also work harder to improve clinical quality or to offer a broader range of services.

We note that payment mechanisms limit incentives for GP practices to improve services only with respect to walk-in services, including the walk-in element of GP-led health centres, but not the registered list practice of GP-led health centres. Current payment mechanisms do create an incentive for GP practices to improve their services in order to retain patients that might otherwise prefer to register with a GP-led walk-in centre. This is because GP practices' income is affected if their patients choose to switch their registration. We did find some evidence suggesting that the introduction of the registered list element of GP-led health centres caused some GP practices to "raise their game."[155]

There are some other financial incentives for GP practices to improve services, including access, such as QOF measures and the nationally-sponsored enhanced service, the Extended Hours Directed Enhanced Services Scheme, which offers additional payments for practices that open beyond core hours.[156] However, it appears that some enhanced services schemes merely encourage additional opening hours and not better practice management of in-hours appointments, or utilisation of those appointments. In addition, commissioners' additional payments to

[155] For example, some practices responded by extending opening hours. See, eg, A. Coleman, et al, *The limits of market-based reforms in the NHS: the case of alternative providers in primary care*, BMC Health Services Research, 24 May 2013. *Ten ways to face down competition from a Darzi centre*, Pulse, 12 Feb. 2010. However, other evidence we received suggested that, in some areas, when GP-led health centres first opened, commissioners placed advertising restrictions on them or decided not to let them register patients (we were told this was in response to concerns from existing GPs in those areas). Also, original procurement guidance from the Department of Health recommended that PCTs define the centres' target population and area "as widely as possible (within reason) to stimulate competition" but at the same time recommended that PCTs adopt the principle of "nil detriment", which meant the new providers had to demonstrate that their services would not negatively impact "existing services in the locality or in near proximity…from a patient perspective." PCTs were to define "protected areas" where the principle would apply. See Department of Health, EAPMC Commercial Strategy, Framework and Provisions Guidance for PCTs, August 2008.

[156] For GMS practices, core hours are from 8:00am to 6:30pm Monday to Friday excluding Good Friday, Christmas Day and bank holidays.

GP practices for enhanced services may or may not represent better value for money than walk-in centres.[157]

NHS England has noted that the current system of capitated remuneration for GP services has been very successful since 2006 in controlling and containing costs. Monitor recognises that any approach to payment must carefully consider all incentives arising from different payment models, including how incentives are likely to affect costs. Primary care payment mechanisms should enable and encourage providers to deliver both higher quality and better value for money. They also need to align with payment structures in secondary care, including urgent and emergency care, so that the entire system offers incentives that continually create more benefits for patients within the limits of NHS funding.

[157] Walk-in centre providers have raised an additional concern about conflicts of interests where CCGs decide to close walk-in centres and commission similar services from member GP practices. See Section 8.4 of this document for a discussion of conflicts of interest.

8. Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services

We found that walk-in centres are most valued today where they were introduced following a careful assessment of local needs, located in an area of the community where the services could be conveniently accessed by those who need it, and procured using a sound process that resulted in value for money.

Good commissioning continues to be critical when taking decisions about the future of walk-in centres. Commissioners' objective is to ensure that they secure high-quality, efficient services that meet patients' needs. The Procurement, Patient Choice and Competition Regulations[158] provide the framework for taking decisions about what services to procure and how to procure them. Monitor has published guidance to assist the sector in understanding the regulations.[159]

There are a number of factors that commissioners are likely to need to consider to be confident that the decisions that they take meet patients' needs and can achieve quality and efficiency improvements. We have set out below the factors likely to be particularly relevant to decisions about the future of walk-in centres, based on the themes that have emerged from our review. In practice, what is best for patients will depend on local circumstances. Commissioners will need to consider the Procurement, Patient Choice and Competition Regulations in the round and should refer to our substantive guidance for more detail on how the regulations apply in practice.[160]

The purpose of this review was not to investigate whether individual commissioners have acted consistently with the Procurement, Patient Choice and Competition Regulations. If stakeholders have concerns that the regulations may have been breached, they may make a formal complaint to Monitor.[161]

[158] The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the "Procurement, Patient Choice and Competition Regulations"). The Regulations replaced the Principles and Rules for Cooperation and Competition and the Procurement Guide for Commissioners of NHS Funded Services.
[159] See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at http://monitor.gov.uk/s75.
[160] See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at http://monitor.gov.uk/s75.
[161] Details of how to do so are set out in Monitor's enforcement guidance, available at www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishEnforcementGuidance20May2013.pdf. Decisions on whether or not to investigate complaints that we receive are taken in accordance with the prioritisation criteria set out in our guidance.

8.1. Assessing patients' needs

Commissioners' main objective is to secure the needs of health care service users and improve the quality and efficiency of services. This is set out in Regulation 2 of the Procurement, Patient Choice and Competition Regulations.[162]

We recognise that commissioners face financial constraints and that some commissioners view walk-in centres as treating illnesses and injuries that could be dealt with through self care or by other existing services.[163] In addition, many commissioners have prioritised consolidating urgent care services into one point of access within or near an A&E department, so that patients can be triaged and those without emergency care needs can be easily directed to an urgent care centre or primary care service. This may involve closing a walk-in centre, including one that may be centrally-located within a community.

However, before developing plans to close or change walk-in centre services, commissioners should do a needs assessment to develop a clear understanding of the health care needs of the particular population for which they are responsible and the role of the walk-in centre in meeting those needs. Doing so will allow commissioners to determine the best model of service to meet patients' needs in their local areas.

Our findings suggest that issues concerning access to care are likely to be highly relevant to patients in most areas.[164] Commissioners may have to consider in particular:

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[162] CCGs also have a general duty to arrange for the provision of health care services to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they are responsible. See section 3 of the National Health Services Act 2006. NHS England has a similar duty to secure primary medical services to such extent as it considers necessary to meet all reasonable requirements. See section 83(1) of the National Health Service Act 2006.

[163] NHS England notes that increases in attendances at walk-in centres and minor injury units since they were introduced could mean the services are meeting previously unmet demand or are creating unwarranted demand or could indicate a failure to meet needs earlier in the system. NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013, p.18. http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf. Evidence that we examined in our review suggests that whilst most people use walk-in centres for needs that are not clinically urgent, almost half of the patients in our survey viewed their conditions as urgent. More than 80% said they would try to use other services if the walk-in centre was not available, with the majority saying that they would seek advice from a GP or A&E. Very few would have self-treated or not sought advice (8%).

[164] Commissioners are also subject to the public sector equality duty (PSED) in the Equality Act 2010. The PSED requires public authorities to have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people who share a protected characteristic (including, for example, age, disability, race, religion or belief) and those who do not; and foster good relations between people who have a protected characteristic and those who do not. The Equality and Human Rights Commission has published guidance on procurement and the Equality Act 2010: Buying better outcomes.

- The needs of people who find it difficult to access traditional primary care services. These might include particular populations, such as those with language barriers, travellers or homeless people, who may have difficulties registering with a GP or booking and keeping appointments.
- The need for primary care services to be available outside of normal working hours, such as during evenings and at weekends and when GP practices are closed in areas where there are large numbers of workers who cannot afford to be absent from work for a GP appointment.
- The extent to which there is a need in the area for better access to same-day or immediate care for conditions that are urgent or that patients view as urgent.
- The need for primary care services to be available across different locations, including, for example, in an area of high deprivation or in rural areas far from hospital or urgent care services, which might lack sufficient primary care services without a walk-in centre.
- Overall primary care and urgent needs, including general demand for primary care services, which a walk-in centre may be helping to meet.
- A need for specific services that are not currently available, indicated by a significant number of patients seeking advice, treatment or services at the walk-in centre that are not provided there or in another local setting.

Based on the commissioning practices examined in our review and on conversations with stakeholders, we identified some examples of best practice that commissioners should normally include as part of a needs assessment. These include:

- Carrying out a patient survey to better understand why patients are using the walk-in centre.
- Examining the range of conditions and injuries presented at the walk-in centre and the types of advice and treatment being offered.
- Engagement in the community, which might include sponsoring public discussion forums, meetings with local patient organisations and local constituent groups, interviews or focus groups with a selection of individual patients, and/or online and community-based communications and outreach activities.[165] Local Healthwatch organisations may be able to help

[165] NHS England and CCGs have an obligation to ensure that patients are involved in (i) planning commissioning arrangements; (ii) developing and considering proposals for changes in commissioning arrangements that impact how services are delivered to patients or the range of services; and (iii) decisions affecting how the arrangements operate where these have such an impact. See Sections 13Q and 14Z2 of the National Health Services Act 2006.

commissioners reach the people within their communities who are likely to be affected by changes in provision, including hard-to-reach groups.

- Engaging with providers across the local health economy to understand how the walk-in centre interacts with other services (for example, with ambulance services, A&E, and local GP practices). This could help determine whether services need to be better integrated for patients.

- Seeking evidence of gaps or duplication in local services. For example, the West Midlands Ambulance Service NHS Foundation Trust maintains the Directory of Services (DOS) and provides information to commissioners about instances when it could have been clinically appropriate to refer a patient calling either 999 or 111 to a walk-in centre, but where none was available.[166] This allows commissioners to identify any areas where a walk-in centre is needed, where hours or services could be altered to meet demand, or where walk-in centres are not being used due to overprovision. Commissioners should consider whether they need to improve the DOS in their areas, as stakeholders told us that in some areas the directory is not up to date or is not being put to its best use in matching demand with services.

8.2. Choosing a service model and provider

Where commissioners have identified that a walk-in centre is meeting particular health care needs in their area, or have identified unmet needs in the course of their review of walk-in centre services, they will need to decide what services to procure, and from whom, to best meet those needs within available funding when the contract with the walk-in centre expires.

Deciding what services to procure to meet patients' needs

Having conducted a needs assessment, commissioners should consider what models of care may be appropriate to best meet the health care needs that it has identified.[167]

It may be that some of the needs that are currently being met by a walk-in centre in the area could be secured through a variety of different models of primary and urgent care. These might include, for example:

- continuing to offer the walk-in centre;

- enhancing walk-in centre services by offering them in a way that is more integrated with other services (see Section 8.3);

[166] See West Midlands Ambulance Service NHS Foundation Trust submission to Monitor's walk-in centre review, p.1.
[167] Commissioners will also need to have regard to the joint strategic needs assessment and joint health and wellbeing strategy prepared by the Joint Health and Wellbeing Board covering their area. See section 116B of the Local Government and Public Involvement in Health Act 2007.

- relocating or reconfiguring the services provided by an existing walk-in centre;
- procuring services targeted specifically at particular vulnerable patient groups (for example, services for the homeless);
- procuring additional services from GP practices;
- enhancing provision of pharmacy or NHS 111 services; or
- some combination of these options.

In some circumstances there may be a more limited number of models that would be suitable. If, for example, the service needs to cater primarily to unregistered people or others with specific needs, it may be that extended or out-of-hours cover from GP practices would not be an appropriate choice.

Commissioners may want to pilot a new arrangement intended to replace a walk-in centre to evaluate whether it is likely to represent the best model for patients. In that case, commissioners should, where funding permits, consider keeping the walk-in centre open until after the pilot is evaluated.

Identifying the best service model to meet patients' needs includes evaluating which model offers the best value for money. Commissioners also should examine the impact of any potential changes to walk-in centre services on other services. This might entail:

- Considering the location, opening hours, capacity, and quality of local GP practices, pharmacies, other walk-in or urgent care centres and A&E departments, and the nature of services available from these providers.
- Analysing likely patient flows under each possible model of care and the potential impact on the costs and quality of other services within the local health care economy (for example, modelling the potential costs associated with increased use of A&E, urgent care centres, or other services if a walk-in centre were to close).
- Looking at data on the impact of walk-in centre closures in other locations with similar local health economies and examining the effectiveness of any alternative models put in place.

Commissioners have a duty to involve patients, and those who may use health services, in decisions.[168] Public consultation can be an effective way of gathering views from the local community on the options being considered by commissioners and the assumptions and evidence underlying those options. A number of

[168] See footnote 166 for a description of the duty to involve patients.

commissioners we spoke to chose to do a formal consultation with the public on proposed changes to walk-in centre services.

We saw examples of Local Healthwatch organisations helping commissioners develop a robust public engagement and consultation plan. They may also be able to connect commissioners with organisations representing hard-to-reach groups to engage with them about plans to reconfigure walk-in centre services.

Following a review, if commissioners decide not to continue to procure walk-in centre services or replacement services (for example, if they intend for patients to seek care from their GP practices), commissioners should, as best practice, develop plans for how local GP practices and other existing services will absorb any additional demand resulting from the closure of the walk-in centre. The plan might include, for example, details about additional appointments that will be available from GP practices. Where a significant number of patients using the walk-in centre are not registered with a GP practice, the plan should also address how those patients might continue to access primary care after the walk-in centre is closed. Commissioners should also consider how to involve patients in developing the plan and how to communicate the proposed service changes to the public in good time.

Choosing a provider(s) to deliver the service model

Regulation 3(3) of the Procurement, Patient Choice and Competition Regulations requires commissioners to procure services from the provider or providers most capable of securing patients' needs and improving services, and that provide best value for money. Regulation 3(2) also requires commissioners to treat providers equally, which includes giving all potential providers of a service a fair opportunity to provide them. These two requirements are closely linked. By giving full consideration to the relative ability of a wide range of different providers, commissioners are more likely to end up securing services from the provider that will achieve the best outcome for patients.

Once commissioners have chosen a particular model of care, there are a number of ways in which they might go about selecting a future provider or providers. What is appropriate will depend on local circumstances. For example:

- Commissioners may decide to procure services through a competitive tender process. This may be appropriate, for example, if there are a large number of potential providers or some providers have contacted commissioners to express an interest in providing the service in the area. It may also be appropriate where commissioners have concerns about the quality or efficiency of existing provision and want to understand whether there are other capable providers in the area.

- Commissioners may decide to announce their intention to extend or renew the contract with an existing provider some time before reaching a final decision.

This may be appropriate, for example, where commissioners are satisfied that the existing provider is delivering a high quality service that is good value for money and is unsure about whether there are other providers that might be interested in providing the service. Commissioners could make this announcement on their website and Supply2Health a reasonably long time before the contract is due to expire, for example, 12 months. This would enable other providers to express interest. If other providers do express an interest, commissioners would need to consider whether those providers might be capable of delivering a better service.

- Commissioners may decide to extend or renew the contract with the existing provider. This may be appropriate, for example, where commissioners are aware that the current provider is the only provider in the area capable of delivering the particular services offered at the walk-in centre; or where the existing provider is performing well and the commissioner is confident, taking all available information and evidence into account, that the provider is the most capable of meeting patients' needs, improving quality and efficiency, and providing the best value for money.

Whatever process commissioners decide to follow, they will need to consider how best to run a proportionate process that it is sufficiently robust to identify the most capable provider.

8.3. Improving services by providing them in a more integrated way

Commissioners are expected to consider ways of improving services, including through services being delivered in a more integrated way.[169]

Some commissioners raised concerns that walk-in centres may be contributing to the fragmentation of care because, for example, walk-in centres generally do not have access to patients' medical records and may not be able to refer patients on to secondary care services. However, we found that the strength of links between walk-in centres and other services in the local health economy varies by locality (see Section 4.5).

Whenever commissioners are considering what services to procure and how to do so, they should consider whether services could be improved by being delivered in a more integrated way with other health and social care services.

Commissioners should not discount a walk-in centre model simply because an existing walk-in centre does not have strong links with other services in the local health economy. Rather, commissioners should consider whether practical steps

[169] This is required by regulations 2 and 3(4)(a) of the Procurement, Patient Choice and Competition Regulations; see also National Health Service Act 2006 sections 13N and 14Z1.

could be taken to ensure that care is delivered in a more integrated way by creating better links between different services (including those provided by a walk-in centre).

Some examples of this might include:

- establishing care pathway protocols between the centre and other primary and secondary care providers;
- developing more and stronger links with public health and social care services;
- introducing access to shared patient records;
- integrating walk-in centre clinicians into multi-disciplinary teams; and
- addressing any confusion that might exist in the community about the different services that are available in the area (including by offering clear information to the public describing what services are on offer at a walk-in centre and when, and ensuring that the name of the centre appropriately signals the services offered at the centre; for example, centres should not be labelled walk-in centres if walk-in services are offered only on a very limited basis).

As some stakeholders pointed out, such a model would also support policies designed to move care into communities and out of hospital settings.

8.4. Managing conflicts of interest

Commissioners are required to comply with a number of rules designed to ensure that conflicts of interest are appropriately declared and managed. These include Regulation 6(1) of the Procurement, Patient Choice and Competition Regulations, which prohibits commissioners from awarding a contract for NHS services where conflicts or potential conflicts between the interests involved in commissioning such services and providing them affect, or appear to affect, the integrity of the award of that contract.[170]

Conflicts of interest may materialise in a number of different ways when decisions are being taken about the future of a walk-in centre. A CCG may decide, for example, to close a walk-in centre and instead buy additional services from member GP practices (such as opening a weekend walk-in clinic at a local GP practice).

[170] CCGs are also required to comply with section 14O of the National Health Service Act 2006. This includes requirements to maintain a register of interests, to declare conflicts of interest and to manage them when they arise. Members of commissioners that are registered doctors must also comply with their professional obligations in so far as they concern conflicts of interest. These are set out in the General Medical Council's guidance Good Medical Practice (see paragraphs 77 to 80 "honesty in financial dealings") and Financial and commercial arrangements and conflicts of interest. In relation to conflicts of interest, this states that if faced with a conflict of interest, doctors must be open about the conflict, declare their interest formally, and be prepared to exclude themselves from decision-making.

Member GP practices of CCGs may therefore have a direct financial interest in decisions about whether or not to continue to procure services from a walk-in centre.

Some stakeholders raised concerns with us that these and other potential conflicts of interest may lead to flawed procurement decisions that are motivated by financial interests rather than the interests of patients.

CCGs are required to ensure that conflicts of interests are declared as soon as practicable and included in the CCG's register of interests (which must be published or otherwise made accessible to the public on request).[171]

Given concerns about potential conflicts of interest, we suggest that CCGs publish on their website details of conflicts of interest ahead of taking any decision that affects a walk-in centre together with an explanation of how they propose to manage them.[172]

Depending on the circumstances, there may be a number of different ways of managing a conflict of interest in order to prevent it from undermining the integrity of a CCG's decision about the future of a walk-in centre. Options may include:

- Excluding conflicted GPs from participating in decision-making (ie, voting on relevant decisions). Relevant decisions – such as decisions about whether or not to close a walk in centre; which provider to select to run a walk-in centre; and/or what services (if any) to procure instead of an existing walk-in centre – could be taken by the non GP members of the governing body of the CCG, including the lay persons, the registered nurse and secondary care consultant (assuming that a quorum can be achieved). What is possible will depend on the CCG's constitution, but another option may be to arrange for other individuals that are not conflicted to be co-opted to vote on decisions about the future of the walk-in centre.

- Excluding conflicted GPs from participating in particular steps involved in the review of walk-in centre services. GPs might be excluded not only from taking decisions, but also from more general participation in the review, such as from drafting proposals for future service provision.

- Arranging for third parties with relevant experience and expertise to review decisions taken to provide ongoing scrutiny. This might include, for example,

[171] CCGs are required to maintain one or more registers of interest. They must also make arrangements to ensure that any conflict or potential conflict of interest is declared as soon as practicable after the person becomes aware of it (and in any event within 28 days) and that any such declaration is included in the register of interests. See section 14O of the National Health Service Act 2006.

[172] See NHS England's Guidance for Clinical Commissioning Groups on Managing Conflicts of Interest which suggests that openness and transparency are integral safeguards for managing conflicts of interest when taking commissioning decisions (p.12).

getting the local health and wellbeing board to review the CCG's proposals at various stages of the process.

- Seeking appropriate expertise and evidence. Regardless of whether there are potential conflicts of interests, commissioners must make sure that their decisions are evidence-based and rely on appropriate expertise. Doing so will also help to ensure that any conflicts of interest that do exist do not affect the decisions that are taken (or appear to do so).

More guidance on handling conflicts of interest is available in Monitor's *Substantive guidance on the Procurement, Patient Choice and Competition Regulations* (Section 7) and NHS England's guidance for CCGs on managing conflicts of interest.[173]

8.5. Acting transparently

Commissioners are required to act in a transparent way when procuring services (Regulation 3(2) of the Procurement, Patient Choice and Competition Regulations). Transparency is important in ensuring that commissioners are accountable for their decisions. As noted, commissioners also have a duty to involve the public in commissioning decisions.

It appears from our review that some decisions about the future of walk in centres may not always be shared or communicated as effectively as they might be. For example, while we saw several examples of a public consultation exercise that explained the processes and reasons for a proposed closure, we also saw examples in which commissioners appeared to have decided to close walk-centres without setting out their reasons for doing so or explaining the process they followed to reach their decision. Some providers also told us that they were unsure about what their local commissioners' intentions were with respect to the walk-in centre services that they provide, even though the contract was due to expire in the near future.

We also saw examples in which commissioners had consulted with the public on proposals to relocate a walk-in centre to an A&E department as an urgent care centre, giving an impression that the centre would still be available to walk-in patients at a new location. However, the actual service put in place triages patients who queue for emergency services. Those not needing emergency care are seen by a primary care service within A&E. The service does not offer a distinct urgent care centre or walk-in centre that is visible to patients. It is important for commissioners, when consulting the public on proposed new models of service, to explain clearly the features of the proposed model and how patients will be able to access it in the future.

Commissioners must consider what steps they should take to ensure that people understand the reasons for the decisions that they are taking and the process that

[173] Guidance for Clinical Commissioning Groups on Managing Conflicts of Interest.

they are following to take them. This may include, for example, announcing when they are proposing to review the future of a walk-in centre, what process they intend to follow, and the decision that they ultimately take and the reasons for it (see our recommendations in Section 9).

9. Our recommendations

In this section, we recommend actions that commissioners can take now to help make walk-in centre services work better for patients. We are aware of the statutory framework for commissioning and the duties placed on NHS England and CCGs. The recommendations in this section are designed to assist commissioners in carrying out their commissioning functions. It is up to commissioners to decide whether to adopt these recommendations or to use a different approach; however, we believe, based on the findings of our review, that these recommendations represent good practice that will help commissioners achieve the best results for patients.

9.1. Bring greater clarity and transparency to commissioning responsibilities for walk-in centres

In Section 7.2, we discussed how the split in commissioning responsibilities has led to confusion about which commissioning bodies are responsible for walk-in centres or particular services offered at walk-in centres. To clear up any confusion, provide more transparency for patients and providers, and promote joint work between NHS England and CCGs, we recommend that commissioners provide more information to the public about walk-in centres.

We recommend that by 31 March 2014, CCGs publish information on their websites that describes for each walk-in centre in their geographic area:

- the name of the centre and the provider;
- the expiration date of the contract for the centre;
- which commissioning body (or bodies) is holding and managing the contracts associated with the centre;
- which commissioning body (or bodies) funds the walk-in centre or, if relevant, funds particular services provided by the walk-in centre;
- the date that any review of walk-in centre services commenced or will commence;
- which commissioning body (or bodies) is leading or will lead the review;
- where walk-in centre services are under review, what other organisations are taking part or will take part in the review and in what role; and
- which commissioning body (or bodies) is ultimately responsible for deciding whether to continue to procure the walk-in centre or particular services provided by the walk-in centre (such as the registered list and the non-registered patient services for GP-led health centres).

The statement should be in plain language so that patients as well as providers have the opportunity to understand what is happening with their local walk-in centre.

We recommend that CCGs publish this information for all open walk-in centres, including those for which a review process is already underway or near completion.

Our purpose in recommending that commissioners publish this information is to help clear up confusion around commissioning responsibilities, and to encourage CCG and NHS England commissioners to work together to clarify their responsibilities. CCGs and NHS England commissioners will need to think about how and when they will take decisions about walk-in centres. CCGs may also need to gather information, such as the date of contract expiration from NHS England if NHS England holds the contract. CCGs should then post this information on pages of their websites that give information about walk-in centre services within their areas. This could be published on a CCG's website as a joint statement with the NHS England local area teams or other local bodies.

We also recommend that the commissioning body responsible for managing a walk-in centre contract ensure that walk-in centre providers are informed of any contract review or other relevant developments (such as possible reconfigurations or changes in services under consideration) at least six months before expiration of the contracts. Six months' notice is sometimes required under contracts, but we are aware of instances in which providers have had no discussions with commissioners even though contracts were due to expire within a few months.

9.2. Ensure that decisions are joined-up

In addition to causing confusion, the split in commissioning responsibilities has created a risk that decisions are not joined-up and do not take into account the impact of changes in walk-in centre provision across local health care economies, affecting both primary and secondary care.

We recommend that CCGs and NHS England local area teams work more closely together to make decisions about the future of walk-in centres.

In particular, NHS England, as the commissioner of primary care, should work with CCGs to consider the effect of any potential closing or change to walk-in centre services (for both registered and non-registered patients) on primary care services in the local area.

CCGs should work with NHS England to consider the effect of any potential closing or changes to walk-in centre services (for both registered and non-registered patients) on other services that the CCG commissions, including urgent care services and A&E departments.

In addition, NHS England local area teams should work with CCGs to co-ordinate the timing of decisions about GP-led health centres. In some areas, we found that CCGs

have decided to close or reconfigure walk-in services for non-registered patients, while NHS England has not yet decided whether to continue the contract for the registered list element of the centre. This has left registered patients uncertain and concerned about whether their GP practice will be available in the future.

NHS England and CCG commissioners also may need to work with local authorities to make decisions about public health services where those types of services are offered at walk-in centres.

We encourage CCG and NHS England commissioners to reach decisions jointly about walk-in centres, both with and without a registered list. Currently, NHS England and CCGs can work together to make joint decisions, although these decisions need separate approval through the governance processes of each respective commissioning body if they relate to CCGs' functions.[174] For these functions, they might make decisions together, for example, by setting up joint working groups, as commissioners in some local areas have done.

NHS England and CCGs also may make joint decisions to exercise NHS England's functions, through a joint committee, without needing separate approval from each commissioning body. Whatever mechanism is used, it will be in patients' best interests for NHS England and CCGs to reach decisions jointly when considering the future of walk-in centres.

9.3. Involve local Healthwatch and health and wellbeing boards

To varying degrees, local Healthwatch and Health and Wellbeing Boards are taking part in commissioners' decisions about walk-in centres. These organisations can bring valuable insight to the process and can help ensure commissioners' decisions are in patients' best interests.

We recommend that commissioners work with their local Healthwatch group to engage and consult with the public, and with their health and wellbeing boards to align their commissioning decisions with local joint health and wellbeing strategies for meeting patients' health and social care needs.

Healthwatch

Healthwatch was created to give patients a stronger voice in decisions about health and social services. We have seen some examples in which local Healthwatch groups have worked with commissioners to develop a public engagement and consultation plan as part of a review of walk-in centre services in their local area. Local Healthwatch groups have been commissioned, in some cases, to conduct patient surveys and sponsor public discussion forums. They have also helped to

[174] The Department of Health has proposed a change to the Health and Social Care Act 2012 that would allow CCGs and NHS England to make decisions by joint committee to carry out CCG functions. See Section 10 for further discussion.

make sure that commissioners have gathered views from all communities and patients that might be affected by changes in walk-in centre services, for example, by identifying and engaging with organisations representing particular groups in the local area (such as travellers).

Healthwatch may be able to play these roles at both the needs assessment stage and when commissioners are consulting or using another form of public involvement to put options before the public.

Health and wellbeing boards

Health and wellbeing boards began in shadow form in 2012 and became fully operational in April 2013. They bring together members of local authorities, CCGs, social care and public health officials, local Healthwatch and others involved in health and social care. Their primary duty is to encourage provision of health and social care services in an integrated way.[175] Most have produced joint strategic needs assessments and joint health and wellbeing strategies.[176]

We examined several examples of how health and wellbeing boards are involved in decisions about walk-in centres. We found that some commissioners are informing or consulting with the boards about their plans for walk-in centres or for urgent care more broadly. Some boards are playing a role similar to a local authority overview and scrutiny committee by trying to ensure that commissioners have a transparent and thorough process, and that their proposals will continue to meet the needs of patients. Others have been supportive of commissioners' proposals and have helped to sponsor public consultation.

CCGs have a duty to consult their health and wellbeing boards about their general commissioning plans.[177] As good practice, CCGs and NHS England local area teams should consult the boards on an ongoing basis about specific proposals to change walk-in centre services or urgent care services generally so that the boards can ensure that proposals are aligned with local needs assessments and strategies.

NHS England representatives are required to appoint a representative to health and wellbeing boards for the purpose of preparing joint strategic needs assessments and joint health and wellbeing strategies for delivering health and social care in an integrated way.[178] NHS England also must have regard to them when commissioning services;[179] however, NHS England local area teams are not required to have

[175] See section 195 of the Health and Social Care Act 2012.
[176] See R. Humphries, A. Galea, The King's Fund, *Health and wellbeing boards: One year on*, Oct. 2013, available at www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf.
[177] See section 14Z13 of the Health and Social Care Act 2012.
[178] See section 197(1) of the Health and Social Care Act 2012. Under sections 197(3) and (4), NHS England must also appoint a representative where the Board requests its participation to consider a matter relating to the exercise or proposed exercise of NHS England's commissioning functions.
[179] See section 116B of the Local Government and Public Involvement in Health Act 2007.

regular membership on the boards, as are CCGs. Where NHS England local area teams are not members, health and wellbeing boards should consider how the local area teams might participate in the board's consideration of proposals related to walk-in centres or urgent care more generally.

9.4. Work with local GP practices to improve access where problems are identified

Walk-in centres may be able to provide commissioners with information that will help them to identify GP practices that may have problems with access (or other problems). The centres usually track where their non-registered patients are registered if they are registered with a GP practice elsewhere.

We recommend that commissioners work with GP practices that have a high number of patients using a walk-in centre to identify and help to address any problems that may be causing patients to have difficulties accessing services.

In Section 7.1.1, we give examples of how some commissioners have used information provided by walk-in centres to identify GP practices with access problems and work with them to improve access, including by better managing demand for same-day care.

9.5. Take steps to ensure that any changes are achieving the desired benefits for patients

We found, generally, a lack of follow-up information on the impact of walk-in centre closures. As with changes to any services, follow-up analysis can help commissioners determine whether patients' needs are being met. It can also provide information and insight to help others in the sector develop a better understanding of how well different models are working for patients within different local health economies.

We recommend that commissioners follow-up decisions to close walk-in centre services with analysis to determine whether the changes are working for patients as intended.

This might be accomplished, for example, through the course of a regular evaluation or review of services commissioned to replace a walk-in centre; or it may be accomplished by doing an impact study on demand for other local services in both primary and secondary care. Commissioners may also seek further engagement with patients and other stakeholders. For example, if commissioners intended patients with minor conditions to consult GPs, NHS 111 or pharmacies, we recommend that they investigate the extent to which patients are doing so and how well those services are working for patients.

We also suggest that commissioners publish follow-up studies or reports on their websites to share with the sector.

10. Long-term work to make services work better for patients

Organisations across the sector are working to bring about changes that are likely to address some of the issues identified in our report, including the need to improve access to primary care, to clarify commissioning responsibilities and join-up decision-making, and to use payment mechanisms that create incentives that benefit patients. It is important that leaders of the sector ensure that this work results in a consistent, coherent framework for improvement that also allows local flexibility.

Improving access to routine and urgent primary care

Efforts are underway at the national and local levels to identify and support drivers of improvement and innovation in GP services and to help practices develop new models of care that are more responsive to patients' needs. These include:

- NHS England is developing a strategic framework for primary care services that includes plans for new models of primary care that will enable general practice to expand access and the scope of services on offer.[180]
- Monitor's call for evidence on GP services has been followed up with a discussion document, published in February 2014, which identifies key issues raised by stakeholders related to:
    - access and quality;
    - the ability of new or existing providers of GP services to develop the scope of their offer to the NHS; and
    - the ability and incentives of providers to work together to benefit patients.

  We have proposed further work for this year to support improvements in general practice, including examining the supply and demand of GP services to gain a better understanding of variations in access and quality across England and how these may be addressed.
- NHS England will soon begin overseeing at least nine pilots, funded through the Prime Minister's £50 million Challenge Fund, to test ways of improving access to appointments for up to half a million patients. The pilots will explore a number of ways to extend access to GP services to better meet local patient needs, including:
    - longer opening hours, such as extended weekday opening (8am to 8pm) and opening on Saturdays and Sundays;

[180] See NHS England, *Improving general practice: a call to action*, at www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/.

- greater flexibility about how people access general practice, for example the option to visit a number of GP surgery sites in their area;
- greater use of technology to provide alternatives to face-to-face consultations via phone, email, webcam and instant messaging;
- greater use of patient online services, including online systems of patient registration;
- greater use of telecare and healthy living apps to help people manage their health without having to visit their GP surgery as often; and
- greater choice of practice.

- The 2014/2015 general medical services (GMS) contract will potentially lead to greater choice for patients by allowing GP practices to register patients from outside their catchment area without responsibility for home visits. The contract also requires practices to promote and offer all patients the ability to book appointments online, order repeat prescriptions online and access their medical notes online.
- The Department of Health has also recognised that vulnerable and disadvantaged groups still face barriers to accessing primary care, and is working to develop better models of care for these groups.
- Beyond general practice, as noted in Section 3, NHS England's Urgent and Emergency Care Review is working to develop a framework for urgent care designed to reduce confusion about where to go for care and to ensure access to high-quality urgent care 24/7.

Making responsibilities clearer and joined-up commissioning easier

Confusion around responsibilities and a risk of fragmented commissioning is not limited to the provision of walk-in centres. The Department of Health is proposing to use a legislative reform order, subject to Parliamentary approval, to create the ability for CCGs to make joint decisions through a joint committee with other CCGs and for CCGs to make joint decisions through a joint committee with NHS England in areas that are within CCG functions.[181] This could facilitate, for example, joint decisions about walk-in centre services.

Further, NHS England, in its Urgent and Emergency Care Review, is considering the appropriate size of commissioning footprints over local health economies. Its intention is to bring together a network of actors within each local footprint to facilitate joined-up decision-making that is based on a local system-wide view. In its

[181] See the Consultation on a proposal to use a Legislative Reform Order to make changes to the National Health Service Act 2006.

planning guidance, NHS England has asked commissioners to identify how they will "be ready to determine the footprint of your urgent and emergency care network during 2014/15".[182]

Using payment mechanisms to generate incentives that lead to benefits for patients

Under the 2012 Act, Monitor and NHS England share responsibility for setting prices within the national tariff payment system. As part of these responsibilities, Monitor and NHS England are working to improve payment mechanisms for urgent and emergency care services. This includes trying to better understand the costs of providing these services.

NHS England and Monitor have also pledged to work together to ensure there is a coherent payment system for both primary and secondary care, particularly for emerging new models of delivering integrated care across primary and secondary care settings.[183] This is an issue that we will continue to consider with NHS England as we develop our long-term strategy for the payment system.

[182] NHS England, Everyone Counts: Planning Patients 2014/15 to 2018/19, p.30.
[183] See *The 2014/15 National Tariff Payment System*, p.8.

Annex 1: Alternatives to walk-in centres

This Annex describes a number of alternatives to walk-in centres that may be available within a locality for people needing advice or treatment for minor illness or injury. The alternatives are:

- urgent care centres;
- minor injuries units;
- A&E departments;
- NHS Direct and NHS 111 services;
- GP services (in hours);
- out-of-hours GP services;
- community pharmacy services; and
- self-care and self-management.

Urgent care centres

Urgent care centres (UCCs) often provide services that are very similar to those offered at walk-in centre, though there can be "wide variation" in the nature of services labelled as urgent care centres.[184] As services are GP-led, many UCCs allow patients to walk in and will treat routine primary cases which could ordinarily be dealt with by out-of-hours GP services or walk-in centres.[185] However, some UCCs will receive only patients who have been streamed from an A&E department, or will direct non-urgent cases back to their own GPs.

Many UCCs are co-located with a hospital with access to a full range of staff and services or are located away from a hospital but act as mini-A&Es with a full range of diagnostics and clinical staff. Others that are remote from a hospital may have more limited services (for example, a limited capability for dealing with fractures).[186]

UCCs are generally open seven days a week; some open for 24 hours a day, others for extended hours.[187] They are required to provide care for patients within the four hour standard, as is required for A&E departments.[188]

[184] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.3. Available at: www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf
[185] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012.
[186] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.8.
[187] Primary Care Foundation, Urgent Care Centres, What works best, Oct. 2012, p.14.
[188] Healthcare for London, A service delivery model for urgent care centres: Commissioning advice for PCTs, p.12, available at: www.londonhp.nhs.uk/wp-content/uploads/2011/03/Urgent-care-centres-

UCCs evolved as a way to reduce A&E attendances, as well as to reduce waiting times for patients with minor conditions who could otherwise face long waiting times at an A&E.[189,190]

Minor injuries units

A minor injuries unit (MIU) is an assessment and treatment centre led by specially trained nurses, such as emergency nurse practitioners.[191,192] It is designed to handle less serious injuries than would ordinarily be treated at an A&E department, including broken bones, sprains, wound infections, minor eye problems, minor burns, bites and cuts.[193] As MIUs do not have the full range of facilities and support services that A&E departments have, the units cannot treat major injuries, chest and stomach pains, breathing difficulties, allergic reactions, overdoses and other more serious health problems.[194,195] If a patient requires further diagnosis and treatment, (s)he will most likely be sent to the A&E department (which may be on another site) or referred to another, more appropriate service. Some MIUs, like some nurse-led WICs, do not treat young children, setting a minimum age for patients that they can treat.[196]

Services at MIUs are available on a walk-in basis.[197] Opening hours vary by location. They are generally open seven days a week; some operating 24 hours a day, others with set opening times (such as 7am-10pm or 9am-8pm). The main difference between an MIU and a walk-in centre is that MIUs do not typically deal with patients' routine primary care needs.[198] The service is nurse-led, and onsite staff are not typically trained in primary care. Like UCCs and major A&E departments, MIUs are required to provide care within a four hour standard.[199]

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delivery-model.pdf; Department of Health, Urgent and emergency care services http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/healthcare/urgentandemergencycare/urgentandemergencycareservices/index.htm

[189] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.3.

[190] For example, Urgent care centre pilot launched at UCH, 19 September 2011, www.uclh.nhs.uk/news/Pages/UrgentcarecentrepilotlaunchedatUCH.aspx

[191] See NHS Choices: Emergency and urgent care services, www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

[192] For example, www.bartshealth.nhs.uk/your-visit/in-an-emergency/

[193] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

[194] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx, www.collemergencymed.ac.uk/asp/document.asp?ID=2980

[195] www.herefordshire.nhs.uk/docs/Policies/MIU_Operational_Policy.pdf

[196] www.herefordshire.nhs.uk/docs/Policies/MIU_Operational_Policy.pdf

[197] For example, www.bartshealth.nhs.uk/your-visit/in-an-emergency/

[198] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

[199] See, eg, www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=3&fldMenu=1&fldSubMenu=0&fldKey=965

MIUs began to appear in the UK in the mid 1990s, typically replacing small A&E departments. This was motivated by policies to move health care into the community and to rationalise and centralise the provision of emergency care.[200]

A&E departments

A&E departments are intended to deal with serious injuries and illnesses. An A&E department can provide care for emergency conditions of all types and for patients of all ages.[201,202] This includes illness and injury, mental health problems and life-threatening emergencies including:

- loss of consciousness;
- acute confused state and fits that are not stopping;
- persistent, severe chest pain;
- breathing difficulties; and
- severe bleeding that cannot be stopped.[203]

Major A&E departments –Type 1 A&Es – are consultant-led and have access to full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.[204]

Most A&E departments offer guaranteed access to care 24 hours a day, seven days a week.[205] Patients can self-present or be brought to A&E by an ambulance.

NHS Direct and NHS 111 services

Rolled out nationally in October 2000, NHS Direct was established as a national provider of a 24-hour nurse-led telephone health advice line. The NHS Direct service was first introduced as part of the government's plans to modernise NHS services, and its main aim was to "provide people at home with easier and faster advice and

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[200] See, for example, Brian Dolan, Jeremy Dale, *Characteristics of self referred patients attending minor injury units*, Journal of Accident and Emergency Medicine, 1997; 14:212-214

[201] A&E may not be suitable for patients with multiple, serious injuries. Such patients may need to be transferred to a major trauma centre. This is a hospital where there is a full range of trauma specialists, including orthopaedics, neurosurgery and radiology teams. Care at major trauma centres is led by a trauma consultant, who is available 24 hours a day.

[202] NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.49.

[203] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx

[204] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206267/15_01final3_v3.pdf

[205] NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.49.

information about health, illness, and the NHS."[206] The service was also meant "to point people in the right direction for the most appropriate form of treatment."[207] The service was replaced from 2013 by the NHS 111 service.

NHS 111 was launched as the new telehealth and patient triage service to help people access NHS health care services for urgent medical problems. It was introduced in response to public concern and frustration about accessing NHS care, especially at weekends and out-of-hours.[208] It is intended to simplify access to non-emergency health care by providing a memorable number (111) that is free to the caller,[209] to provide consistent clinical assessment at the first point of contact, and to route customers to the right NHS service first time. A key difference to the NHS Direct service is that the NHS 111 service is commissioned locally, and is intended to be linked electronically to a skills-based directory of local services. It is hoped that this will make the service more integrated with the local health economy and therefore make it easier for users to access the most appropriate health care service, quickly.[210]

The service is available 24 hours each day of the year. Calls are free of charge from landlines and mobile phones. The service is designed for situations that are not life threatening[211] and where callers are unsure about what service they need or they need access to care out-of-hours. Key features of the service are:

- calls are assessed by a trained, non-clinical call adviser using clinical assessment software to determine both the type of service needed and the timescale within which help is required;
- where possible, appointments are made with the correct service at the time of the call;
- calls that require further clinical assessment can be transferred to a clinical nurse advisor or GP within the same call; and
- if a call requires an emergency ambulance response, a vehicle can be dispatched without the need for further triage.[212]

[206] Pilot NHS Direct programmes began in 1998 and a complimentary website was launched in 1999. www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/History
[207] www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/History
[208] www.england.nhs.uk/2013/06/07/nhs-111-improving/
[209] NHS Direct operated a national phone line; while the service was free to use, callers would incur calling charges.
[210] University of Sheffield, Evaluation of NHS 111 pilot sites, Final Report, August 2012. www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf
[211] The NHS 111 service is not intended to replace the 999 number for life threatening emergencies. www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx
[212] University of Sheffield, Evaluation of NHS 111 pilot sites, Final Report, August 2012. www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf

The service was first introduced as a pilot scheme in 2010. Initially due for rollout to the whole of England by April 2013, the deadline was extended in some areas by up to six months. [213,214]

A range of providers have been contracted to provide the service, including Ambulance Service Trusts and out-of-hours GP service providers.[215] NHS Direct was originally contracted to provide the service to about a third of England's population. However, it withdrew from the 111 service on financial grounds[216] and has since announced that it will cease operations at the end of March 2014.[217]

The launch of the 111 service has not run smoothly and may take some time to win public confidence. For example, when NHS Direct launched its two largest services in March 2013, it found that it did not have sufficient capacity to handle the calls it received. Calls had to be diverted back to GP out-of-hours organisations and to its original service.[218] Some have expressed concerns regarding inadequately trained staff, a lack of personnel, long waits and out-of-hours GPs having to take on extra work.[219]

[213] Department of Health, Subject: NHS 111 rollout deadline extension, 14 June 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214977/dh_134585.pdf
[214] Eight CCGs apply for NHS 111 delay, *Pulse*, 1 August 2012, www.pulsetoday.co.uk/eight-ccgs-apply-for-nhs-111-delay/14370420.article#.UmK9C7wYLVo
[215] By way of example, NHS 111 in Devon is run by the South Western Ambulance Service Foundation Trust; the service in Nottinghamshire is operated by Derbyshire Health United, a GP-led social enterprise company operating the Out-of-Hours GP service. www.bbc.co.uk/news/uk-england-devon-23935801 http://www.nottinghamnortheastccg.nhs.uk/community/reassurance-over-nhs-111/
[216] NHS Direct, The Future of NHS Direct's 111 Services: press release, 29 July 2013, www.nhsdirect.nhs.uk/About/~/media/Files/2013PressReleases/NHS%20Direct_111future20130729.ashx
[217] NHS Direct, NHS Direct To Close At The End Of The Financial Year: press release, 24 October 2013, http://www.nhsdirect.nhs.uk/News/LatestNews/NHSDirectToClose
[218] NHS Direct, The Future of NHS Direct's 111 Services: press release, 29 July 2013, www.nhsdirect.nhs.uk/About/~/media/Files/2013PressReleases/NHS%20Direct_111future20130729.ashx
[219] CCG places NHS 111 rollout on hold indefinitely, *Pulse*, 13 May 2013, www.pulsetoday.co.uk/commissioning/commissioning-topics/urgent-care/nhs-111-implodes-as-gpc-withdraws-support-for-urgent-care-hotline/20002392.article#.Ul2Sz7wYLVo

Out-of-hours GP services

The out-of-hours (OOH) GP service is an urgent primary care service provided outside of standard GP practice working hours.[220] The service is available from 6.30pm – 8am during weekdays, and 24 hours at weekends and on bank holidays.

If a patient urgently needs to see a GP when a GP practice is closed, and the patient cannot wait until the practice is open, the patient can call the OOH service using a given phone number.[221] A nurse or GP will assess the caller's symptoms over the phone and the caller will then be:

- given advice over the phone on how to best manage their symptoms;
- asked to come into the nearest OOH centre for an appointment with a GP or nurse; or
- offered a home visit from a GP or nurse.[222]

OOH GP services are not designed to deal with routine primary care needs; therefore the provider will not, for example, make routine appointments on the caller's behalf or issue routine prescriptions. Instead, the caller will be advised to contact their GP practice during opening hours.[223]

Changes to the GP contract in 2004 gave practices that had previously been required to provide OOH services to their patients the ability to opt-out of OOH services. Where GPs have opted out, OOH services are commissioned from a separate provider.[224] It has been estimated that around 90% of GPs have opted out.[225]

Out-of-hours cover may include some or all of the services below:

- GPs working in A&E departments, MIUs or walk-in centres;
- teams of health care professionals working in A&E departments, MIUs or walk-in centres;

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[220] This service is distinct from extended opening hours schemes that many GP practices provide which allow patients to receive their normal in-hours GP services beyond the core times of 8am – 6.30pm.
[221] The intention is that once the 111 service is operational in an area all calls to the out-of-hours GP service will be transferred automatically to 111. During transition, depending on the arrangements for the GP practice, a patient calling her/his GP practice when it is closed will either be given the OOH GP service phone number or asked to call NHS 111 or will be automatically directed through to one of these numbers.
[222] OFT, Completed Acquisition by Care UK Group of HWH Group Limited, ME/5840/12, 8 March 2013, paragraph 11.
[223] www.pelc.nhs.uk/services/out-of-hours-gp-services.html
[224] www.england.nhs.uk/wp-content/uploads/2013/04/pri-med-care-ccg.pdf
[225] OFT, Completed Acquisition by Care UK Group of HWH Group Limited, ME/5840/12, 8 March 2013, paragraph 13. www.oft.gov.uk/shared_oft/mergers_ea02/2013/care-uk.pdf

- GPs or other health care professionals operating from mobile facilities making home visits; and/or
- ambulance services moving patients to places where they can be seen by a GP or nurse, to reduce the need for home visits.[226]

GP practices (in hours)

GP practices provide a broad range of health services to patients, including but not limited to, health advice, assessment of symptoms, prescription of drugs, care or advice for minor illness, urgent primary care, and management of long-term conditions.[227] GP practices are usually staffed by GPs and nurses, but may also include other health care professionals such as health assistants and health visitors.[228] Practices may have other health professionals co-located in the same building, such as pharmacists, physiotherapists, midwives, and district nurses.

If a GP cannot treat a patient, the GP is able to refer the patient to a specialist health practitioner or to a hospital for further investigation and treatment.[229]

Core opening hours for GPs under the GMS contract and PMS and APMS contracts providing essential services are from 8:00am to 6:30pm, Monday to Friday, except Good Friday, Christmas day or bank holidays.[230] In addition, NHS England, and previously PCTs, must offer directed enhanced services (DES) contracts to GPs for extended hours, based on a formula of 30 minutes per week for every 1,000 registered patients.[231] But GPs need not offer extended hours. Some GP practices – particularly single-GP practices – close for one or more afternoons a week or during holidays or other breaks.

Services are available for patients registered at the GP practice, although practices may also see out-of-area patients as temporary residents.[232]

For the most part, patients must book an appointment to see a GP, although the process for managing appointments often differs across practices. Some practices may provide offer a web-based online booking system or telephone consultations.

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[226] www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/out-of-hours-services.aspx
[227] www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx
[228] A health visitor is a nurse with a specialist training particularly related to children and pregnancy. Health visitors can be employed by the GP practice, but more often are salaried NHS staff.
[229] www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx
[230] NHS Employers, BMA, NHS England, 2013/14 extended hours directed enhanced service guidance, May 2013. www.nhsemployers.org/Aboutus/Publications/Pages/2013_14_extended_hours_DES_guidance.aspx
[231] Id.
[232] People may register as a temporary resident with a GP practice in England if they are in an area for longer than 24 hours but less than three months. NHS Choices, www.nhs.uk/chq/Pages/how-do-i-register-as-a-temporary-resident-with-a-gp.aspx?CategoryID=68&SubCategoryID=158

For urgent appointments, some practices triage requests with a GP telephone consultation to assess the patient, provide advice or make a same-day appointment, or provide a queuing service by making a certain number of urgent same-day appointment slots available on a first come first served basis; these are allocated either by patients arriving during set times of the day on a first come first served basis, or by patients telephoning the practice and being allocated an appointment time. [233] GP practices are required to provide emergency and immediately necessary treatment to anyone, whether or not they are registered with the GP practice.

Community pharmacy services

The traditional role of community pharmacies has been to prepare and dispense prescription and non-prescription medicines to the general public, and offer advice on the safe use of medicines. However, this role has expanded recently to include:

- advice and treatment of minor ailments (such as coughs, colds, aches and pains, minor injuries, skin conditions and allergies);
- the provision of advice to promote healthy lifestyles (such as advice on healthy eating and stopping smoking);
- testing and screening for particular conditions (such as pregnancy testing, chlamydia screening and treatment); and
- supporting people with particular long-term conditions using new medicines. [234]

Some pharmacies may also do flu jabs, medicines reviews, emergency contraception and weight management.

Pharmacists can also help patients decide whether they need to see a GP.[235]

Pharmacies are often located within the community, and they may be co-located within a primary care setting (such as a GP practice or walk-in centre). Sometimes they are located near or within a hospital setting.[236]

Services are accessible without patients needing to make an appointment. Consultation can also be private; around 85% of pharmacies now have a private

[233] www.hsj.co.uk/home/innovation-and-efficiency/better-gp-access-better-ae-outcomes/5061857.article
[234] www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx; and NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.33.
[235] www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx
[236] www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx

consultation area where patients can discuss issues with pharmacy staff without being overheard by other members of the public.[237]

Community pharmacy services are currently seen as playing an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions. However, reports suggest that there is little public awareness of the range of services provided by pharmacies.[238]

Self-care and self-management

Self-care for minor ailments and self-management of long-term conditions are increasingly being promoted within the NHS. Around 80% of all health problems are currently treated or managed at home without the use of NHS services, and it is thought that, by improving access and encouraging the use of support for self-care and self-management, this can help free capacity in routine primary care and prevent unnecessary use of urgent and emergency care services.[239]

There is a range of services available to support self-care and self-management. This includes:

- web-based health tools (for example, online symptom checker applications provided by NHS Choices);
- self-management education programmes and courses for patients;
- establishment of peer support groups;
- embedding self-care and self-management support into primary care environments.[240]

[237] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.33.
[238] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.33.
[239] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.29.
[240] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.29.

Annex 2: List of current walk-in centres

Name	Address
1. 8am to 8pm Health Centre	79a Upper Parliament Street, Nottingham, NG1 6LD
2. Accrington Victoria Health Access Centre	Accrington Victoria Community Hospital, Haywood Road, Accrington, BB5 6AS
3. All Day Health Centre	Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral, CH49 5PE
4. Angel Medical Practice	34 Ritchie Street, London, N1 0DG
5. Ashford Health Centre	Ashford Hospital, London Road, Ashford, Middlesex, TW15 3FE
6. Ashton GP Led Health Centre	Old street, Ashton under Lyne, OL6 7SR
7. Banbury Health Centre	58 Bridge Street, Banbury, Oxfordshire, OX16 5QD
8. Barbara Castle Way Health Centre	Simmons' St, Blackburn, BB2 1AX
9. Barkantine Practice	121 Westferry Road, London, E14 8JH
10. Bath NHS Healthcare Centre	Riverside Health Centre, James Street West, Bath , BA1 2BT
11. Battle Hill Health Centre	Battle Hill Health Centre, Belmont Close, Wallsend, Tyne and Wear, NE28 9DX
12. Birmingham NHS Walk-in Centre	66 High Street, Birmingham, West Midlands, B4 7TA
13. Bitterne Walk-in Centre	Commercial Street, Southampton, Hampshire, SO18 6BT
14. Blackpool GP Led Walk-in Centre	Whitegate Health Centre, 150-158 Whitegate Drive, Blackpool, FY3 9ES
15. Blaydon GP Practice and Minor Injury and Illness Unit	Shibdon Road, Blaydon, NE21 5NW
16. Boscombe & Springbourne Health Centre	66-68 Palmerston Road, Bournemouth , BH1 4JT

17. Brent GP Access Centre	Wembley Centre for Health & Care, 116 Chaplin Road, Wembley, HA0 4UZ
18. Brighton Station Health Centre	Aspect House, 84-87 Queens Road, Brighton, BN1 3XE
19. Broad Street Medical Centre	Morland Road, Dagenham, RM10 9HU
20. Broadmead Medical Centre	59 Broadmead, Bristol , BS1 3EA
21. Broughton Gate Health Centre	Glyn Valley Place, Broughton, Milton Keynes, Buckinghamshire, MK10 7EF
22. Bunny Hill Minor Injury and Illness Unit	Bunny Hill Primary Care Centre, Hylton Lane, Downhill, Sunderland, SR5 4BW
23. Burntwood Health and Wellbeing Centre	High Street, Chasetown, Burntwood, Staffordshire, WS7 3XH
24. Bury Walk-in Centre	Moorgate Primary Care Centre, 22 Derby Way, Bury, BL9 0NJ
25. Calder Community Practice	82 Halifax Road, Lower George Street, Todmorden, OL14 5RN
26. Camphill GP Led Health Centre	Ramsden Avenue, Camphill, Nuneaton, CV10 9EB
27. Cardrew Health Centre	60 Cardrew Industrial Estate, Cardrew Industrial Estate, Redruth, TR15 1SS
28. Carfax NHS Medical Centre	Swindon Health Centre, Carfax Street, Swindon, SN1 1ED
29. Castle Health Centre	3-4 York Place, Scarborough, North Yorkshire, YO11 2NP
30. Cator Medical Centre	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3FD
31. Chester Walk-in Centre	Countess of Cheshire Hospital, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL
32. City Health Centre	32 Market Street, Manchester, Lancashire, M1 1PL
33. City of Coventry NHS Walk-in and Healthcare Centre	Stoney Stanton Road, Coventry, CV1 4FS
34. Clifton Nurse Access Point	Clifton Cornerstone, Southchurch Drive, Nottingham, NG11 8EW

35. Clover Health Centre	Equitable House, 10 Woolwich New Road, London, SE18 6AB
36. Crawley Health Centre	Cross Keys House, 14 Haslett Avenue West, Crawley, West Sussex, RH10 1HS
37. Cricklewood GP Health Centre	Barnet Hospital A&E, Britannia Business Village, Cricklewood, Barnet, NW2 1DZ
38. Darwen Health Centre	James St West, Darwen, BB3 1PY
39. Derby NHS Walk-in Centre	Entrance C, London Road Community Hospital, Osmaston Road, Derby, Derbyshire, DE1 2GD
40. Derby Open Access Centre	Lister House, 207 St Thomas Road, Derby, DE23 8RJ
41. Doncaster 8-8 Health Centre	The Flying Scotsman Centre, St Sepulchre Gate West, Doncaster, DN1 3AP
42. Dudley Borough Walk-in Centre	Holly Hall Clinic, Stourbridge Road, Dudley, DY1 2ER
43. Earls Court Health & Wellbeing Centre	2B Hogarth Road, Earls Court, London, SW5 0PT
44. Easington Healthworks Medical Centre	Paradise Lane, Easington Colliery, Peterlee, County Durham, SR8 3EX
45. Eastbourne Station Health Centre	Eastbourne Station, Terminus Road, Eastbourne, BN21 3QJ
46. Eastham Walk-in Centre	Eastham Clinic, Eastham Rake, Wirral, Merseyside, CH62 9AN
47. Edgware NHS Walk-in Centre	Edgware Community Hospital, Burnt Oak Broadway, Edgware, Middlesex , HA8 0AD
48. Edmonton GP-led Walk-in Service	1 Smythe Close, Edmonton, Middlesex, N9 0TW
49. Edridge Road Health Centre	Impact House, 2 Edridge Road, Croydon, Surrey, CR9 1PJ
50. Encompass Health Centre	The Galleries Health Centre, Washington, Tyne and Wear, NE38 7NQ
51. Erdington GP Health and Wellbeing Walk In Centre	196 High Street Erdington, Erdington, B23 6SJ

52. Eston Grange NHS Health Care Centre	Low Grange Health Village, Normanby Road, Middlesbrough, TS6 6TD
53. Featherstone Road Health Centre	Hartington Road, Southall, Middlesex, UB2 5BQ
54. Fellview Medical Practice	Cleator Moor Health Centre, Birks Road, Cleator Moor, Cumbria, CA25 5HP
55. Finchley NHS Walk-in Centre	Finchley Memorial Hospital, Granville Road, London, N12 0JE
56. Folkestone Walk-in Centre	Royal Victoria Hospital, Radnor Park Avenue, Folkestone, Kent, CT19 5BN
57. Fulham Centre for Health	Charing Cross Hospital, Fulham Palace Road, London, W6 8RF
58. Fylde and Wyre Same Day Health Centre	Same Day Health Centre, Fleetwood Health & Wellbeing Centre, Dock Street, Fleetwood, Lancashire, FY7 6HP
59. Gateshead Walk-in Service	Queen Elizabeth Hospital, Gateshead, NE9 6SX
60. Gloucester Health Access Centre	Eastgate House, 121-131 Eastgate Street, Gloucester, Gloucestershire, GL1 1PX
61. Gosbury Hill GP Clinic	Orchard Gardens, Chessington, Surrey, KT9 1AG
62. Gracefield Gardens GP Centre	2-8 Gracefield Gardens, Streatham, London, SW16 2ST
63. Greyfriars Health Centre	Phoenix House, Howard Street South, Great Yarmouth, Norfolk, NR30 2PT
64. Grindon Lane Minor Injury and Illness Unit	Grondon Lane Primary Care Centre, Grindon Lane, Sunderland, SR3 4DE
65. Guildhall Walk Healthcare Centre	27 Guildhall Walk, Portsmouth, PO1 2DD
66. Halewood Walk in Centre	The Halewood Centre, Roseheath Drive, Halewood, Liverpool, L26 9UH
67. Half Penny Steps Health Centre	427-429 Harrow Road, London, W10 4RE
68. Hammersmith Centre for Health	Hammersmith Hospital, Du Cane Road, W12 0HS

69. Hanley Health and Wellbeing Centre	Potteries Shopping Centre, 69/71 Stafford Street, Hanley, Stoke-on-Trent, ST1 1LW
70. Harold Wood GP Walk in Centre	St Clements Avenue, Off Gubbins Lane, Harold Wood, RM3 0FE
71. Hartlepool NHS Healthcare Centre	One Life Hartlepool, Park Road, Hartleepool, TS24 7PW
72. Hastings Medical Practice & Walk-in Centre	Station Plaza Health Centre, Station Approach, Hastings, TN34 1BA
73. Hawthorn Medical Centre	Unit K, Fallowfield Retail Park, Birchfields Road, Levenshulme, M14 6FS
74. Hayes Town Medical Centre	52 Station Road, Hayes, Middlesex, UB3 4DD
75. Haywood Community Hospital Walk-in Centre	Haywood Hospital, High Lane, Burslem, ST6 7AG
76. Herefordshire GP Access Centre	ASDA Building, Belmont Road, Hereford, HR2 7JE
77. Hillside Bridge Health Centre	Hillside Bridge Health Centre, 4 Butler Street, Bradford, BD3 0BS
78. Huyton Walk in Centre	Nutgrove Villa, Westmoreland Road, Huyton, L36 6GA
79. Jarrow Health Centre	Palmer Community Hospital, Wear Street, Jarrow, NE32 3UX
80. John Radcliffe Hospital GP-led walk-in centre	John Radcliffe Hospital, Headley Way, Headington, Oxford, OX3 9DU
81. King Street Health Centre	47 King Street, Wakefield, WF1 2SN
82. Kirkby Walk in Centre	St Chads Clinic, St Chads Drive, Kirkby, L32 8RE
83. Langbaurgh Medical Centre	Coatham Health Village, Coatham Road, Redcar, TS10 1SR
84. Leigh Walk-in Centre	Leigh Health Centre, The Avenue, Leigh, Lancashire, WN7 1HR
85. Lincoln Walk-in centre	63 Monks Road, Lincoln, LN2 5HP
86. Lindley Medical Practice	Integrated Care Centre, New Radcliffe Street, Oldham, Lancashire, OL1 1NL

87. Litherland Town Hall Health Centre	Hatton Hill Road, Litherland, Liverpool, L21 9JN
88. Liverpool City Centre NHS Walk-in Centre	52 Great Charlotte Street, Liverpool, L1 1HU
89. Locala Walk in Centre	Dewsbury & District Hospital, Halifax Road, Dewsbury, West Yorkshire, WF13 4HS
90. Malling Health Telford	39-41 Sherwood Row, Town Centre, Telford, Shropshire, TF3 4DZ
91. Malling Health Wrekin	Princess Royal Hospital, Apley Castle, Apley, Telford, Shropshire, TF1 6WL
92. Market Hill 8 to 8 Health Centre	The Ironstone Centre, West Street, Scunthorpe, North Lincolnshire, DN15 6HX
93. Medway NHS Healthcare Centre	547 - 553 Canterbury Street Gillingham, Kent, ME7 5LF
94. Middleton Health Centre	Middleton Shopping Centre, Middleton, Greater Manchester, M24 4EL
95. Midway Medical and Walk-in Centre	Morton House, The Midway,Newcastle-under-Lyme, ST5 1QG
96. Molineux Street Walk-in Centre	Molineaux NHS Centre, Off Shields Road, Byker, NE6 1SG
97. New Cross GP Walk-in Centre	Suite 3 Waldron Health Centre, Amersham Vale, London, SE14 6LD
98. NHS Parsonage Street Health Centre	Parsonage Street, West Bromwich, West Midlands, B71 4DL
99. NHS Sheffield Walk-in Centre	Rockingham House, 75 Broad Lane, Sheffield, S1 3PB
100. NHS Walk-in Centre Widnes	Health Care Resource Centre, Oaks Place, Caldwell Road, Widnes, Cheshire, WA8 7GD
101. North Chelmsford NHS Healthcare Centre	Sainsbury's, 2 White Hart LANE, Chelsmford, Essex, CM2 5EF
102. North Colchester Healthcare Centre	Colchester Primary Care Centre, Turner Road, Colchester, Essex, CO4 5JR
103. North West London Medical Centre	56 Maida Vale, London, W9 1PP

104. Northumberland Health Medical Centre	Hind Crescent, Erith, Kent, DA8 3DB
105. Oadby and Wigston Walk-in Centre	18 The Parade, Oadby, Leicestershire, LE2 5BJ
106. Old Swan Walk-in Centre	Crystal Close, St Oswald St, Liverpool, L13 2GA
107. Oliver Road Polyclinic	Oliver Road Polyclinic Walk-in Service, 75 Oliver Road, Leyton, E10 5LG
108. Orchard Village Walk in Centre	2 Roman House, Roman Close, Rainham, RM13 8QA
109. Park Community Practice	Horne Street Medical Centre, Hanson Lane, Halifax, HX1 5UA
110. Parsons Green NHS Walk-in Centre	5-7 Parsons Green, London, SW6 4UL
111. Peckham GP Walk in Centre	Lister Health Centre, 101 Peckham Road, London, SE15 5LJ
112. Peterborough Walk-in Centre	City Care Centre, Thorpe Road, Peterborough, PE3 6DB
113. Phoenix Centre	Phoenix Centre, Parkfield Road, Wolverhampton, WV4 6ED
114. Ponteland Road Health Centre	169 Ponteland Road, Newcastle upon Tyne, NE5 3AE
115. Prestwich Walk-in Centre	Fairfax Road, Prestwich, Manchester, Lancashire, M25 1BT
116. Primary Care Emergency Centre	Manchester Royal Infirmary, Oxford Road/Upper Brook Street, Manchester, M13 9WL
117. Putnoe Medical Centre	93 Queen's Drive, Bedford, MK41 9JE
118. Quayside Medical Centre	76b Cleethorpe Road, Grimsby, Linconshire, DN31 3EF
119. Reading Walk-in Health Centre	1st Floor 103-105 Broad St Mall, Reading, RG1 7QA
120. Resolution Health Centre	11 Trinity Mews, North Ormesby, Middlesbrough, Cleveland, TS3 6AL
121. Rotherham NHS Walk-in Centre	Rotherham Community Health Centre, Greasbrough Road, Rotherham , S60 1RY

122. Royal Devon & Exeter Walk-in Centre	Royal Devon and Exeter Hospital, Barrack Road, Exeter, EX2 5DW
123. Rugby Walk-in Centre	Rugby Urgent Care Centre, Hospital of St Cross, Barby Road, Rugby, CV22 5PX
124. Salisbury Walk-in Health Centre	Avon Approach, Salisbury, Wiltshire, SP1 3SL
125. School House Practice	Dewsbury Health Centre, Wellington Rd, WF13 1HN
126. Shakespear Medical Practice	Burmantofts medical centre, Cromwell Mount, Leeds , LS9 7TA
127. Sheppey NHS Healthcare Centre	Sheppey Community Hospital, Plover Road, Minster-on-Sea, Sheerness, ME12 3LT
128. Shiremoor Health Resource Centre	Earsdon Road, Shiremoor, Newcastle Upon Tyne, Tyne And Wear, NE27 0HJ
129. Showell Park Health and Walk In Centre	Fifth Avenue, Showell Park, Wolverhampton, West Midlands, WV10 9ST
130. Shrewsbury Walk-in Health Centre	Whitehall, Monkmoor Road, Shrewsbury, Shropshire, SY2 5AP
131. Sidwell Street Walk-in Centre	31 Sidwell Street, Exeter, Devon, EX4 6NN
132. Skelmersdale NHS Walk-in Centre	116-118 The Concourse, Skelmersdale, WN8 6LJ
133. Slough Walk-in Health Centre	Upton Hospital, Albert Street, Slough, SL1 2BJ
134. Soho Walk-in Centre	1 Frith Street, London, W1D 3HZ
135. Solihull Healthcare and Walk in centre	Solihull hospital, Lode Lane, B91 2AE
136. South Birmingham GP Walk-in Centre	15 Katie Rd, Birmingham, B29 6JG
137. South Liverpool NHS Walk-in Centre	Church Road, Garston, L19 2LW
138. Spring House Medical Centre	Ascots Lane, Welwyn Garden City, Hertfordshire, AL7 4HL

139. SSAFA Care CIC Health and Walk In Centre	1 Spinney Hill Road, Leicester, Leicestershire, LE5 3GH
140. St Andrews Health Centre	2 Hannaford Walk, Bow, London, E3 3FF
141. St Helens Minor Injuries Unit and Walk in Centre	The Millennium Centre, Corporation Street, St Helens , WA10 1HJ
142. St Luke's Health Centre	Pantile Avenue, Southend on Sea, Essex, SS2 4BD
143. St Neot's Health Centre	24 Moores Walk, St Neots, Cambridgeshire, PE19 1AG
144. St Oswald's Hospital Walk-in Centre	St Oswald's Hospital, Clifton Road, Ashbourne, Derbyshire , DE6 1DR
145. Stockton NHS Healthcare Centre	Tithebarn House, High Newham Road, Hardwick Estate, Stockton-on-Tees, TS19 8RH
146. Story Street Medical Practice and Walk-in Centre	Wilberforce Centre, 6-10 Story Street, Hull, HU1 3SA
147. Summerfield GP and Urgent Care Centre	Summerfield Primary Care Centre, 134 Heath Street, Winson Green, Birmingham, B18 7AL
148. Teddington Walk-in Centre	Teddington Memorial Hospital, Hampton Road, Teddington, Middlesex, TW11 0JL
149. Thamesmead NHS Health Centre	4 - 5 Thames Reach, London, SE28 0NY
150. The Beacon Health Centre	St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, P030 5TG
151. The Connaught Square Practice	41 Connaught Square, London, W2 2HL
152. The Hill General Practice and Urgent Care Centre	Sparkhill Primary Care Centre, 856 Stratford Road, Sparkhill, Birmingham, B11 4BW
153. The Junction Health Centre	Arches 5-8 , Clapham Junction Station, SW11 2NU
154. The Nottingham NHS Walk-In Centre	Seaton House, London Road, Nottingham, Nottinghamshire, NG2 4LA
155. The Orchard Medical Centre	Macdonald Walk, Kingswood, Bristol, BS15 8NJ
156. The Pinn Medical Centre	37 Love Lane, Pinner, Middlesex, HA5 3EE

157. The Practice Loxford, Loxford Polyclinic	Loxford Polyclinic, 417 Ilford Lane, Ilford, Essex, IG1 2SN
158. The Ridgeway Surgery	Alexandra Avenue Health and Social Care Centre, 275 Alexandra Avenue, Rayners Lane, Harrow, HA2 9DX
159. The Skelton Medical Centre	Byland Road, Skelton-in-Cleveland, North Yorkshire, TS12 2NN
160. The Wilson Health Centre	Cranmer Road, Mitcham, Surrey, CR4 4TP
161. Thurrock Health Centre	57 High Street, Grays, Essex, RM17 6NJ
162. Timber Hill Health Centre	Level 4, 115-117 The Castle Mall, Norwich, NR1 3DD
163. Tollgate Lodge Healthcare Centre	57 Stamford Hill, Stoke Newington, N16 5SR
164. Town Centre GP Surgery	14-16 Chapel Street, Luton, LU1 2SE
165. Trafford Health Centre	Trafford general hospital, Moorside Road, Davyhulme, Manchester, M41 5SL
166. Upney Lane Walk-in Centre	Barking Community Hospital, 132 Upney Lane, Barking, IG11 9LX
167. Urgent Care Centre, Guy's Hospital	Guy's Hospital, Great Maze Pond , SE1 9RT
168. Vicarage Lane Health Centre	10 Vicarage Lane, Stratford, E15 4ES
169. Victoria Central Walk-in Centre	Mill Lane, Wallasey, Wirral, CH44 5UF
170. Walsall Walk-in-Health Centre	19-21 Digbeth, Market Square, Walsall, West Midlands, WS1 1QZ
171. Wansbeck Primary Care Access Centre	Wansbeck General Hospital, Woodhorn Lane, Ashington, Northumberland, NE63 9JJ
172. Warren Farm Urgent Care Centre	Warren Farm Rd, Kingstanding, B44 0PU
173. Washwood Heath Urgent Care Centre	Washwood Heath Health and Wellbeing Centre, Clodeshall Rd, Saltley, B8 3SN
174. West Herts Medical Centre	Hemel Hempsted Hospital, Hillfield Rd, Hemel Hempstead, Hertfordshire, HP2 4AD

175. West Lancashire Health Centre	Ormskirk & District Hopsital, Wigan Road, Ormskirk, Lancashire, L39 2AZ
176. Westgate Walk in Centre	Westgate Road, Newcastle-upon-Tyne, NE4 6BE
177. Westminster & Pimlico Health Centre	15 Denbigh Street, London, SW1V 2HF
178. Westwood 8 to 8 Primary Care Centre	Pelham Street, Worksop, S80 2TR
179. Weybridge Walk-in Centre	Weybridge Community Hospital, 22 Church Street, Weybridge, KT13 8DY
180. Weymouth GP-led Walk In Centre	Weymouth Community Hospital, 3 Melcombe Avenue, Weymouth, Dorset, DT4 7TB
181. White Horse Surgery & Walk-in Centre	Vale Rd, Northfleet, Gravesend, Kent, DA11 8BZ
182. Woking Walk-in Centre	Woking Hospital, Heathside Road, Woking, GU22 7HS
183. Wolds View Primary Care Centre	Bridlington and District Hospital, Bessingby Road, Bridlington, YO16 4QP
184. Worcester Walk-In Health Centre	Farrier House, Farrier Street, Worcester, WR1 3BH
185. Yeovil Health Centre	37 Middle Street, Yeovil, BA20 1SB

Annex 3: List of closed walk-in centres

Name	Address
1. Alma Road Primary Care Centre	Central Peterborough, PE1 3FG
2. Ancoats Walk-in Centre	Old Mill Street, Ancoats, M4 6HH
3. Ashfield Walk-in Centre	Kirkby-in-Ashfield, NG17 7AE
4. Bexley North Health Centre	Crayford Road, Bexley, DA1 4ER
5. Blackpool NHS Walk-in Centre	26, Talbot Road, Blackpool, Lancashire, FY1 1LF
6. Bolton Walk-in Centre	Lever Chambers, Bolton, BL1 1SQ
7. Bristol City Gate Walk-in Centre	Broad Street, Bristol, BS1 2EZ
8. Canalside Medical Centre	Monton, Greater Manchester, M30 8AR
9. Canary Wharf NHS Walk-in Centre	30 Marsh Wall, Isle of Dogs, London , E14 9TP
10. Crown Health Centre	Withersfield Road, Haverhill, CB9 9LA
11. Croydon Walk-in Centre	45 High Street, Croydon, Surrey, CR0 1QD
12. Darlington Urgent Care Centre (Dr Piper House)	King Street, Darlington, DL3 6JL
13. Forum Health Walk-in Service	Forum Square, Wythenshawe, M22 5RX
14. Hampshire Healthcare Centre	Basingstoke and North Hampshire Hospital, Basingstoke, RG24 9NA
15. Harlow Walk-in Centre	1a Wych Elm, Harlow, Essex, CM20 1QP
16. Harness Harrow Walk in Centre	46 South Parade, Mollison Way, Edgware, HA8 5QL
17. Headrow NHS Walk-in Centre	Balcony Level 7, The Light, The Headrow, Leeds, LS1 8TL
18. Hornsey Central Walk-in Clinic	Park Road, London, N8 8JD
19. Ilford Walk-in Centre	201-205 Cranbrook Road, Ilford, Essex, IG1 4TD
20. Ilkeston Family Practice and Walk-in Centre	Ilkeston Community Hospital, Derbyshire, DE7 8LN

21. Lakeside Plus/Corby Urgent Care Centre	Corby, NN17 2UR
22. Laurels Neighbourhood Practice	Haringey, North London, N15 5AZ
23. Leighton Hospital Walk-in Centre	Leighton Hospital, Crewe, CW1 4QJ
24. Little Hulton Walk-in-Centre	Haysbrook Avenue, Worsley, Manchester, M28 0AY
25. Liverpool Street NHS Walk-in Centre	Exchange Arcade, 175 Bishopsgate, London, EC2M 3WA
26. Loughborough Walk-in Centre	Pinfold Gate, Loughborough, Leicestershire, LE11 1BE
27. Manchester Picadilly Walk-in Centre	1st Floor Gateway House, Station Approach, Piccadilly South, M1 2GH
28. Mersey View GP Access Centre	Everton Road, Liverpool, L6 2EH
29. Milton Keynes Walk-in Centre	Hospital Campus, Standing Way, Eaglestone, Milton Keynes , MK6 5NG
30. Monkgate Walk-in Centre	Monkgate Health Centre, 31-33 Monkgate, York, YO31 7WA
31. Mount Gould Local Care Centre	Plymouth, PL4 7QD
32. Newcastle Central Walk-In Centre	Unit 5,The Bar (Jury's Inn) Newcastle, NE1 4BH
33. NHS Barnsley Health Centre	Unit 1, Gateway Plaza , Sackville Street, Barnsley, South Yorkshire , S70 2RD
34. Pendleton Walk-in-Centre	Rear of Pendleton House, Off Broughton Road, Salford , M6 6LS
35. Rochdale Walk-in Centre	Rochdale Infirmary, 90 Whitehall Street, Rochdale , OL12 0ND
36. Royal Surrey County Hospital Walk-in Centre	Royal Surrey County Hospital, Egerton Road, Guildford, GU2 7XX
37. Shirley NHS Walk-in Centre	1a Howards Grove, Southampton, Hampshire, SO15 5PR
38. South Bristol Walk-in Centre	Knowle West, Bristol, BS4 1WH

39. Stapleford Walk-in Centre	Church Street, Stapleford, NG9 8DA
40. Stockport Health Centre (Walk-In Centre)	Wellington Road, Stockport, SK2 6NW
41. The Bay Health Centre	Torbay Hospital, Newton Road, Torquay, Devon, TQ2 7AA
42. The Practice Heart Of Hounslow NHS Walk In Centre	92 Bath Road, Hounslow, Middlesex, TW3 3LN
43. Tooting Walk-in Centre	A&E department, St George's Hospital, Blackshaw Road, Tooting, London, SW17 0QT
44. Victoria NHS Walk-in Centre	63 Buckingham Gate, SW1E 6AT
45. Wakefield NHS Walk-in Centre	Thornhill Street, Wakefield, West Yorkshire, WF1 1PG
46. Walk in Centre	Royal Hallamshire Hospital, S10 2TB
47. Warrington GP Health Centre	Sankey Street, Warrington, WA1 1TD
48. Weston Urgent Care Service	Weston General Hospital, Somerset, BS23 4TQ
49. Whitechapel Walk-in Centre	174 Whitechapel Road, London, E1 1BZ
50. Withington Walk-in Centre	Withington Community Hospital, Manchester, M20 2LR
51. Wycombe GP Health Centre	Queen Alexandra Road, High Wycombe, Buckinghamsire, HP11 2TT

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

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Monitor

Making the health sector work for patients

Advice and recommendations for commissioners: deciding the future of walk-in centres

www.monitor.gov.uk

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Find out more: www.monitor.gov.uk

Introduction

Across England, many contracts for walk-in centres, including GP-led health centres, are due to expire in 2014 or 2015.[1] Commissioners need to decide whether or not to continue to procure walk-in centre services for patients in their local areas. In some cases, commissioners are making this decision in the context of developing a wider urgent care strategy.

This document, developed from research on walk-in centre provision in England, contains advice and recommendations that aim to help commissioners who are reviewing or preparing to review walk-in centre services reach decisions in a manner that will achieve the best results for local patients.

Monitor researched walk-in centre provision in England during the second half of 2013. Our purpose was to understand why local commissioners in many cases had decided to close walk-in centres during the previous three years. We also wanted to understand the possible impact of closures on patients, how well commissioning arrangements for walk-in centres are working for patients, and whether payment mechanisms for walk-centres and general practice services are leading to benefits for patients.

Our research was wide-ranging, including a survey of almost 2,000 patients using walk-in centres. We also spoke to stakeholders throughout the sector, including commissioners, providers, and health and wellbeing boards.

We have based the advice and recommendations in this document on the findings of our research.

Section 1 sets out the factors that commissioners should consider when deciding the future of a walk-in centre. These factors are reflected in commissioners' obligations under the Procurement, Patient Choice and Competition Regulations. Those most likely to be relevant to decisions about walk-in centres include:

- assessing the needs of patients in the local area and understanding what role the walk-in centre may play in meeting them;
- deciding what services to continue to procure, if any, and from whom when a contract for a walk-in centre is due to expire;
- considering whether services can be delivered in a more integrated way;
- managing any conflicts of interest; and

[1] GP-led health centres (sometimes referred to as "Darzi centres" or "equitable access centres") offer a walk-in service for non-registered patients as well as an option for patients to register with a GP practice at the centre. For more information, see our final report.

- ensuring transparency in decision making.

Section 2 of this document recommends steps that commissioners can take now to address the findings of our review that:

- in some cases, walk-in centre closures may adversely affect some patients' access to primary care; and
- the split in commissioning responsibilities between NHS England and clinical commissioning groups (CCGs) is causing confusion about walk-in centres and creating a risk that commissioning decisions do not take into account the potential impact of closing or changing walk-in centre services across primary and secondary care.

The main goal of the recommendations in this section is to encourage NHS England and CCGs to consider jointly the future of walk-in centres in their areas. It is up to commissioners to decide whether to adopt these recommendations or to take a different approach. However, on the basis of our review, we believe that these recommendations will help commissioners make the best decisions for patients.

Section 3 describes how our findings about walk-in centres fit into a larger context of work to improve services.

This document is an excerpt from Monitor's *Walk-in centre review: final report and recommendations*. The final report, available at www.monitor.gov.uk/WIC, provides information and data about walk-in centre provision across England, and sets out the key findings of our review. We invite you to read the report in full, and send any questions or comments to cooperationandcompetition@monitor.gov.uk.

We also encourage you to refer to our *Substantive Guidance on the Procurement, Patient Choice and Competition Regulations*, which offers more information about how the regulations apply in practice and provides Hypothetical Case Scenarios, which set out how the regulations might apply in six hypothetical cases.

1. Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services

Our review found that walk-in centres are most valued today where they were introduced following a careful assessment of local needs, located in an area of the community where the services could be conveniently accessed by those who needed them, and procured using a sound process that resulted in value for money.

Good commissioning continues to be critical when taking decisions about the future of walk-in centres. Commissioners' objective is to ensure that they secure high-quality, efficient services that meet patients' needs. The Procurement, Patient Choice and Competition Regulations[2] provide the framework for taking decisions about what services to procure and how to procure them. Monitor has published guidance to help the sector understand the regulations.[3]

There are a number of factors that commissioners are likely to need to consider to be confident that the decisions that they take meet patients' needs and can achieve quality and efficiency improvements. We have set out below the factors likely to be particularly relevant to decisions about the future of walk-in centres, based on the themes that have emerged from our review. In practice, what is best for patients will depend on local circumstances. Commissioners will need to consider the Procurement, Patient Choice and Competition Regulations in the round and should refer to our substantive guidance for more detail on how the regulations apply in practice.[4]

The purpose of our review was not to investigate whether individual commissioners' decisions were consistent with the Procurement, Patient Choice and Competition Regulations. If stakeholders have concerns that a regulation may have been breached, they may make a formal complaint to Monitor.[5]

[2] The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the "Procurement, Patient Choice and Competition Regulations"). The Regulations replaced the Principles and Rules for Cooperation and Competition and the Procurement Guide for Commissioners of NHS Funded Services.
[3] See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at http://monitor.gov.uk/s75.
[4] See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at http://monitor.gov.uk/s75.
[5] Details of how to do so are set out in Monitor's enforcement guidance, available at www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishEnforcementGuidance20May2013.pdf. Decisions on whether or not to investigate complaints that we receive are taken in accordance with the prioritisation criteria set out in our guidance.

1.1. Assessing patients' needs

Commissioners' main objective is to secure the needs of health care service users and improve the quality and efficiency of services. This is set out in Regulation 2 of the Procurement, Patient Choice and Competition Regulations.[6]

We recognise that commissioners face financial constraints and that some commissioners view walk-in centres as treating illnesses and injuries that could be dealt with through self care or by other existing services.[7] In addition, many commissioners have prioritised consolidating urgent care services into one point of access within or near an A&E department, so that patients can be triaged and those without emergency care needs can be easily directed to an urgent care centre or primary care service. This may involve closing a walk-in centre, including one that may be centrally located within a community.

However, before developing plans to close or change walk-in centre services, commissioners should do a needs assessment to develop a clear understanding of the health care needs of the particular population for which they are responsible and the role of the walk-in centre in meeting those needs. Doing so will allow commissioners to determine the best model of service to meet patients' needs in their local areas.

Our findings suggest that issues concerning access to care are likely to be highly relevant to patients in most areas.[8] Commissioners may have to consider in particular:

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[6] CCGs also have a general duty to arrange for the provision of health care services to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they are responsible. See section 3 of the National Health Services Act 2006. NHS England has a similar duty to secure primary medical services to such extent as it considers necessary to meet all reasonable requirements. See section 83(1) of the National Health Service Act 2006.

[7] NHS England notes that increases in attendances at walk-in centres and minor injury units since they were introduced could mean the services are meeting previously unmet demand or are creating unwarranted demand or could indicate a failure to meet needs earlier in the system. NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013, p.18. http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf. Evidence that we examined in our review suggests that whilst most people use walk-in centres for needs that are not clinically urgent, almost half of the patients in our survey viewed their conditions as urgent. More than 80% said they would try to use other services if the walk-in centre was not available, with the majority saying that they would seek advice from a GP or A&E. Very few would have self-treated or not sought advice (8%).

[8] Commissioners are also subject to the public sector equality duty (PSED) in the Equality Act 2010. The PSED requires public authorities to have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people who share a protected characteristic (including, for example, age, disability, race, religion or belief) and those who do not; and foster good relations between people who have a protected characteristic and those who do not. The Equality and Human Rights Commission has published guidance on procurement and the Equality Act 2010: Buying better outcomes.

- The needs of people who find it difficult to access traditional primary care services. These might include particular populations, such as those with language barriers, travellers or homeless people, who may have difficulties registering with a GP or booking and keeping appointments.

- The need for primary care services to be available outside of normal working hours, such as during evenings and at weekends and when GP practices are closed in areas where there are large numbers of workers who cannot afford to be absent from work for a GP appointment.

- The extent to which there is a need in the area for better access to same-day or immediate care for conditions that are urgent or that patients view as urgent.

- The need for primary care services to be available across different locations, including, for example, in an area of high deprivation or in rural areas far from hospital or urgent care services, which might lack sufficient primary care services without a walk-in centre.

- Overall primary care and urgent needs, including general demand for primary care services, which a walk-in centre may be helping to meet.

- A need for specific services that are not currently available, indicated by a significant number of patients seeking advice, treatment or services at the walk-in centre that are not provided there or in another local setting.

Based on the commissioning practices examined in our review and on conversations with stakeholders, we identified some examples of best practice that commissioners should normally include as part of a needs assessment. These include:

- Carrying out a patient survey to better understand why patients are using the walk-in centre.

- Examining the range of conditions and injuries presented at the walk-in centre and the types of advice and treatment being offered.

- Engagement in the community, which might include sponsoring public discussion forums, meetings with local patient organisations and local constituent groups, interviews or focus groups with a selection of individual patients, and/or online and community-based communications and outreach activities.[9] Local Healthwatch organisations may be able to help

[9] NHS England and CCGs have an obligation to ensure that patients are involved in (i) planning commissioning arrangements; (ii) developing and considering proposals for changes in commissioning arrangements that impact how services are delivered to patients or the range of services; and (iii) decisions affecting how the arrangements operate where these have such an impact. See Sections 13Q and 14Z2 of the National Health Services Act 2006.

commissioners reach the people within their communities who are likely to be affected by changes in provision, including hard-to-reach groups.

- Engaging with providers across the local health economy to understand how the walk-in centre interacts with other services (for example, with ambulance services, A&E, and local GP practices). This could help determine whether services need to be better integrated for patients.

- Seeking evidence of gaps or duplication in local services. For example, the West Midlands Ambulance Service NHS Foundation Trust maintains the Directory of Services (DOS) and provides information to commissioners about instances when it could have been clinically appropriate to refer a patient calling either 999 or 111 to a walk-in centre, but where none was available.[10] This allows commissioners to identify any areas where a walk-in centre is needed, where hours or services could be altered to meet demand, or where walk-in centres are not being used due to overprovision. Commissioners should consider whether they need to improve the DOS in their areas, as stakeholders told us that in some areas the directory is not up to date or is not being put to its best use in matching demand with services.

1.2. Choosing a service model and provider

Where commissioners have identified that a walk-in centre is meeting particular health care needs in their area, or have identified unmet needs in the course of their review of walk-in centre services, they will need to decide what services to procure, and from whom, to best meet those needs within available funding when the contract with the walk-in centre expires.

Deciding what services to procure to meet patients' needs

Having conducted a needs assessment, commissioners should consider what models of care may be appropriate to best meet the health care needs that the assessment has identified.[11]

It may be that some of the needs that are currently being met by a walk-in centre in the area could be secured through a variety of different models of primary and urgent care. These might include, for example:

- continuing to offer the walk-in centre;

- enhancing walk-in centre services by offering them in a way that is more integrated with other services (see Section 1.3);

[10] See West Midlands Ambulance Service NHS Foundation Trust submission to Monitor's walk-in centre review, p.1.
[11] Commissioners will also need to have regard to the joint strategic needs assessment and joint health and wellbeing strategy prepared by the Joint Health and Wellbeing Board covering their area. See section 116B of the Local Government and Public Involvement in Health Act 2007.

- relocating or reconfiguring the services provided by an existing walk-in centre;
- procuring services targeted specifically at particular vulnerable patient groups (for example, services for the homeless);
- procuring additional services from GP practices;
- enhancing provision of pharmacy or NHS 111 services; or
- some combination of these options.

In some circumstances, there may be a more limited number of models that would be suitable. If, for example, the service needs to cater primarily to unregistered people or others with specific needs, it may be that extended or out-of-hours cover from GP practices would not be an appropriate choice.

Commissioners may want to pilot a new arrangement intended to replace a walk-in centre to evaluate whether it is likely to represent the best model for patients. In that case, commissioners should, where funding permits, consider keeping the walk-in centre open until after the pilot is evaluated.

Identifying the best service model to meet patients' needs includes evaluating which model offers the best value for money. Commissioners should also examine the impact of any potential changes to walk-in centre services on other services. This might involve:

- Considering the location, opening hours, capacity, and quality of local GP practices, pharmacies, other walk-in or urgent care centres and A&E departments, and the nature of services available from these providers.
- Analysing likely patient flows under each possible model of care and the potential impact on the costs and quality of other services within the local health care economy (for example, modelling the potential costs associated with increased use of A&E, urgent care centres, or other services if a walk-in centre were to close).
- Looking at data on the impact of walk-in centre closures in other locations with similar local health economies and examining the effectiveness of any alternative models put in place.

Commissioners have a duty to involve patients, and those who may use health services, in decisions.[12] Public consultation can be an effective way of gathering views from the local community on the options being considered by commissioners and the assumptions and evidence underlying those options. A number of

[12] See footnote 9 for a description of the duty to involve patients.

commissioners we spoke to chose to do a formal consultation with the public on proposed changes to walk-in centre services.

We saw examples of local Healthwatch organisations helping commissioners develop a robust public engagement and consultation plan. They may also be able to connect commissioners with organisations representing hard-to-reach groups to engage with them about plans to reconfigure walk-in centre services.

Following a review, if commissioners decide not to continue to procure walk-in centre services or replacement services (for example, if they intend for patients to seek care from their GP practices), commissioners should, as best practice, develop plans for how local GP practices and other existing services will absorb any additional demand resulting from the closure of the walk-in centre. The plan might include, for example, details about additional appointments that will be available from GP practices. Where a significant number of patients using the walk-in centre are not registered with a GP practice, the plan should also address how those patients might continue to access primary care after the walk-in centre is closed. Commissioners should also consider how to involve patients in developing the plan and how to communicate the proposed service changes to the public in good time.

Choosing a provider(s) to deliver the service model

Regulation 3(3) of the Procurement, Patient Choice and Competition Regulations requires commissioners to procure services from the provider or providers most capable of securing patients' needs and improving services, and that offer best value for money. Regulation 3(2) also requires commissioners to treat providers equally, which includes giving all potential providers of a service a fair opportunity to provide them. These two requirements are closely linked. By giving full consideration to the relative ability of a wide range of different providers, commissioners are more likely to end up securing services from the provider that will achieve the best outcome for patients.

Once commissioners have chosen a particular model of care, there are a number of ways in which they might go about selecting a future provider or providers. What is appropriate will depend on local circumstances. For example:

- Commissioners may decide to procure services through a competitive tender process. This may be appropriate, for example, if there are a large number of potential providers or some providers have contacted commissioners to express an interest in providing the service in the area. It may also be appropriate where commissioners have concerns about the quality or efficiency of existing provision and want to understand whether there are other capable providers in the area.

- Commissioners may decide to announce their intention to extend or renew the contract with an existing provider some time before reaching a final decision.

This may be appropriate, for example, where commissioners are satisfied that the existing provider is delivering a high-quality service that is good value for money and is unsure about whether there are other providers that might be interested in providing the service. Commissioners could make this announcement on their website and on Supply2Health a reasonably long time before the contract is due to expire, for example, 12 months. This would enable other providers to express interest. If other providers do express an interest, commissioners would need to consider whether those providers might be capable of delivering a better service.

- Commissioners may decide to extend or renew the contract with the existing provider. This may be appropriate, for example, where commissioners are aware that the current provider is the only provider in the area capable of delivering the particular services offered at the walk-in centre; or where the existing provider is performing well and the commissioner is confident, taking all available information and evidence into account, that the provider is the most capable of meeting patients' needs, improving quality and efficiency, and providing the best value for money.

Whatever process commissioners decide to follow, they will need to consider how best to run a proportionate process that it is sufficiently robust to identify the most capable provider.

1.3. Improving services by providing them in a more integrated way

Commissioners are expected to consider ways of improving services, including through services being delivered in a more integrated way.[13]

Some commissioners raised concerns that walk-in centres may be contributing to the fragmentation of care because, for example, walk-in centres generally do not have access to patients' medical records and may not be able to refer patients on to secondary care services. However, we found that the strength of links between walk-in centres and other services in the local health economy varies by locality (see Section 4.5 of our full report).

Whenever commissioners are considering what services to procure and how to do so, they should consider whether services could be improved by being delivered in a more integrated way with other health and social care services.

Commissioners should not discount a walk-in centre model simply because an existing walk-in centre does not have strong links with other services in the local health economy. Rather, commissioners should consider whether practical steps

[13] This is required by regulations 2 and 3(4)(a) of the Procurement, Patient Choice and Competition Regulations; see also National Health Service Act 2006 sections 13N and 14Z1.

could be taken to ensure that care is delivered in a more integrated way by creating better links between different services (including those provided by a walk-in centre).

Some examples of this might include:

- establishing care pathway protocols between the centre and other primary and secondary care providers;
- developing more and stronger links with public health and social care services;
- introducing access to shared patient records;
- integrating walk-in centre clinicians into multi-disciplinary teams; and
- addressing any confusion that might exist in the community about the different services that are available in the area (including by offering clear information to the public describing what services are on offer at a walk-in centre and when, and ensuring that the name of the centre appropriately signals the services offered at the centre. For example, centres should not be labelled walk-in centres if walk-in services are offered only on a very limited basis).

As some stakeholders pointed out, such a model would also support policies designed to move care into communities and out of hospital settings.

1.4. Managing conflicts of interest

Commissioners are required to comply with a number of rules designed to ensure that conflicts of interest are appropriately declared and managed. These include Regulation 6(1) of the Procurement, Patient Choice and Competition Regulations, which prohibits commissioners from awarding a contract for NHS services where conflicts or potential conflicts between the interests involved in commissioning such services and providing them affect, or appear to affect, the integrity of the award of that contract.[14]

Conflicts of interest may materialise in a number of different ways when decisions are being taken about the future of a walk-in centre. A CCG may decide, for example, to close a walk-in centre and instead buy additional services from member GP practices (such as opening a weekend walk-in clinic at a local GP practice).

[14] CCGs are also required to comply with section 14O of the National Health Service Act 2006. This includes requirements to maintain a register of interests, to declare conflicts of interest and to manage them when they arise. Members of commissioners that are registered doctors must also comply with their professional obligations in so far as they concern conflicts of interest. These are set out in the General Medical Council's guidance Good Medical Practice (see paragraphs 77 to 80 "honesty in financial dealings") and Financial and commercial arrangements and conflicts of interest. In relation to conflicts of interest, this states that if faced with a conflict of interest, doctors must be open about the conflict, declare their interest formally, and be prepared to exclude themselves from decision-making.

Member GP practices of CCGs may therefore have a direct financial interest in decisions about whether or not to continue to procure services from a walk-in centre.

Some stakeholders raised concerns with us that these and other potential conflicts of interest may lead to flawed procurement decisions that are motivated by financial interests rather than the interests of patients.

CCGs are required to ensure that conflicts of interests are declared as soon as practicable and included in the CCG's register of interests (which must be published or made accessible to the public on request).[15]

Given concerns about potential conflicts of interest, we suggest that CCGs publish on their website, details of conflicts of interest ahead of taking any decision that affects a walk-in centre together with an explanation of how they propose to manage the conflicts.[16]

Depending on the circumstances, there may be a number of different ways of managing a conflict of interest in order to prevent it from undermining the integrity of a CCG's decision about the future of a walk-in centre. Options may include:

- Excluding conflicted GPs from participating in decision-making (ie, voting on relevant decisions). Relevant decisions – such as decisions about whether or not to close a walk-in centre; which provider to select to run a walk-in centre; and/or what services (if any) to procure instead of an existing walk-in centre – could be taken by the non-GP members of the governing body of the CCG, including the lay persons, the registered nurse and secondary care consultant (assuming that a quorum can be achieved). What is possible will depend on the CCG's constitution, but another option may be to arrange for other individuals that are not conflicted to be co-opted to vote on decisions about the future of the walk-in centre.

- Excluding conflicted GPs from participating in particular steps involved in the review of walk-in centre services. GPs might be excluded not only from taking decisions, but also from more general participation in the review, such as from drafting proposals for future service provision.

- Arranging for third parties with relevant experience and expertise to review decisions taken to provide ongoing scrutiny. This might include, for example,

[15] CCGs are required to maintain one or more registers of interest. They must also make arrangements to ensure that any conflict or potential conflict of interest is declared as soon as practicable after the person becomes aware of it (and in any event within 28 days) and that any such declaration is included in the register of interests. See section 14O of the National Health Service Act 2006.

[16] See NHS England's Guidance for Clinical Commissioning Groups on Managing Conflicts of Interest which suggests that openness and transparency are integral safeguards for managing conflicts of interest when taking commissioning decisions (p.12).

getting the local health and wellbeing board to review the CCG's proposals at various stages of the process.

- Seeking appropriate expertise and evidence. Regardless of whether there are potential conflicts of interests, commissioners must make sure that their decisions are evidence-based and rely on appropriate expertise. Doing so will also help to ensure that any conflicts of interest that do exist do not affect the decisions that are taken (or appear to do so).

More guidance on handling conflicts of interest is available in Monitor's *Substantive guidance on the Procurement, Patient Choice and Competition Regulations* and NHS England's guidance for CCGs on managing conflicts of interest.[17]

1.5. Acting transparently

Commissioners are required to act in a transparent way when procuring services (Regulation 3(2) of the Procurement, Patient Choice and Competition Regulations). Transparency is important in ensuring that commissioners are accountable for their decisions. As noted, commissioners also have a duty to involve the public in commissioning decisions.

It appears from our review that some decisions about the future of walk-in centres may not always be shared or communicated as effectively as they might be. For example, while we saw several examples of a public consultation exercise that explained the processes and reasons for a proposed closure, we also saw examples in which commissioners appeared to have decided to close walk-centres without setting out their reasons for doing so or explaining the process they followed to reach their decision. Some providers also told us that they were unsure about what their local commissioners' intentions were, with respect to the walk-in centre services they provide, even though the contract was due to expire in the near future.

We also saw examples in which commissioners had consulted with the public on proposals to relocate a walk-in centre to an A&E department as an urgent care centre, giving an impression that the centre would still be available to walk-in patients at a new location. However, the actual service put in place triages patients who queue for emergency services. Those not needing emergency care are seen by a primary care service within A&E. The service does not offer a distinct urgent care centre or walk-in centre that is visible to patients. It is important for commissioners, when consulting the public on proposed new models of service, to explain clearly the features of the proposed model and how patients will be able to access it in the future.

[17] NHS Commissioning Board (NHS England), *Managing conflicts of interest: guidance for clinical commissioning groups*, 28 March 2013.

Commissioners must consider what steps they should take to ensure that people understand the reasons for the decisions that they are taking and the process that they are following to take them. This may include, for example, announcing when they are proposing to review the future of a walk-in centre, what process they intend to follow, and the decision that they ultimately take and the reasons for it (see our recommendations in the next section).

2. Our recommendations

In this section, we recommend actions that commissioners can take now to help make walk-in centre services work better for patients. We are aware of the statutory framework for commissioning and the duties placed on NHS England and CCGs. The recommendations in this section are designed to assist commissioners in carrying out their commissioning functions. It is up to commissioners to decide whether to adopt these recommendations or to use a different approach; however, we believe, based on the findings of our review, that these recommendations represent good practice that will help commissioners achieve the best results for patients.

2.1. Bring greater clarity and transparency to commissioning responsibilities for walk-in centres

In Section 7.2 of our full report, we discussed how the split in commissioning responsibilities has led to confusion about which commissioning bodies are responsible for walk-in centres or particular services offered at walk-in centres. To clear up any confusion, provide more transparency for patients and providers, and promote joint work between NHS England and CCGs, we recommend that commissioners provide more information to the public about walk-in centres.

We recommend that CCGs publish information on their websites by 31 March 2014 that describes for each walk-in centre in their geographic area:

- the name of the centre and the provider;
- the expiration date of the contract for the centre;
- which commissioning body (or bodies) is holding and managing the contracts associated with the centre;
- which commissioning body funds the walk-in centre or, if relevant, funds particular services provided by the walk-in centre;
- the date that any review of walk-in centre services commenced or will commence;
- which commissioning body (or bodies) is leading or will lead the review;
- where walk-in centre services are under review, what other organisations are taking part or will take part in the review and in what role; and
- which commissioning body (or bodies) is ultimately responsible for deciding whether to continue to procure the walk-in centre or particular services provided by the walk-in centre (such as the registered list and the non-registered patient services for GP-led health centres).

The statement should be in plain language so that patients as well as providers have the opportunity to understand what is happening with their local walk-in centre.

We recommend that CCGs publish this information for all open walk-in centres, including those for which a review process is already underway or near completion.

Our purpose in recommending that commissioners publish this information is to help clear up confusion around commissioning responsibilities, and to encourage CCG and NHS England commissioners to work together to clarify their responsibilities. CCGs and NHS England commissioners will need to think about how and when they will take decisions about walk-in centres. CCGs may also need to gather information, such as the date of contract expiration from NHS England if NHS England holds the contract. CCGs should then post this information on pages of their websites that give information about walk-in centre services within their areas. This could be published on a CCG's website as a joint statement with NHS England local area teams or other local bodies.

We also recommend that the commissioning body responsible for managing a walk-in centre contract ensure that walk-in centre providers are informed of any contract review or other relevant developments (such as possible reconfigurations or changes in services under consideration) at least six months before expiration of the contracts. Six months' notice is sometimes required under contracts, but we are aware of instances in which providers have had no discussions with commissioners even though contracts were due to expire within a few months.

2.2. Ensure that decisions are joined-up

In addition to causing confusion, the split in commissioning responsibilities has created a risk that decisions are not joined-up and do not take into account the impact of changes in walk-in centre provision across local health care economies, affecting both primary and secondary care.

We recommend that CCGs and NHS England local area teams work more closely together to make decisions about the future of walk-in centres.

In particular, NHS England, as the commissioner of primary care, should work with CCGs to consider the effect of any potential closing or change to walk-in centre services (for both registered and non-registered patients) on primary care services in the local area.

CCGs should work with NHS England to consider the effect of any potential closing or changes to walk-in centre services (for both registered and non-registered patients) on other services that the CCG commissions, including urgent care services and A&E departments.

In addition, NHS England local area teams should work with CCGs to co-ordinate the timing of decisions about GP-led health centres. In some areas, we found that CCGs

have decided to close or reconfigure walk-in services for non-registered patients, while NHS England has not yet decided whether to continue the contract for the registered list element of the centre. This has left registered patients uncertain and concerned about whether their GP practice will be available in the future.

NHS England and CCG commissioners may also need to work with local authorities to make decisions about public health services where those types of services are offered at walk-in centres.

We encourage CCG and NHS England commissioners to reach decisions jointly about walk-in centres, both with and without a registered list. Currently, NHS England and CCGs can work together to make joint decisions, although these decisions need separate approval through the governance processes of each respective commissioning body if they relate to CCGs' functions.[18] For these functions, they might make decisions together, for example, by setting up joint working groups, as commissioners in some local areas have done.

NHS England and CCGs may also make joint decisions to exercise NHS England's functions, through a joint committee, without needing separate approval from each commissioning body. Whatever mechanism is used, it will be in patients' best interests for NHS England and CCGs to reach decisions jointly when considering the future of walk-in centres.

2.3. Involve local Healthwatch and health and wellbeing boards

To varying degrees, local Healthwatch and health and wellbeing boards are taking part in commissioners' decisions about walk-in centres. These organisations can bring valuable insight to the process and can help ensure commissioners' decisions are in patients' best interests.

We recommend that commissioners work with their local Healthwatch group to engage and consult with the public, and with their health and wellbeing boards to align their commissioning decisions with local joint health and wellbeing strategies for meeting patients' health and social care needs.

Healthwatch

Healthwatch was created to give patients a stronger voice in decisions about health and social services. We have seen some examples in which local Healthwatch groups have worked with commissioners to develop a public engagement and consultation plan as part of a review of walk-in centre services in their local area. Local Healthwatch groups have been commissioned, in some cases, to conduct patient surveys and sponsor public discussion forums. They have also helped to

[18] The Department of Health has proposed a change to the Health and Social Care Act 2012 that would allow CCGs and NHS England to make decisions by joint committee to carry out CCG functions. See Section 10 of our full report for further discussion.

make sure that commissioners have gathered views from all communities and patients that might be affected by changes in walk-in centre services, for example, by identifying and engaging with organisations representing particular groups in the local area (such as travellers).

Healthwatch may be able to play these roles at both the needs assessment stage and when commissioners are consulting or using another form of public involvement to put options before the public.

Health and wellbeing boards

Health and wellbeing boards began in shadow form in 2012 and became fully operational in April 2013. They bring together members of local authorities, CCGs, social care and public health officials, local Healthwatch and others involved in health and social care. Their primary duty is to encourage provision of health and social care services in an integrated way.[19] Most have produced joint strategic needs assessments and joint health and wellbeing strategies.[20]

We examined several examples of how health and wellbeing boards are involved in decisions about walk-in centres. We found that some commissioners are informing or consulting with the boards about their plans for walk-in centres or for urgent care more broadly. Some boards are playing a role similar to a local authority overview and scrutiny committee by trying to ensure that commissioners have a transparent and thorough process, and that their proposals will continue to meet the needs of patients. Others have been supportive of commissioners' proposals and have helped to sponsor public consultation.

CCGs have a duty to consult their health and wellbeing boards about their general commissioning plans.[21] As good practice, CCGs and NHS England local area teams should consult the boards on an ongoing basis about specific proposals to change walk-in centre services or urgent care services generally so that the boards can ensure that proposals are aligned with local needs assessments and strategies.

NHS England representatives are required to appoint a representative to health and wellbeing boards for the purpose of preparing joint strategic needs assessments and joint health and wellbeing strategies for delivering health and social care in an integrated way.[22] NHS England also must have regard to them when commissioning services;[23] however, NHS England local area teams are not required to have regular

[19] See section 195 of the Health and Social Care Act 2012.
[20] See R. Humphries, A. Galea, The King's Fund, *Health and wellbeing boards: One year on*, Oct. 2013, available at www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf.
[21] See section 14Z13 of the Health and Social Care Act 2012.
[22] See section 197(1) of the Health and Social Care Act 2012. Under sections 197(3) and (4), NHS England must also appoint a representative where the Board requests its participation to consider a matter relating to the exercise or proposed exercise of NHS England's commissioning functions.
[23] See section 116B of the Local Government and Public Involvement in Health Act 2007.

membership on the boards, as are CCGs. Where NHS England local area teams are not members, health and wellbeing boards should consider how the local area teams might participate in the board's consideration of proposals related to walk-in centres or urgent care more generally.

2.4. Work with local GP practices to improve access where problems are identified

Walk-in centres may be able to provide commissioners with information that will help them to identify GP practices that may have problems with access (or other problems). The centres usually track where their non-registered patients are registered if they are registered with a GP practice elsewhere.

We recommend that commissioners work with GP practices that have a high number of patients using a walk-in centre to identify and help to address any problems that may be causing patients to have difficulties accessing services.

In Section 7.1.1 of our full report, we give examples of how some commissioners have used information provided by walk-in centres to identify GP practices with access problems and work with them to improve access, including by better managing demand for same-day care.

2.5. Take steps to ensure that any changes are achieving the desired benefits for patients

We found, generally, a lack of follow-up information on the impact of walk-in centre closures. As with changes to any services, follow-up analysis can help commissioners determine whether patients' needs are being met. It can also provide information and insight to help others in the sector develop a better understanding of how well different models are working for patients within different local health economies.

We recommend that commissioners follow up decisions to close walk-in centre services with analysis to determine whether the changes are working for patients as intended.

This might be accomplished, for example, through the course of a regular evaluation or review of services commissioned to replace a walk-in centre; or it may be accomplished by doing an impact study on demand for other local services in both primary and secondary care. Commissioners may also seek further engagement with patients and other stakeholders. For example, if commissioners intended patients with minor conditions to consult GPs, NHS 111 or pharmacies, we recommend that they investigate the extent to which patients are doing so and how well those services are working for patients.

We also suggest that commissioners publish follow-up studies or reports on their websites to share with the sector.

3. Long-term work to make services work better for patients

Organisations across the sector are working to bring about changes that are likely to address some of the issues identified in our report, including the need to improve access to primary care, to clarify commissioning responsibilities and join-up decision-making, and to use payment mechanisms that create incentives that benefit patients. It is important that leaders of the sector ensure that this work results in a consistent, coherent framework for improvement that also allows local flexibility.

Improving access to routine and urgent primary care

Efforts are underway at the national and local levels to identify and support drivers of improvement and innovation in GP services and to help practices develop new models of care that are more responsive to patients' needs. These include:

- NHS England is developing a strategic framework for primary care services that includes plans for new models of primary care that will enable general practice to expand access and the scope of services on offer.[24]
- Monitor's call for evidence on GP services has been followed up with a discussion document, published in February 2014, which identifies key issues raised by stakeholders related to:
    - access and quality;
    - the ability of new or existing providers of GP services to develop the scope of their offer to the NHS; and
    - the ability and incentives of providers to work together to benefit patients.

  We have proposed further work for this year to support improvements in general practice, including examining the supply and demand of GP services to gain a better understanding of variations in access and quality across England and how these may be addressed.
- NHS England will soon begin overseeing at least nine pilots, funded through the Prime Minister's £50 million Challenge Fund, to test ways of improving access to appointments for up to half a million patients. The pilots will explore a number of ways to extend access to GP services to better meet local patient needs, including:
    - longer opening hours, such as extended weekday opening (8am to 8pm) and opening on Saturdays and Sundays;

[24] See NHS England, *Improving general practice: a call to action*, at www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/.

- greater flexibility about how people access general practice, for example the option to visit a number of GP surgery sites in their area;
- greater use of technology to provide alternatives to face-to-face consultations via phone, email, webcam and instant messaging;
- greater use of patient online services, including online systems of patient registration;
- greater use of telecare and healthy living apps to help people manage their health without having to visit their GP surgery as often; and
- greater choice of practice.

- The 2014/2015 general medical services (GMS) contract will potentially lead to greater choice for patients by allowing GP practices to register patients from outside their catchment area without responsibility for home visits. The contract also requires practices to promote and offer all patients the ability to book appointments online, order repeat prescriptions online and access their medical notes online.
- The Department of Health has also recognised that vulnerable and disadvantaged groups still face barriers to accessing primary care, and is working to develop better models of care for these groups.
- Beyond general practice, as noted in Section 3 of our full report, NHS England's Urgent and Emergency Care Review is working to develop a framework for urgent care designed to reduce confusion about where to go for care and to ensure access to high-quality urgent care 24/7.

Making responsibilities clearer and joined-up commissioning easier

Confusion around responsibilities and a risk of fragmented commissioning is not limited to the provision of walk-in centres. The Department of Health is proposing to use a legislative reform order, subject to Parliamentary approval, to create the ability for CCGs to make joint decisions through a joint committee with other CCGs and for CCGs to make joint decisions through a joint committee with NHS England in areas that are within CCG functions.[25] This could facilitate, for example, joint decisions about walk-in centre services.

Further, NHS England, in its Urgent and Emergency Care Review, is considering the appropriate size of commissioning footprints over local health economies. Its intention is to bring together a network of actors within each local footprint to facilitate joined-up decision-making that is based on a local system-wide view. In its

[25] See the Consultation on a proposal to use a Legislative Reform Order to make changes to the National Health Service Act 2006.

planning guidance, NHS England has asked commissioners to identify how they will "be ready to determine the footprint of your urgent and emergency care network during 2014/15".[26]

Using payment mechanisms to generate incentives that lead to benefits for patients

Under the Health and Social Care Act 2012, Monitor and NHS England share responsibility for setting prices within the national tariff payment system. As part of these responsibilities, Monitor and NHS England are working to improve payment mechanisms for urgent and emergency care services. This includes trying to better understand the costs of providing these services.

NHS England and Monitor have also pledged to work together to ensure there is a coherent payment system for both primary and secondary care, particularly for emerging new models of delivering integrated care across primary and secondary care settings.[27] This is an issue that we will continue to consider with NHS England as we develop our long-term strategy for the payment system.

[26] NHS England, *Everyone Counts: Planning Patients 2014/15 to 2018/19*, p.30.
[27] See *The 2014/15 National Tariff Payment System*, p.8.

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

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About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Find out more at www.monitor.gov.uk

Responses to our preliminary report

This document contains non-confidential responses to our publication *Walk-in centre review: preliminary report* (November 2013).

We have published these responses with permission but have removed text which was identified as being confidential. We have also removed names where the author wished to remain anonymous. Removal of content is indicated by this sign: [✂]

Please click on items in the list below to jump to the submission(s) you require:

You can view all the documents related this walk-in centre work, including the final report (February 2014), on our website.

From: John Dale, Ideas 4 Use

I believe this is another labour bashing move by the government.

Walk in Centres do a wonderful job and closing them will have another unwelcome impact on A&E. A&E figures are still rising and they are under strain as we go into the most busy time of year. Closing WIC's will impact on this to the detriment of the hospitals.

From: Brenda Dawson

How is it that some walk in centres are only open when the gp surgery is open and not weekends at all

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From: Jayne Heaney [speaking in a personal capacity]

Dear Sir/Madam

As a patient, a carer and a healthcare professional I cannot stress too strongly how important walk in centres are to the effective provision of healthcare in the Merseyside area.

As a service user they are my first choice because they are perfect for my needs and those of my family and are open *and happy to receive us and treat us in a timely and caring fashion* when we have urgent unplanned needs for advice, investigation and treatment - which GPs are often not, and attendance at A&E is unnecessary (and the wait is usually too long and staff too stressed).

As the Emergency Planning and Business Continuity Manager for a large DGH and Burn Unit I know that coordinated planning with the local walk in centres provides the Trust with effective back up and resilience in times of crisis and excessive pressures and helps to keep A&E/ hospital attendances on a normal day a lot lower than they would otherwise be.

Without the walk in centres there will be no contingency back up or resilience in the whole healthcare economy when pressures increase or a major emergency incident occurs. (e.g. They take our minor injuries when we receive Major Incident casualties and stay open longer and run Radiology longer in coordination with us when there is a problem with utility failure, etc).

GPs cannot take any more pressure and commissioners will overload them if they stop funding and close walk in centres which are run very effectively by Community Health Service Trusts. I know there is a shortage of funding but I really feel from

every aspect the walk in centres are the solution and not the problem. It is not duplication it is health provision the way it should be.

[✂]

From: Ken Holton, Holbrooks Health Team (1)

Sir,

Monitor press release is not accurate about cost-effectiveness in the NHS.

Walk in centres were supposed to cost £13 per contact when they were set up in 2004, in fact the lowest cost per contact was double that, with the highest costs around £62 per contact. From the start they were costing more per contact than GP surgery contacts with GPs (£19) and nurses (£14), despite taking the easiest cases. Patients with long-term conditions, or requiring referral, take about 70% more time than people walking in with minor infections and injuries. The operational brief for walk-in centres when faced with a complex patient was simply to redirect them to somebody else. So they were, and are, doing easier work for double the price. Exactly the same scenario occurred with the removal of out of hours care from GPs. The costs doubled.

If, instead of investing in yet more infrastructure, the additional staff were simply seconded into existing facilities, the NHS would have saved some of the cost. This argument is still true. I agree that the funding needs to be revised to make walk-in-centres operate on the same level as general practice. The walk-in-centres would not receive QOF, or DES, since that is voluntary and in any case relates to long-term-conditions (which walk-in-centres do not treat) so the average funding available to walk-in-centres would halve, and that would be much more fair.

Monitor research does not account for selection bias and response bias in the reported user responses.

Our practice has analysed responses from service users of emergency departments and walk-in-centres. If you ask these users WHY they attended <u>when they are attending</u>, they will report that it is because of difficult access to primary care. However, if you contact them from the practice, explaining that the enquiry is from the practice, they do not give this answer. I attach the latest analysis from our practice (we have been doing these every few years since 1989) and on page 5 you will find a chart relating to WIC attendance for the year. At any one hour, this equates to approximately one attendance every 6 months. The idea that this is caused by poor access to primary care is preposterous. On page 7 we analysed how many days of the entire year it had not been possible to obtain an appointment AFTER attendance at ED, and on weekdays this was only bank holiday Mondays. On page 8 there is a chart showing how long a patient would have had to wait for the

next available appointment in GP after they walked in to WIC or ED – for the majority it is less than an hour – the longest waits relate to attendance between mid-night and 07:00. On page 9 there is a chart showing attendances out-of-hours, which you can see amounts to approximately 1 per hour over the year. It is not economically feasible to open a general practice for that sort of number. Undoubtedly more than 1 per hour would attend, but this does not equate to need, and therefore one should question if this is good expenditure of limited resources simply to provide convenience. It is the long-term-sick who are disadvantaged by dilution of the service.

I hope you find this helpful. We do have a vast amount more information if you would like to see it (for example, that walk-in-centres only attract users from the immediate vicinity, but the rate of ED use in that vicinity is not reduced by the presence of the walk-in-centre).

From: Ken Holton, Holbrooks Health Team (2)

As promised, here is the analysis we did a couple of years ago [Monitor note: this is inserted below]. The walk-in-centre is shown schematically on pages 8 and 9 for the self-referrals to ED and the discharges without treatment from ED.

In both cases you will note that the take up of ED services is actually higher from residents around the walk-in-centre than from some areas that are equidistant from the emergency department.

The schematic does show some areas with very high use of ED and these are mainly those closest to ED.

I have asked [✂] if he can find the analysis we did of actual WIC attendance, however this shows an uptake almost exclusively along the North-South road on which the centre is based. The uptake from areas which also use the ED excessively are generally lower than districts that are equidistant from the walk-in-centre. This shows that whatever market the WIC is supplying, it is not based on acute medical need, nor is it reducing misuse of the Emergency Department.

In Healthcare we have a paradigm of demand for services compromising the ability of the service to meet the need of those who have greatest need for medical care. Walk-in services do not appear to mitigate the effect of demand, and because they cost more and are generally not well situated for the benefit of most of the population, they are not a good solution.

We currently have a secretary of state who appears to be unable to distinguish between need and want, and cannot comprehend how diluting the available resources over even more hours is detrimental to continuity of care for those who actually need it most. It is not unreasonable to propose that walk-in services could solve the problem of demand, but to my way of thinking, the provision of walk-in

access needs to be a parochial solution, not an institutional provision such as walk-in centres.

If I can get hold of the actual attendance data for the WIC, I will send that too.

Unscheduled attendance

An analysis of current patterns

January 2011

K M Holton & J Clinton

Contents

Acknowledgements

These statistics and graphs have been prepared from information supplied by the following:

Introduction

In the year 2009-10 there were 20,511,908 unscheduled care attendances of which 15,489,615 were to accident and emergency departments[i]. Of these attendances, approximately 80% were deemed to be inappropriate, indeed 3% of attendees leave without being seen[ii].

Men account for 52% of attendances[iii], compared to appointments in primary care for which they account for only 31%[iv].

NHS Coventry has an attendance rate slightly above the regional average and considerably below the national average. The patterns of attendance are similar in Coventry to the patterns nationally.

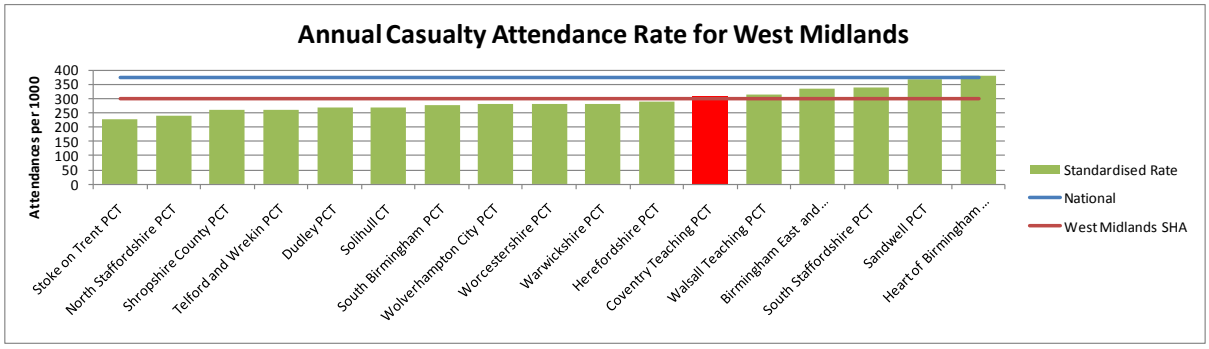


Figure 1 Casualty attendance Coventry compared to West Midlands

Peak attendance is on Monday mornings at 10:00 a.m.

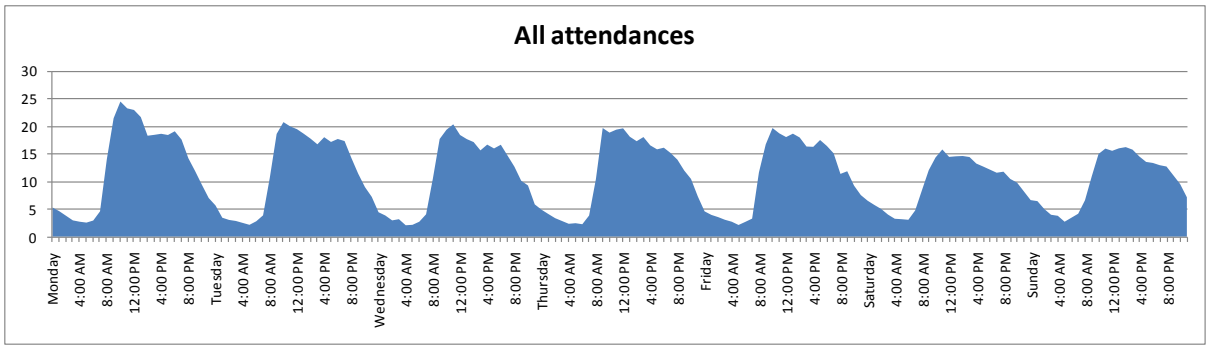


Figure 2 Casualty attendance pattern by day and hour

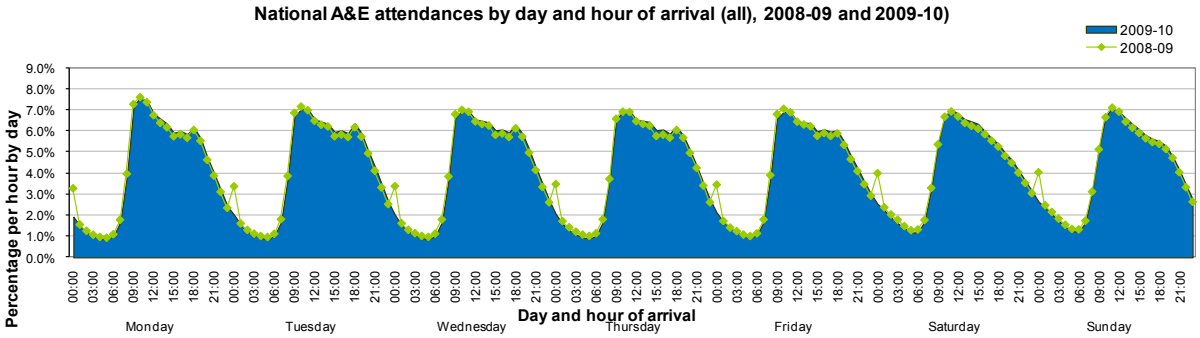


Figure 3 HES data for National Casualty Attendance pattern

There is a different pattern at weekends with fewer attendances overall.

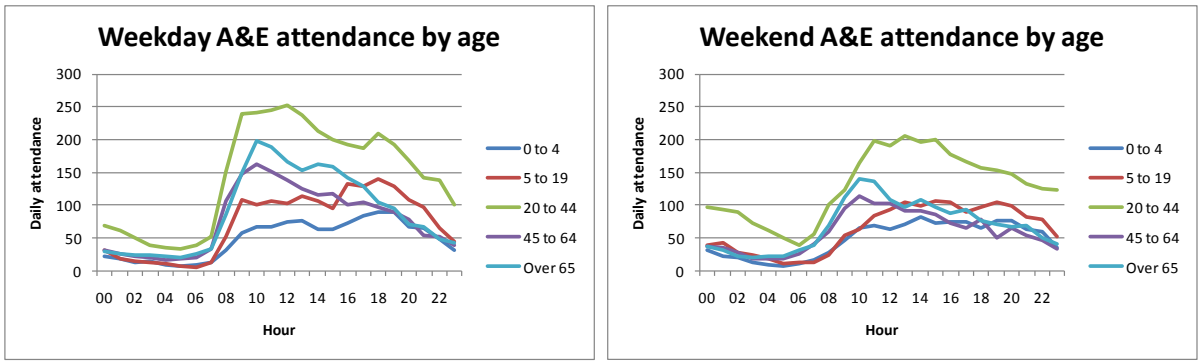


Figure 4 Comparing weekday and weekend attendance by age

Note that children show a peak in the late afternoon on weekdays and all other age groups show a peak in the morning, with the 20-44 age group also showing a relative increase between 9 and 11.

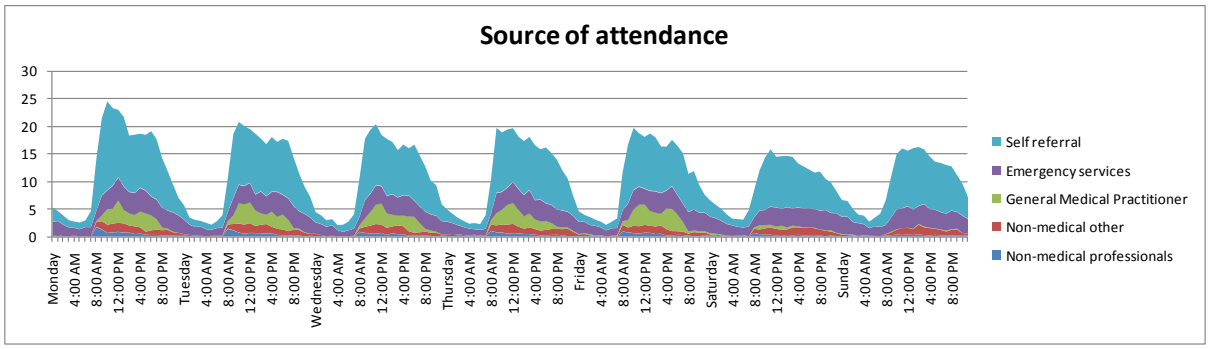


Figure 5 Source of attendance by hour and day

The cause of the increased attendance on weekdays and particularly in the morning appears to be partly GPs and partly self referral.

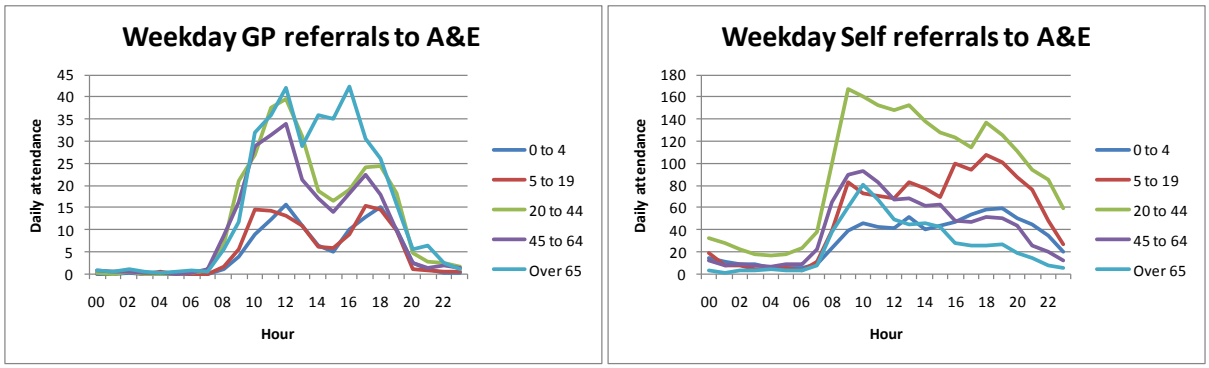


Figure 6 Pattern of GP and self initiated weekday A&E attendances

Both GP initiated and self-initiated child attendances increase in the afternoon. The rise is less at weekends. This may be due to the ability to obtain an immediate GP opinion.

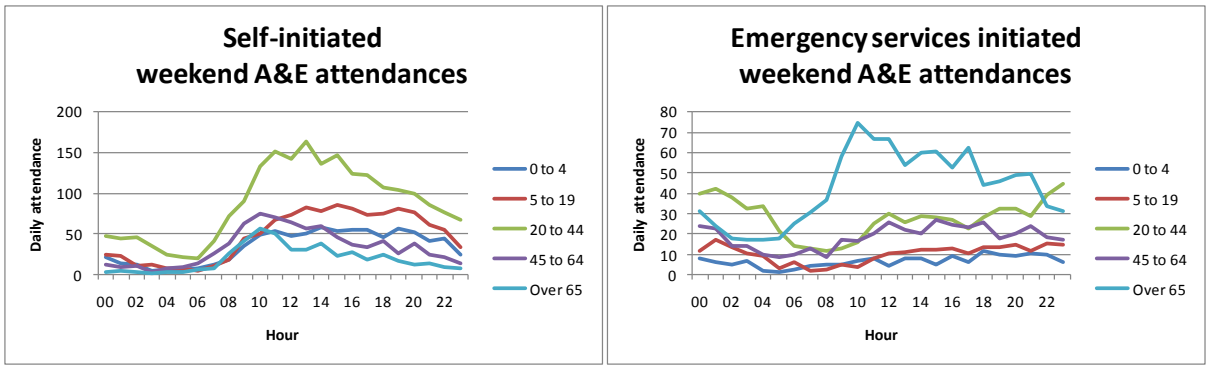


Figure 7 Weekend attendances by hour and source

The absolute number and proportion of all groups except over 65 rises with time for emergency service initiated referrals, however this is less than the fall with time of self-initiated referrals. The pattern for all groups except children is similar to weekend self-referrals and with the exception of 20-44 year group is also of the same magnitude on average. It may be that the relative rise in self-initiated childhood attendance on weekdays is related to the availability of primary care services.

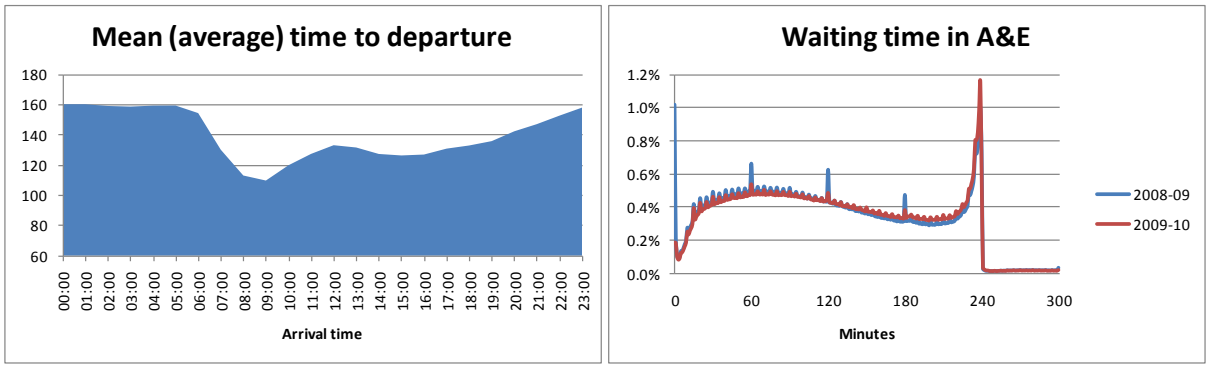


Figure 8 Waiting time in A&E[v]

The peak activity in A&E coincides with the shortest average waiting time, although this is still around 2 hours[vi]. From midnight until 06:00 the average waiting time is 4 hours. The waiting time does relate in part to the disposal with non-treated patients leaving earlier.

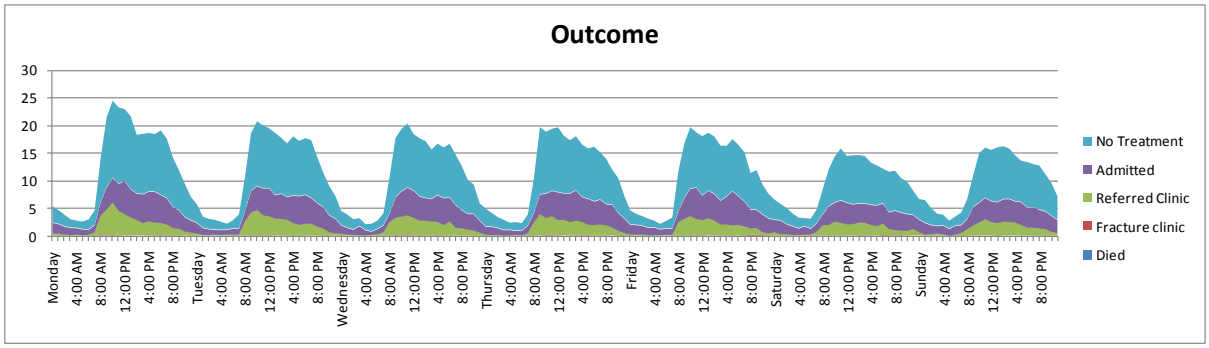


Figure 9 Outcome of A&E attendance

Admissions occur at a relatively even rate through 24 hours.

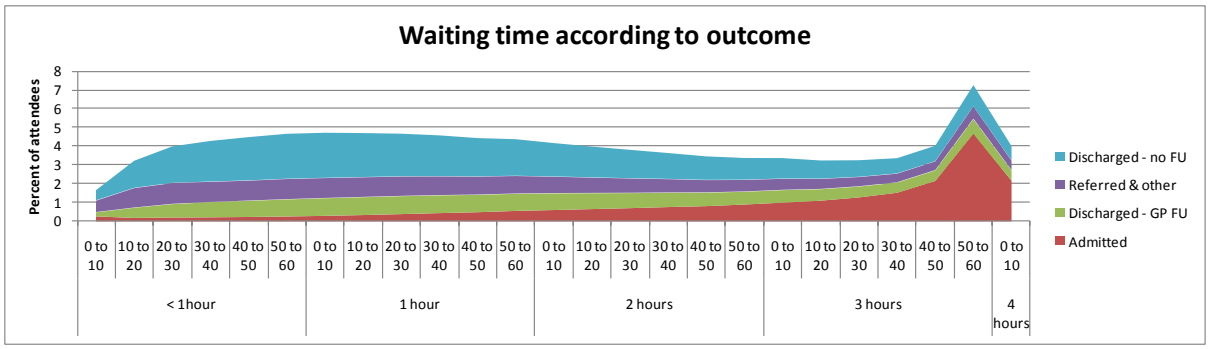


Figure 10 Waiting time according to outcome

This illustrates what may be a problem: patients are able to get an opinion in less than an hour and if this also requires investigations, the waiting time is usually less than two hours. Providing a rapid assessment, even if this is to advise that no medical treatment is required, may be stimulating further attendance.

Mode of attendance

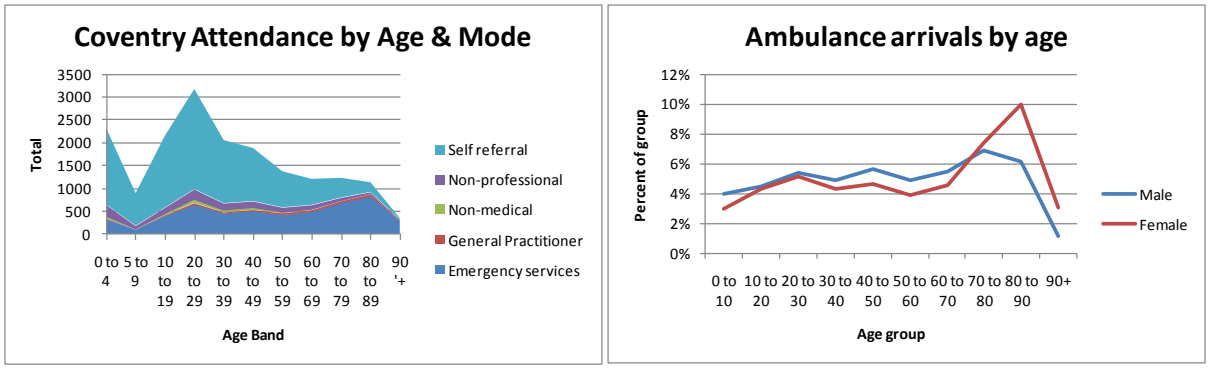


Figure 11 Attendance pattern by age and mode of arrival

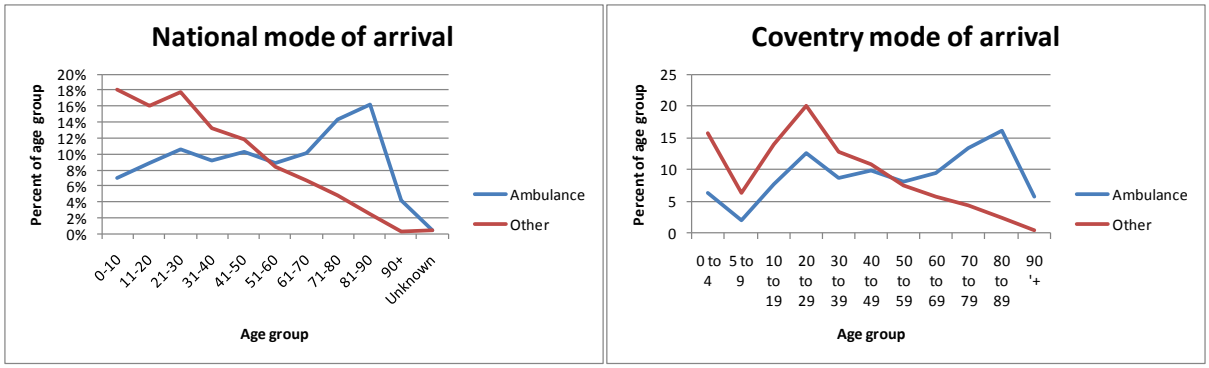


Figure 12 Comparing mode of arrival by age[vii]

Note that Coventry 1 to 9 figures are subdivided into 2 categories.

Outcomes

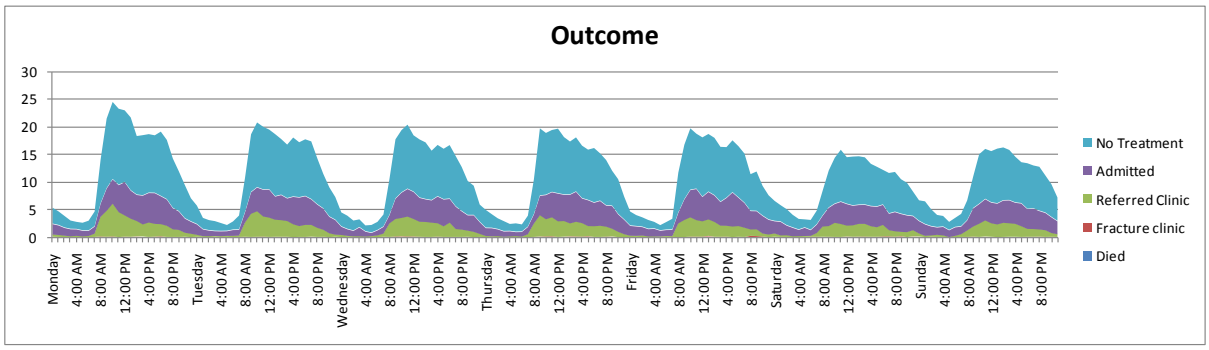


Figure 13 Outcome according to day and hour

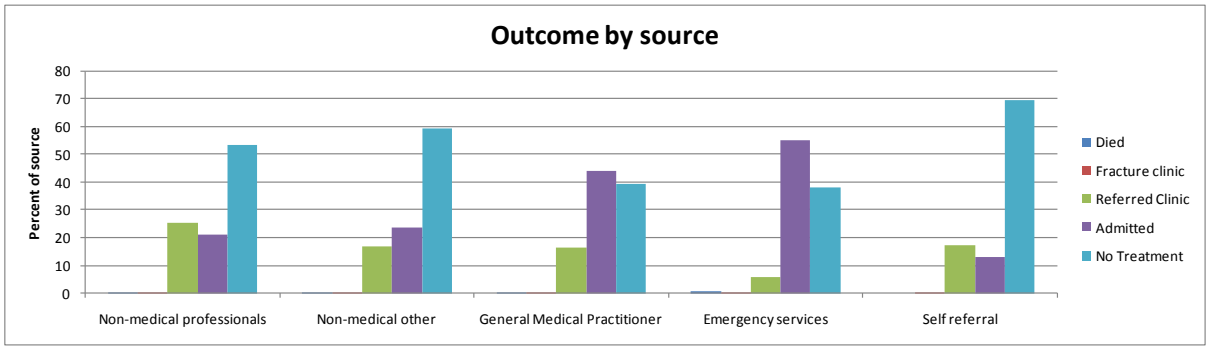


Figure 14 Outcome according to source

Treatments

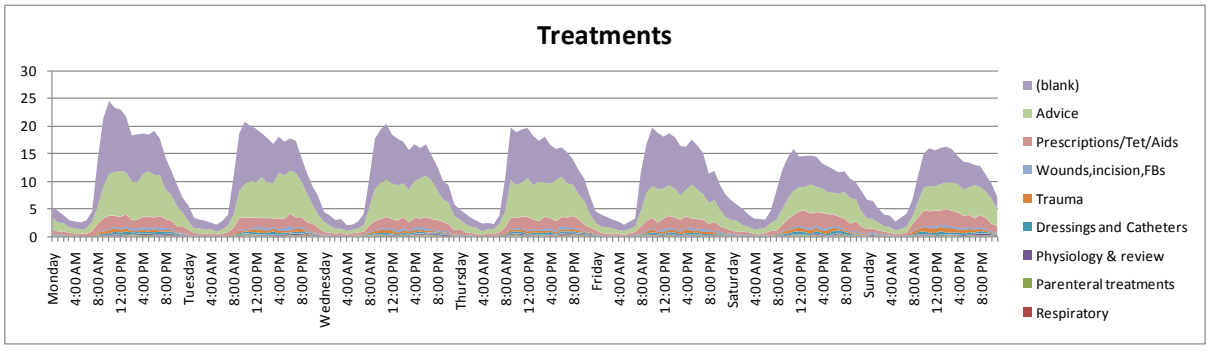


Figure 15 Treatments according to time of day

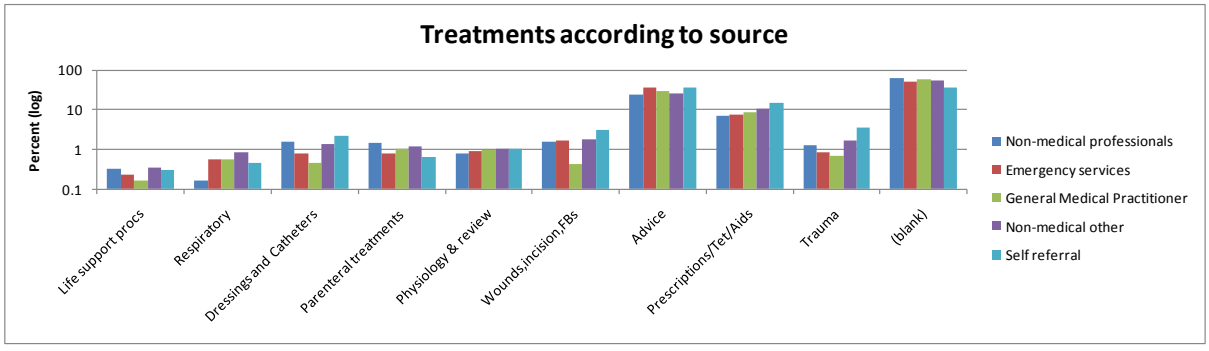


Figure 16 Treatments according to source

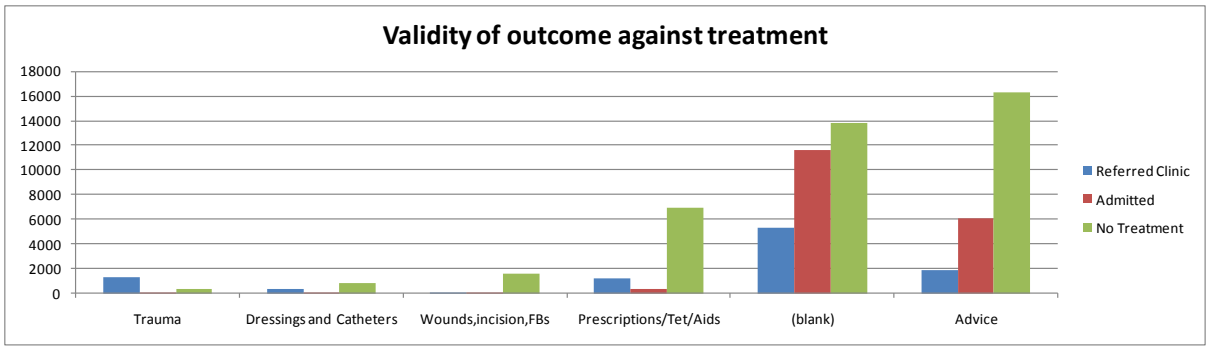


Figure 17 Comparing reported treatment against outcome

GP and demographic factors

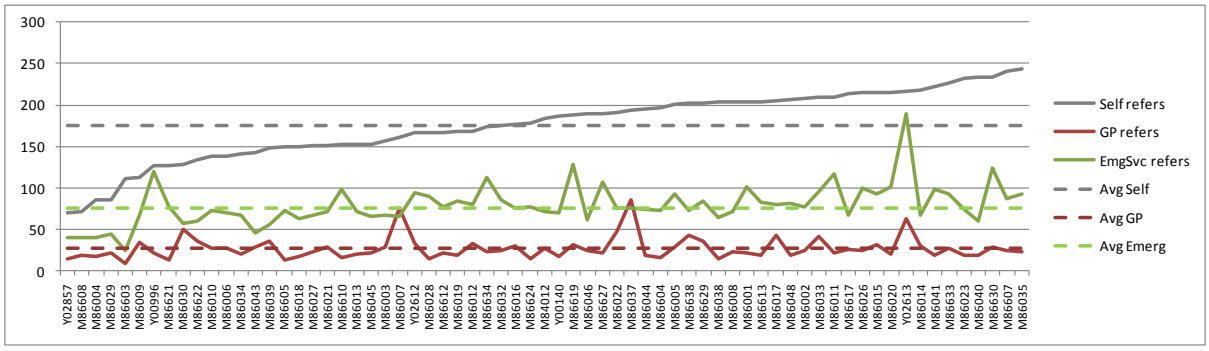


Figure 18 Patterns of referral by practice

Note the red line is GP initiated referrals. The 3 high referring practices are also visible in the following charts.

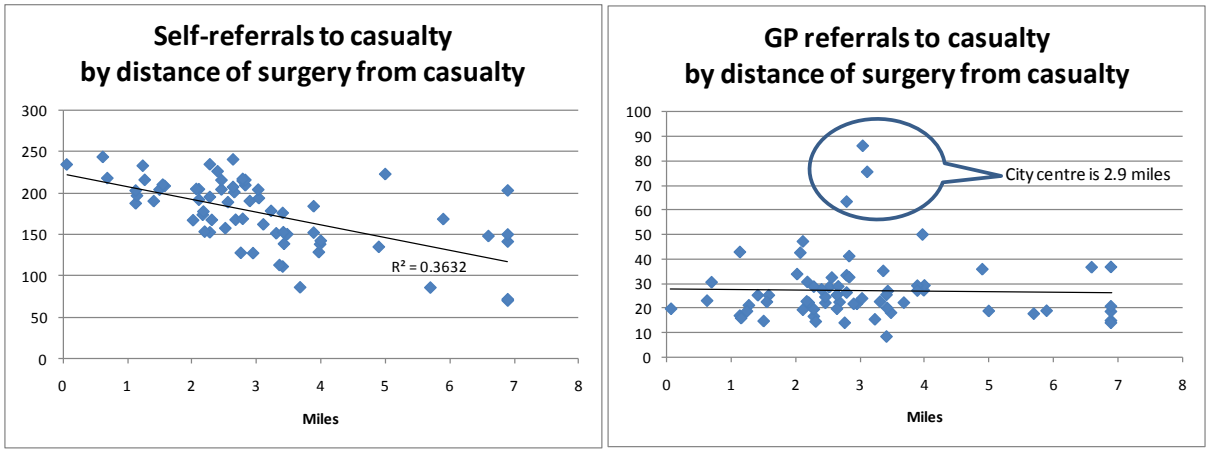


Figure 19 Self referrals and GP referrals according to distance from casualty

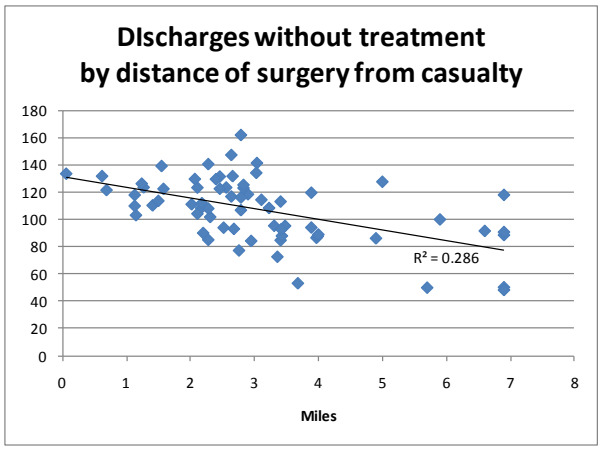


Figure 20 Discharge without treatment by distance from casualty

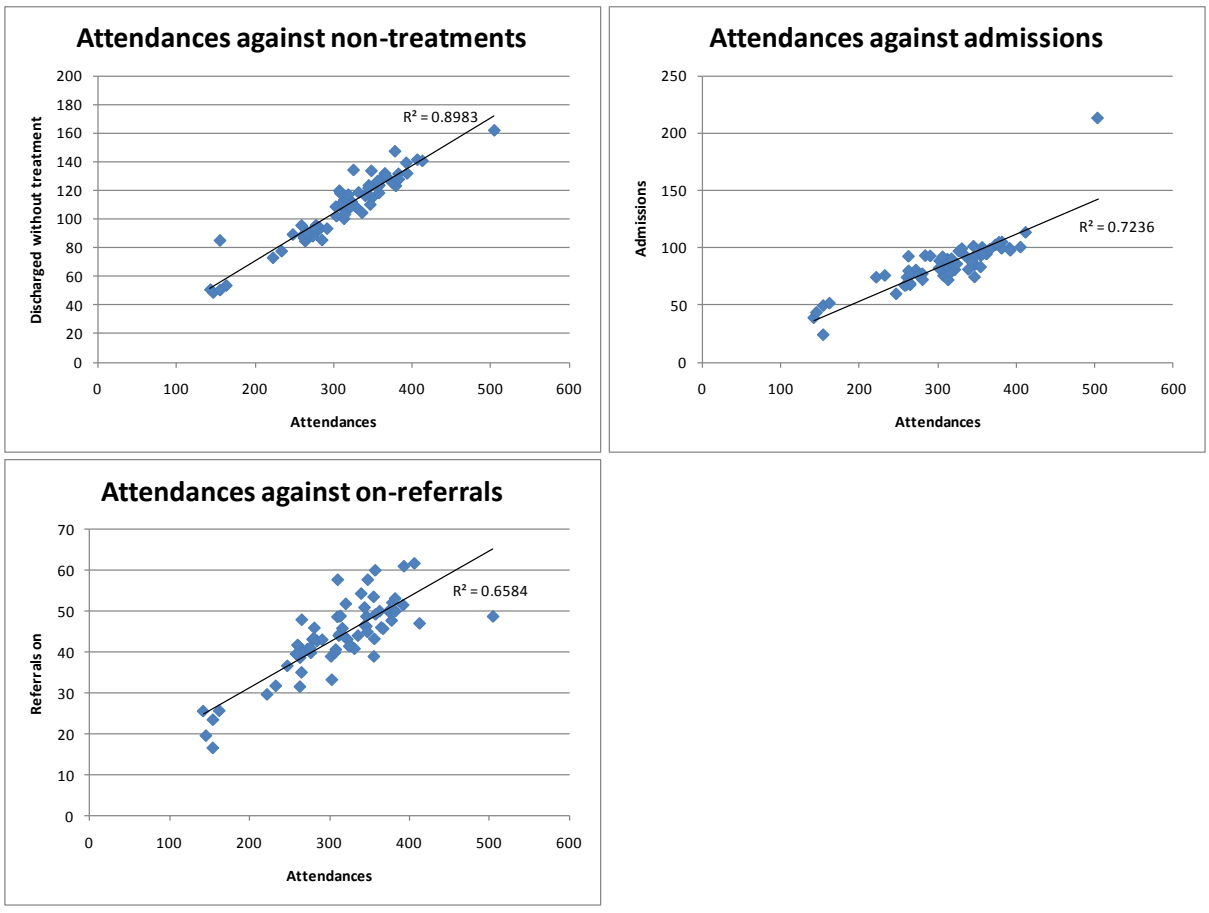


Figure 21 Practice level outcomes against attendance rate

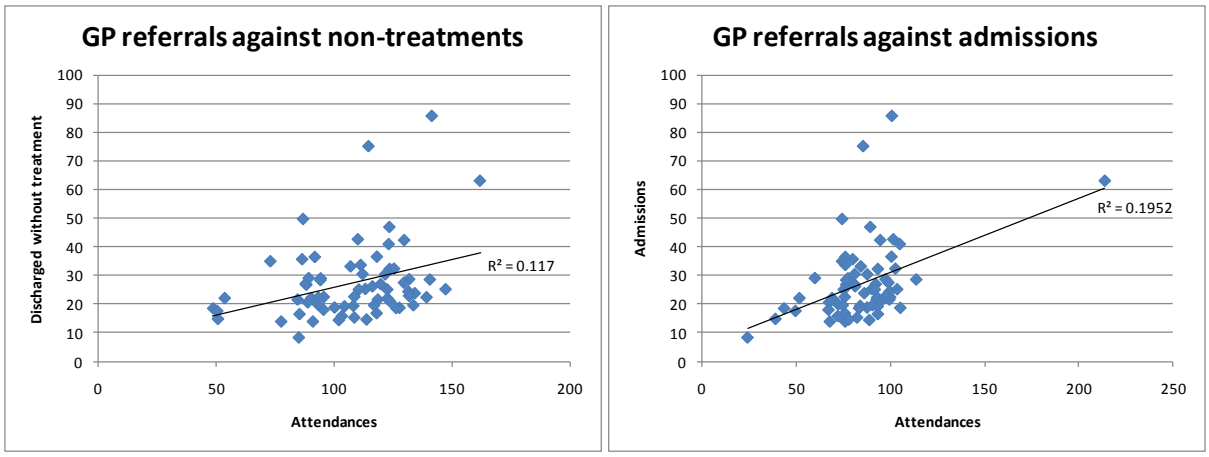


Figure 22 Admissions and non-treatments for GP initiated attendance

Thematic analysis

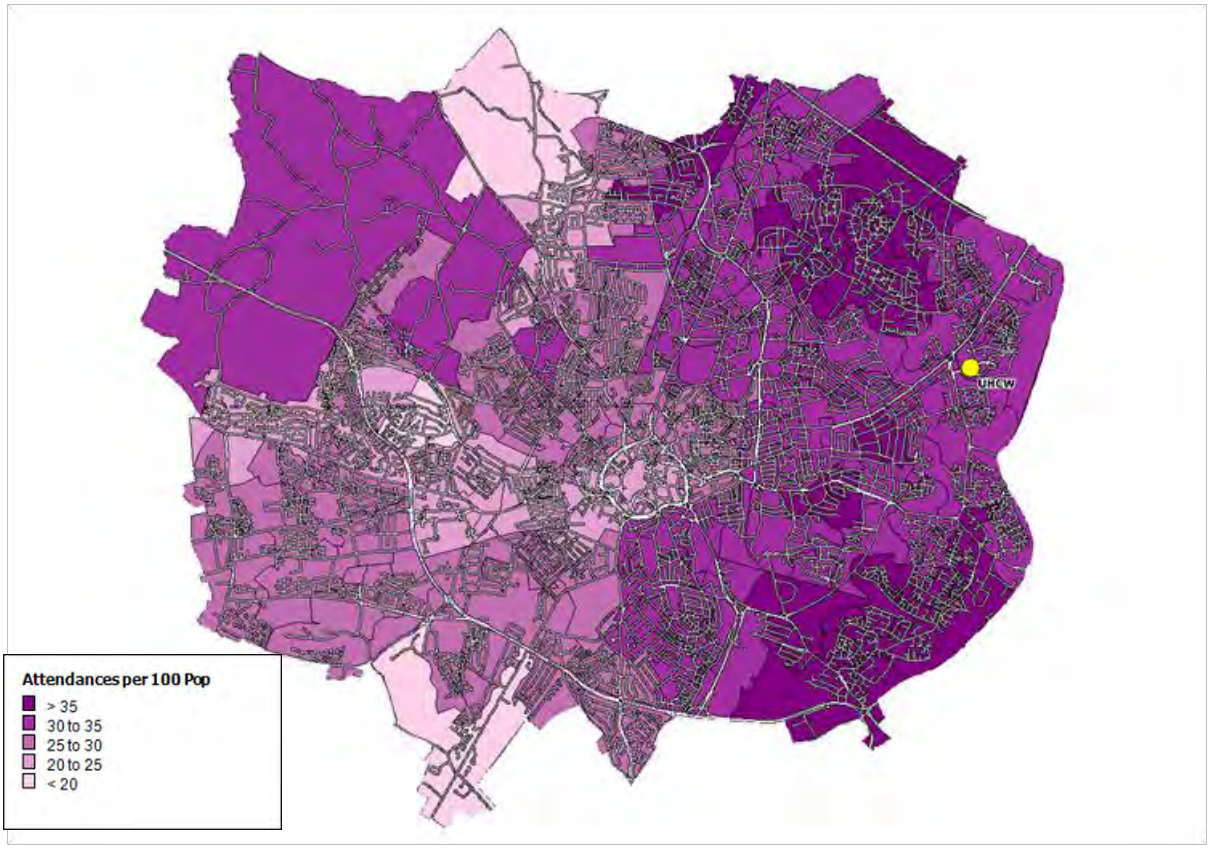
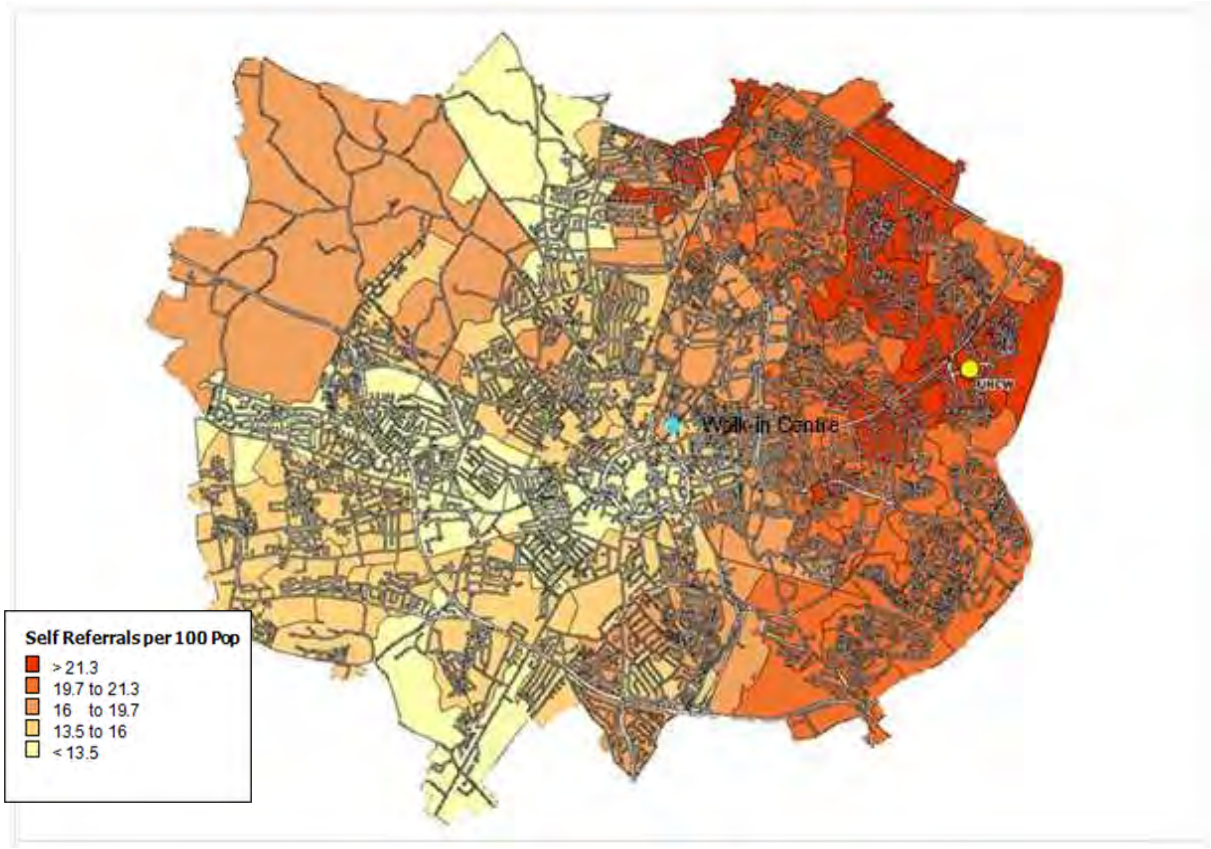


Figure 23 Casualty attendance by ward of residence

Figure 24 Self referrals by ward of residence



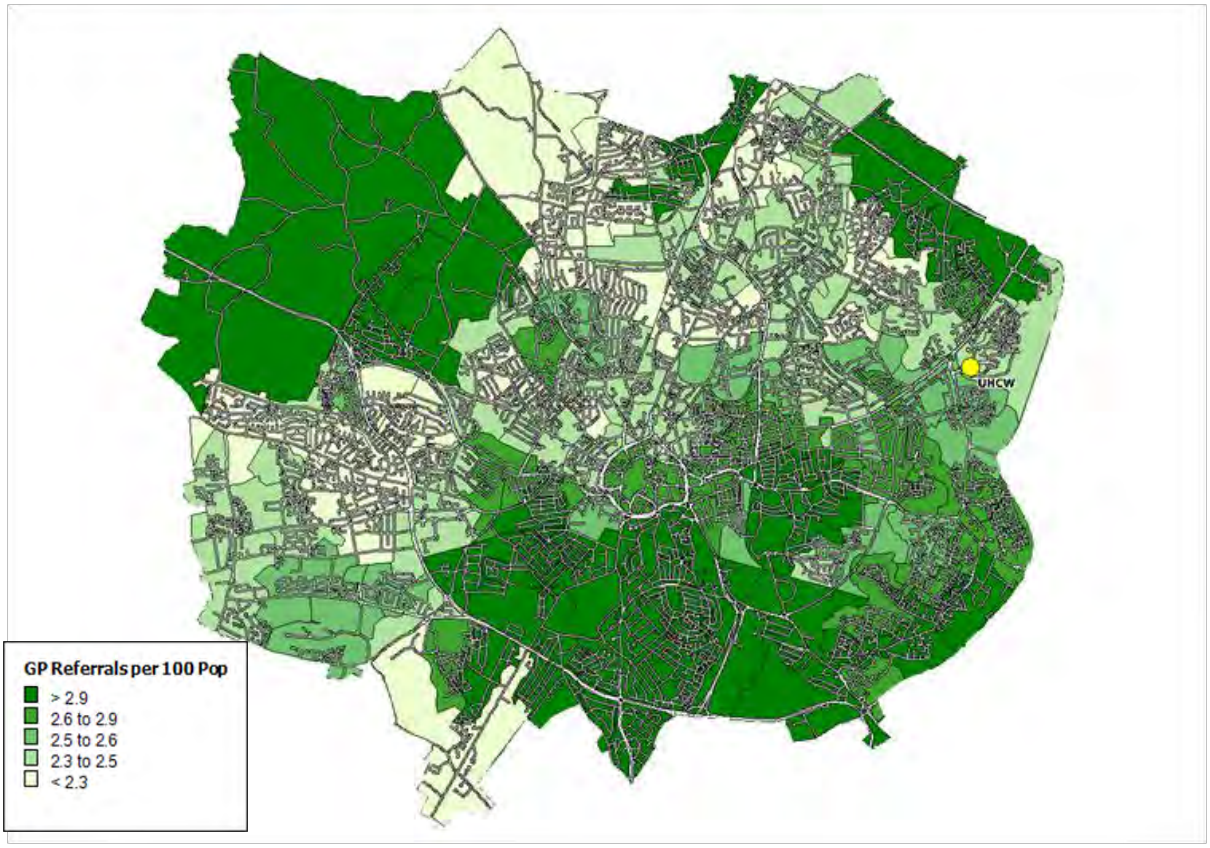
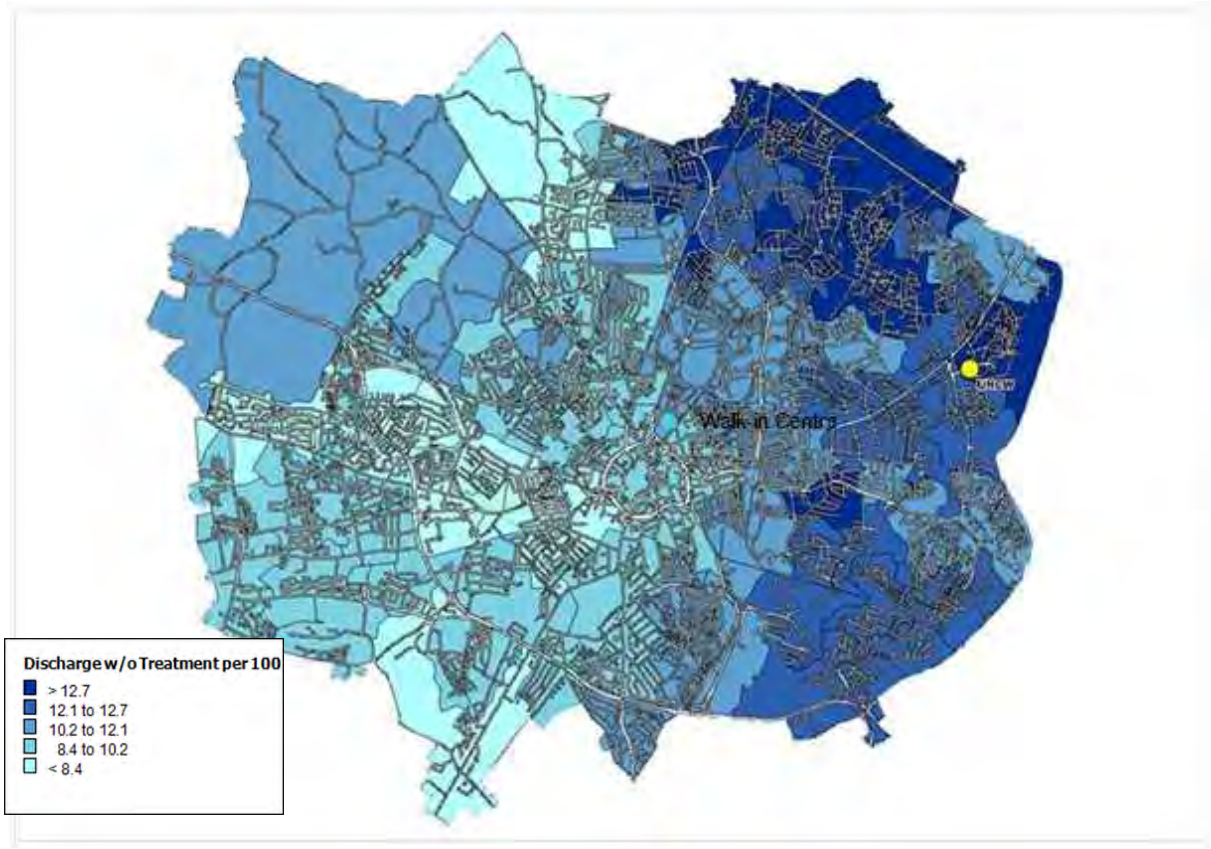


Figure 25 GP referrals by ward of residence

Figure 26 Discharge without treatment by ward of residence



Sources not referenced within text.

All other sources are those compiled by Jon Clinton and Ken Holton

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[i] Source The Information Centre.
[ii] Source HES-on-line
[iii] Source HES-on-line
[iv] Source Holbrooks-Health-Team
[v] Source HES-on-line
[vi] Source HES-on-line
[vii] Source HES-on-line

From: NHS England Midlands and East Regional Commissioning

NHS England Midlands and East Region welcomes the excellent and comprehensive Monitor Walk in Centre Preliminary Report which captures the many and complex issues and challenges involved in commissioning and reconfiguring these services. We also recognize the value that the report has in engaging stakeholders in the debate and potentially involving stakeholders in solutions to these challenges.

We particularly recognise and agree with the advice for commissioners to:

- Assess and consider the needs of vulnerable patients when considering reconfiguring these services
- Ensure an integrated approach to Urgent Care so that any WiC reconfiguration does not destabilise other part of the system
- Take an approach that is transparent particularly where there may be conflicts of interest

However, we also consider that the primary payment mechanisms for WiC arrangements do lead to duplication of payment for some primary care services and we are repeatedly informed by Patients that the combination of Out of Hours, Walk in Centre, GP Services and Accident and Emergency leads to Patients being confused where to attend and when. Therefore, as and when these service contracts are reviewed these issues as well as the wider health inequalities must also be considered by Commissioners.

In particular, NHS England Midlands and East Region would wish to continue engaging with Monitor in understanding the views it has independently received so we can achieve the best solutions to the challenges outlined in this report.

Once again thank you for producing a first-rate report which will help guide Commissioners in their decision making.

From: John Noton

With regard to the comments about your report some observations from a practice manager

1. Men of a working age seem to use these more frequently possibly as they have to get advice when they are not working
2. Convenience, people some times use these as they are more convenient but it does duplicate provision

3. Being too easily available means people may not choose advice from pharmacies regarding viral illnesses and IT INCREASES THE DEPENDENCY CULTURE

4. They struggle to staff them and often end up using many different locums, this sometimes means the quality of the care and safety can be in deficit

5. We need to encourage individuals to take ownership of their health and increase the focus on prevention not availability

There is a role for these but not so if we move to 7 day 12 hour availability of primary care as being sought by the government, they may be better for big cities or something equivalent in primary care

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From: Helen Osborn

Comments on re view of WIC

1- Reasons for closing WIC usually pragmatic and based on VFM and avoiding duplication of services. Walk in centres were initially centrally funded and were set up in parallel to other services as a “must-do”

2- Wider issues of primary care funding and contracting are touched on, but without reference to the need to plan ahead for our increasing elderly population with many LTC including dementia. Managing appropriately people with LTC and urgent is a high priority in sharp contrast to current role of WIC dealing on the whole with minor self- limiting illness.

3- CCG best placed to manage future of WIC in order to make better use of them and ensure address high priority needs of local population with input from AT for those WIC providing predominantly primary care service for registered population

4- Payment mechanisms for WIC and primary care do not currently work- Primary care is becoming overloaded with the need to address LTC and Urgent but with no additional investment. WIC currently dealing with low priority work which does not represent good value for money

5- Current work carried out in our local WIC is if low value and would be better managed by self-management , community pharmacist or primary care

6- Ease of access of WIC valued by those attending but in these days of austerity this seems a luxury which can no longer be afforded.

7- WIC could be re-commissioned by CCG to provide services which help to meet the high priority needs of the population eg urgent care and LTC

8- Priority should be to develop good supporting services to manage our elderly population with LTC, improving communication between services and avoiding fragmentation

9- I am not convinced that market forces have a part to play in the current economic climate with reduced opportunities for profit margins

10- Procurement, Patient choice and Competition regulations are cumbersome. This has fostered fragmentation of services rather than integration as parts of services are put out to tender. Procurements exercises are also very time consuming and expensive with the added complication of seeking more expensive legal advice about how to avoid a possible challenge- Not the way to go if we are looking to develop integrated services

11- In terms of patient choice- when are we going to have an open public debate about how much can we afford to spend on health care? And what is the NHS going to stop providing?

From: Malathi Reddy

The findings of the review was informative. Service configurations have become so complex that the only thing which appears to be functioning for the convenience of the patient are the walkin centres. It would be useful however to have some accountability and to continue to support these services.

From: Zena Wigram

Dear Sir

It seems that commissioners / DoH / NHS England / whoever is in charge (who is in charge?) aren't at all sure what the NHS is for, let alone what walk-in centres are for. If the NHS is to treat people's health, to make people who are ill better and people who are well stay well, then it's very odd that a walk-in centre should be closed because it's too popular: too many people are getting the health treatment that the NHS was set up to offer. What? While others are closing because not enough people use them (was there really no demand at all in that area or are the people in that area just going to A&E? Just spreading TB or AIDS or whatever because they can't get treatment at all? Or they're all super-healthy there?). It's much cheaper if people who are disempowered and not registered with a GP are sick outside in cardboard boxes and don't have any access to healthcare, rather than paying to have a centre where they could be treated.

This seems symptomatic of the whole problem with the new-look NHS: no-one is sure what should be done, let alone who should be doing it. Dividing things up into little bits (commissioners, providers, GPs, Monitor, CQC, NHS England, CSUs) means that everyone wants to meet their own separate targets, in the short term, and no-one is taking the longer-term whole population view. It used to be that there was a battle between social services and the NHS over who should pay the bills to support very elderly people who needed support to stay healthy at home. Now we have battles between all the divided up NHS people over whose responsibility those elderly people are. Is it Monitor's fault, or CQC's fault, or NHS England's fault, or the CCG's fault if they're sick in hospital and don't get proper care? Or perhaps the nurses' fault - but there are so few nurses with so many posts unfilled, that makes it no-one's fault. Someone, somewhere will do an inspection and write a report sometime. So that's OK then - tough luck on old Mrs X, of course, but no-one's fault or responsiblity.

And if a mother with a child sick on a Sunday goes to A&E instead of a walk-in centre, that's A&E's problem not the CCG's problem, or the local authority's problem, and she could just sit in A&E for six hours among the drunks, but that's not their fault or their problem, so that's OK then.

I suggest the solution is to fire all the politicians and fat-cats making a mint out of the health service and bring back a single commissioning and providing group, which is paid on the basis of how many people are healthy, not how many people are sick and seek treatment. I'm currently well and healthy, but I despair of what will happen if I get run over in the street, let alone get a major long-term condition, because the NHS is crashing down about our ears, and all we get are reams of reports and a lot of political hot air about what great improvements have been made and how good the system now is.

From: Babs Williams

Invest in WICs, allow CCGs to own and commission them to fit with local needs. Allow CCGs to develop services offered in them.

Give them **time** to get established and work.

From: [✂]

Hello

Please don't close the Shrewsbury WIC. In my previous job I had to start living away during the week. I left home at 6am on Monday and returned late on Friday evening, which was an incredibly stressful arrangement. It was such a relief that I could become a registered patient at the WIC (I don't know if all WIC's are also a normal GP practice). Without this service which has weekend opening I would literally not have ever been able to go to the GP without taking a whole day's annual leave on a Monday or Friday. Patients are not allowed to register at two GP surgeries, so I couldn't even have registered with one at home and one where I worked.

Thankfully I now work in Shrewsbury but work is stressful enough without trying to fit in GP appointments during work time, so it is such a relief to be able to go in the evenings and weekends.

Why close WICs at the same time as suggesting 7 day GP opening? The idea for 7 day GP opening will not be an effective substitute for WICs - it's only a pilot and it won't end up being widespread due to lack of GPs, lack of money, etc.

From: [✂]

Walk in centres deal with two ends of the population spectrum - those who work hard, and pay most of the taxes in this country, but who do not have the time to spend all day on a phone trying to get a GP appointment, and those at the other end, often vulnerable people whose more chaotic lifestyle prevents them from making and keeping appointments, but who need good primary care more than many who take up most of the GP appointments.

Visit any GP surgery and see who is sitting there waiting for the appointment that they had the time to make - the elderly (but not the ones that are causing the ED pressure) and middle class mothers with young children - both groups probably need care, but possibly not as much as they get.

What do GPs do all day - measure BP and cholesterol, tick boxes for their QOF points, but does that activity actually give improved outcomes - not as much as are needed? They are not addressing the inequalities in outcomes that are widening in the UK, or preventing the relentless rise in ED attendance and hospital admission.

The system must change if the NHS is to survive, we must address inequalities and GPs and walk in centres can both be part of that solution, but it needs to be properly planned, with service provision based on population need and not demand.

Having moved Public Health away from the NHS, I'm not convinced they can influence commissioners as they need to. Commissioners are led by GPs who have a vested interest in keeping general practice as it is. Public health consultants have no axe to grind and are trained to assess population need, evidence of effectiveness and to evaluate outcomes of services, but are rarely allowed to follow through such a cycle to help us ensure that we have the effective services that are based on need not demand, and are delivering improved outcomes wherever they are delivered.

I am an ex-GP and semi-retired public health consultant, so you may think I also have an axe to grind. I may do, but it's my tax payer axe that wants to see public money spent on needed, effective services that will deliver better outcomes and reduced inequalities. Fiddling about while the NHS burns won't do this.

From: [✂]

The general opinion of my colleagues and of friends and family in Bolton is the closure of the WIC 2 years ago has been a great loss. Politics should not come into delivery of primary care, there are all sorts of positive ripple effects from having the convenience of a late and weekend opening WIC, not to mention potential cost savings and general feeling of being 'valued' and 'cared for' by the general public. Had a chat with my team and they all agreed:

- WIC's are convenient and accessible as long as they're situated in a central position in town for general public, in particular the young, the old and the Mums & toddlers who I'm sure are probably the most prolific users of GP's surgeries
- Speed – No capacity at GP or A&E
- Potential for further development, i.e. offering smears, flu jab, imms & vaccs etc… Could use as a public health promotion and advice centre as well as healthcare

Thank you for the opportunity to share our views.

From: [✂]

Dear Sir/Madam

I just felt I needed to pen some words on behalf of the great treatment I received from my walk in centre in Stockport (before it closed). I struggled with a series of UTI's and diabetes for a number of months while my walk in centre was still open. My flare ups always co- in sided with my gp surgery being closed on Wednesday afternoons, Saturday mornings or late at night, without my walk in centre I would

have had to use my local hospital. Staff were kind, helpful and always gave me the antibiotics I needed to get me though till I could see my gp.

From: [✂]

Dear Sir or Madam,

I am responding to the helpful report by Monitor on walk in centres. I am responding in a personal capacity but unusually over the years of the policy I have had a number of roles, these included being the medical director or a private health company bidding for contracts, as a clinical GP who worked in one for over 6 months and then as a medical director and director of a PCT with responsibility to oversee one. This included efforts to change the model that was commissioned.

I come from the backdrop that there is an issue of access to primary care and general practice in particular in many areas. There are many factors to this, but there are many constraints on the general practice workforce and the way it works, not least the overall demand for primary care. Some surgeries (such as mine) has changed its appointment system to Doctor First, whereby we now offer most consultations on the telephone. Whilst there are risks with this approach and it does not suit everyone, in a session we will now manage 30+ patients as compared to a routine 18-20. This is a significant increase in productivity and we have reduced our A & E attendances (which were not high by local comparison by 20%. A major constraint though is the number of GPs in particular and the funding, not for doctors for ancillary and nursing staff and this is to a degree hampering developments in the out of hours time frames.

To turn to the walk-in centre, the view [✂] in particular is that this was the solution to a “London problem” rolled out nationally. Actually what we wanted to do (and were not able to) is to open one of our larger surgeries in the county as an urgent care centre after 630pm and at weekends. This would have been considerably cheaper than the [✂] current spend or we could have replicated the system in the major towns locally for the same money. It would also have increased access and in our opinion reduced A & E attendance. As it is the local walk-in-centre whilst liked by patients has stimulated supply side demand as there is evidence that 80% of patients who attend as walk in patients are registered with local practices. Whilst they can always do better, the county ranks as one of the best for the provision of general practice in the UK when measured by QOF etc. So overall I think the walk in centre policy has been a missed opportunity to actually increase access to general practice generally. It might work in the conurbations where there is generally poor access to general practice, but if allowed, we could have commissioned things a very different way that benefitted many more patients.

To turn to your specific questions...

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

Too expensive, increases supply side demand, capacity already present in other practices

2. Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?

Yes

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients?

Probably right, but specific contracts for hostels, homeless etc can be delivered under specific contracts by other providers. We used to do this with a specific surgery and there is no reason why this cannot work if correctly commissioned.

[✂]

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients?

The current "mess" of division between commissioning by CCGs and NHS England needs to change. There needs to be absolute clarity on where the responsibility lies.

[✂]

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care? If so, which body and why?

Recommend place with CCGs. This is very important as they need to find local solutions to their difficulties, rather than a "one size fits all" policy.

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients?

Monitor (understandably) is coming from the perspective that competition will improve standards. The evidence base for this is very marginal at best and my contention is that better value and quality can be achieved by sensible commissioning.

[✂]

7. Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?

Yes

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

Look at the barriers to why GP practices do not open at weekends now. These revolve around nursing and ancillary staff, availability of buildings and availability of GPs. I would contract these separately to the GP contract.

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful?

Would further advice or guidance be helpful?

As mentioned the procurement and competition rules are frequently barriers to what we need to do. They often ensure a “race to the bottom” and prevent integration. They also drive unhelpful behaviours from individuals and organisations.

I trust that these comments are helpful. If I can be of further assistance, please let me know.

From: [✂]

Would like to know where the 50 WIC are that have been closed…. obviously these are going to be in remote areas and not busy residential areas. Also will I get an appointment at my GPs within a next day or two of feeling unwell or will I have to wait at week like I did two weeks ago!!!!! And when I did complain I got an appoint 3 days later!!! With a nurse clinician (same as the WIC nurses) and not my GP.

Are the general public being asked for their comments on this subject, because the positive feedback we receive in our WIC regarding the service the people of Halewood are receiving, I think there will be quite lot of resistance to closing any WIC.

From: [✂]

Hello, there is confusion in the urgent care system and partly that is why so many patients attend A&E.

There is also confusion around terminology:

Walk in Centres in the context of recent news, I believe refers to “Darzi” practices. We obviously have more conventional WICs which treat minor injuries and minor illness and are usually nurse led. However, I would consider closing the majority and concentrate those resources and skills in one place….currently A&E.

They could be renamed, but the important point is that the service would be offered (majors, minors, primary care, diagnostics etc) in one place – which is exactly where patients currently go!! The 24 hour supermarket mentality. People do not want to wait too long and certainly don’t wish to passed from pillar to post.

This model I simplistically describe is one I have been pushing in my area for years – a lone voice in this area!! However, perhaps one day it will come to fruition.

“Radical” is the order of the day, otherwise we will contine to go round and round in circles reinventing what has gone before! I am now in the closing months of my 40 year NHS career and after working in the majority of clinical areas over the years feel totally dismayed and tired of hearing “review” this, “monitor” that, gain “assurance” etc etc, without actually getting on with the job and delivering the superb care the NHS is capable of!!

[✂]

From: [✂]

Dear Sirs,

[✂] I felt obliged to respond to the questions raised in your report. The report seems fair and balanced and raises the most relevant questions.

I think one of the major difficulties is that Walk-in Centres are so diverse that it is difficult to generalise. Our contract is coming up for review and the process has been long and drawn-out and largely unsatisfactory. Despite the fact that [✂] was one of the first wave it is clear that staff at our CCG and LAT really have only limited comprehension of what we do here. This is compounded by the fact that our LAT includes few if any staff that previously worked for our local PCT, and they have minimal knowledge of the local health community.

We provide many services that other local providers have been reluctant to provide or fail to appreciate. We offer extended hours and flexibility to increase access for the sizeable local population of difficult-to-reach patients including the homeless, substance misusers, the seriously mentally ill, those recently released from prison, asylum seekers etc. We are one of only two local organisations prepared to accept designated violent patients. We have public health responsibilities, providing TB screening, diagnostic and follow-up services and BCG vaccination in an area that is seeing a rapidly rising incidence of TB.

The GP practice element of our organisation has over 10,000 registered patients, which would appear to be larger by far than the list size figures given in your report. Should our organisation be allowed to fail this would have serious implications for the local health community, when other local practices are bordering on failure and applying to close lists. Our WIC clearly copes with the overflow from a number of local practices which would be in danger of failing should our service be withdrawn abruptly. I understand the argument that this is paying twice for primary care services which other practices should be providing but WICs should not be made scapegoats for the chronic under-funding and over-working of primary care in the UK.

It seems clear that local commissioners seem to be motivated only by the opportunity to save funds by closing services, rather than considering the wider implications. I note that your report makes no mention of the wider professional environment. Our organisation has sponsored the extended training of a number of nurses which has added to the value and quality of the local pool of nurses with extended skills. Our GP arm is a training practice which has been earmarked for expansion of training numbers as part of the national expansion of GP training. We have one extant educational supervisor and three other GPs in training to be educational or clinical supervisors. This activity has not been factored into anyone's calculations because service budget holders have no interest in it. We also have a training department which provides clinical skills and theory and safeguarding training to the local health economy. Activities such as these appear to be beyond the view of those commissioning and assessing clinical services and yet have importance to the wider professional environment.

In terms of our clinical activities we have generally performed very well against contractual targets, and we believe that we provide an efficient service in terms of both quality of activity and financial value. Our integral place in the local area is attested to by our place in the emergency planning arrangements and the on-going pilot by which we are taking ambulance cases from South-Western Ambulance Service to reduce ED attendances and provide appropriate one site medical care.

We can only foresee a future in which we will not exist and this change needs to be planned and handled carefully to avoid major adverse effects on the local healthcare environment.

BMA response to Monitor's Walk-in centre review preliminary report

The BMA responded to Monitor's initial review of the provision of walk-in centre services in England[1], and we welcome the opportunity to respond to the report into preliminary findings. We have restricted our response to areas of particular pertinence for the BMA.

Following Lord Darzi's Next Stage Review report of October 2007,[2] it became Department of Health policy that every PCT should commission at least one walk in centre. The result was that walk-in centres were created without regard to existing local services or gaps in provision. It is unsurprising, therefore, that in some areas; local commissioners have taken the decision that to continue walk-in centre contracts is not the most appropriate use of resources. The roll-out and subsequent decommissioning of walk-in centres in some areas shows that a blanket, top down approach is not appropriate and commissioners must be able to take account of existing local provision and local need when commissioning services.

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

In many areas there is no clear evidence that walk-in centres are meeting unmet need, and in some cases they are duplicating services[a]. There is a compelling case, therefore, to invest resources more efficiently to reduce pressures on other parts of the system, such as general practice and accident and emergency services.

We strongly believe that any service closures should be clinically led and based on good clinical evidence. We agree that decisions relating to walk-in centre closures should be done in a transparent and open fashion[b], taking a holistic view of healthcare provision within a local health economy. We believe that the closure or reconfiguration, or commissioning of any service should occur as a result of a thorough needs and impact assessment.

We were concerned by Monitor's finding that no follow up studies had been done to analyse the impact of walk-in centre closures on patients[c]; this may, however, be due to the short time-scales since walk-in centres have been closed. It would be helpful if such a study could be undertaken, to better understand the impact of closure in those areas.

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients?

Monitor expresses concerns that walk-in centre closures may restrict access to primary care services. However, where local commissioners have identified that their local walk-in centres are an inefficient use of resources and/or are creating demand as opposed to relieving pressure[3], this resource could be used to improve access to GP services.

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[a] "Commissioners argue that walk-in centres duplicate services already provided because patients attend the centres for the same reasons that they would see their GP, often during GP core hours. They believe that patients should see their GP as a "first port of call"." – page 47 Monitors walk-in centre review preliminary report

[b] "We also saw examples in which commissioners appeared to have decided to close walk-in centres without setting out their reasons for doing so and explaining the process they followed to reach their decisions." – Page 71 Monitors walk-in centre review preliminary report

[c] "we found no post-closure studies evaluating the impact on patients' access to primary care and whether patients' needs are being met elsewhere or not." – page 54 Monitors walk-in centre review preliminary report

The BMA agrees with some of the analysis presented by Monitor, such as the emphasis placed on the impact on health inequalities[d]. It is important that all stakeholders in local healthcare keep health inequalities in mind when taking decisions which impact on the wider healthcare economy.

There is a general principle underlying Monitor's analysis[e] that speed of access is always clinically necessary and desirable. GPs are adept at managing risk, prioritising urgent patients and supporting patients to self-care where possible. Many GP practices offer telephone consultations with a nurse or a doctor and this may mean that there is less need for a face to face consultation.

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What other information or evidence related to this topic should Monitor consider? and;
5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care?

The BMA notes that Monitor has taken on board the points made in the BMA's initial submission concerning the confusion that has arisen regarding commissioning responsibility for walk-in centres. The current division (the practice-list based elements commissioned by Area Teams and the 'walk-in' elements commissioned by CCGs) should be retained, in order to prevent conflicts of interest arising. We would welcome, instead, clear guidance on who has responsibility for which elements, with guidance that sets out how Area Teams and CCGs can best work together to make decisions.

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients? What other information or evidence related to this topic should Monitor consider?

Monitor states[f] that current payment mechanisms 'do not strengthen incentives for GP practices to improve quality and efficiency of their services so that their patients are more likely to choose their services instead of using a walk-in centre'. This statement misconstrues the purpose of walk-in centres. At present, although there is some concern over the duplication of services, the walk-in centre model is not designed to stimulate competition with general practices. If improvements are needed in general practice then appropriate steps should be taken to support practices to improve quality and efficiency.

There are significant assumptions that redesigning payment mechanisms to stimulate competition between walk-in centres and GP practices would 'drive GP practices and walk-in

[d] "people from lower socio-economic groups tend to be the most common users of walk-in centres" –page 38
[e] "of those that were able to get an appointment (87% of all respondents), only about half were able to get an appointment either on the same day or on the next working day (49%); 33% had to wait a few days and 15% had to wait a week or more." – page 51 Monitors walk-in centre review preliminary report
[f] "the current payment mechamisms 'do not strengthen incentives for GP practices to improve quality and efficiency of their services so that their patients are more likely to choose their services instead of using a walk-in centre". – page 61 Monitors walk-in centre review preliminary report

centres to continually improve their own services' [g]. These assumptions lack a clear evidence base.

Furthermore, walk-in centres are designed to treat minor ailments and isolated illnesses requiring medical attention, which as mentioned above can include creating excess demand. GP practices provide long term coordinated care for chronic illnesses, as well as acute presentations and minor ailments. There is a risk in creating competition for funding from the same pot between walk-in centres and GP practices, in that they are different types of providers with potentially different groups of patients.

Incentivising providers to 'encourage patients to use their services', as suggested on page 64, may not lead to well designed services tailored to patient need, but could create a perverse incentive for providers to encourage patient attendances. In the current financial climate, commissioners should be focussing attention on how to create responsive and easily accessible services, whilst also promoting self care and preventative measures to try and reduce pressures on existing services.

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

The GP contract changes for 2014-15 included initiatives to improve access, including giving practices the option to work with other practices across a locality to provide extended hours. We welcome the changes which we believe will refocus GP time on treating patients in a holistic manner. It is changes like these that will help deliver patient benefits and ensure best use of NHS funding[4].

In addition, enhanced services are a valuable lever for commissioners to use to improve quality and create locally responsive services. CCGs need to be encouraged to use these levers to improve local services, for example by providing clear guidance about how to manage conflicts when commissioning services from member practices.

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful? Would further advice or guidance be helpful?

The BMA would welcome further guidance for commissioners on the commissioning and closure of walk-in centres[56]. This review, whilst helpful in clarifying certain issues surrounding the application of the regulations to walk-in centre closures, still leaves unanswered questions for commissioners. We would welcome greater clarity concerning the commissioning requirements for walk-in centres.

Endnotes

[1] British Medical Association (2013). BMA response to Monitor's review of walk-in centres. London, BMA.

[2] Health, D. o. (2007). Our NHS Our future: NHS next stage review - interim report.

[g] "If payment mechanisms created stronger incentives for GP practices to encourage their patients to choose their services instead of using a walk-in centre, this competition for patients could drive GP practices and walk-in centres to continually improve their own services." – page 64 Monitors walk-in centre review preliminary report

[3] Smith, J., H. Holder, et al. (2013). Securing the future of general practice: new models of primary care, The King's Fund & Nuffield Trust.

[4] Doran, T., E. Kontopantelis, et al. (2011). "Effect of financial incentives on incentivised and non-incentivised clinical activities: longitudinal analysis of data from the UK Quality and Outcomes Framework." BMJ **342:**: d3590.

[5] British Medical Association (2013). BMA written evidence for the 2013 Accountability Hearing with Monitor.

[6] British Medical Association (2013). BMA response to the statutory consultation on the 2014/15 National Tariff Payment System.

Review of the provision of walk-in centre services in England
November 2013

About Celesio UK

Celesio UK is a leading provider of integrated healthcare services to the NHS specialising in medicines, pharmaceutical care and primary care patient services.

With almost 20,000 employees, over 1,500 community pharmacies, a UK-wide logistics network and dispensing in excess of 150 million items a year, we work in partnership with the NHS, community pharmacies and medicines manufacturers to help UK citizens live longer, healthier and more positive lives. We provide our customers, the NHS and patients with high levels of service, value, efficiency and innovation.

Celesio UK comprises Lloydspharmacy, AAH Pharmaceuticals, Evolution Homecare, Wilkinsons Healthcare, Dr Thom and Betterlife. Celesio UK is part of Celesio: a leading international trading company and provider of logistics and services in the pharmaceutical and healthcare sector. Celesio takes a proactive and preventive approach to ensuring that patients receive the products and support that they require for optimum care. We operate in 16 countries around the world and have about 38,000 employees.

Every day, we serve over 2 million customers – at 1,500 pharmacies of our own and 4,100 participants in our brand partnership schemes. With around 130 wholesale branches, we supply approximately 65,000 pharmacies and hospitals every day with up to 130,000 pharmaceutical products. Our services benefit a patient pool of about 15 million per day.

Celesio UK response

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

2. Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?

The concerns listed are, in our view, comprehensive. They highlight the tension between the convenience of multiple access points and patient choice on the one hand and the most efficient use of resources on the other.

That should not detract from the broad consensus that if the nation is to address the healthcare challenges it faces then the NHS needs to improve patient access to primary healthcare advice, support and treatment.

Contact: James Lindsay, Head of Government Affairs and Corporate Communications
Celesio UK
james.lindsay@celesio.co.uk
Tel: 02476 432219

That in turn means the NHS needs to consider a range of primary care providers in local communities which complement and supplement the role of GP surgeries and A&E departments.

The range and volume of patient demand is too great to funnel all needs towards GP surgeries and there is ample evidence that for a variety of reasons, such as convenient access during working hours, patients want advice, support and treatment in care settings outside of GP surgeries.

Commissioners therefore need to consider what existing community healthcare assets could be used to achieve improved access and outcomes for patients, in particular community pharmacies.

The report listed the main reasons why patients have presented at WICs – including coughs, colds and flu-like symptoms; skin conditions or skin infections; stomach upset or pain; breathing problems (such as asthma): these are conditions which could and should be treated at community pharmacies.

Therefore, when commissioners are considering reducing access and choice by closing WICs they should think about replacing that access and maintaining choice through service provision in community pharmacies.

Much more effort needs to be undertaken to help educate the public when it is most appropriate to self-care, go to their local pharmacy or their GP practice.

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients? What additional information or evidence should Monitor consider?

We agree with the view that commissioners need to have in place alternative routes to advice, support and treatment for patients who commonly use WICs: in the absence of a WIC patients who use those centres may not necessarily refer themselves to their GP surgery even if they are registered with one. Those that do will add to the demand pressures which many GP surgeries are already facing and some may present at A&E departments thereby increasing pressure there.

We think Monitor needs to assess what other routes to care already exist in local communities and could provide the kind of support, advice and treatment commonly made available at WICs and which therefore avoid adding demand pressures to GP surgeries and A&E departments.

Contact: James Lindsay, Head of Government Affairs and Corporate Communications
Celesio UK
james.lindsay@celesio.co.uk
Tel: 02476 432219

We contend that community pharmacies are best placed to provide a route to primary care which complements and supplements the role of the GP.

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What other information or evidence related to this topic should Monitor consider?

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care?

If so, which body and why?

Celesio UK supports the concept of patient-centric care pathways: service provision should be built around the needs of individual patients.

However, commissioning and funding silos make that concept difficult to realize in practice.

One lead commissioning body could help join up service provision better than is currently the case.

That would allow a comprehensive analysis of primary care needs and how best those needs can be met from a range of providers.

This would also help patients to understand better the care choices they have: when is it most appropriate to seek advice from a community pharmacist as opposed to a GP? If we help people make informed choices then we drive a more efficient NHS and achieve better outcomes for patients.

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients? What other information or evidence related to this topic should Monitor consider?

7. Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

We believe there is a need to align how the GP and community pharmacy contracts are funded to drive cross-professional working.

Contact: James Lindsay, Head of Government Affairs and Corporate Communications
Celesio UK
james.lindsay@celesio.co.uk
Tel: 02476 432219

We also reiterate the point that many of the services which patients want and use in WIC setting are available or could be made available in community pharmacies.

For example, it is estimated that the cost to the NHS of a pharmacy-led minor ailment intervention is half of the cost of a GP-led intervention and yet 40% or more of GPs' time is spent on minor ailments (which in most cases lead to a prescription which is fulfilled at a community pharmacy.

This is neither economically or clinically efficient and it does not offer easy, convenient access to healthcare for patients.

In the new NHS commissioners need to think beyond the default position of "how do we get GPs to do more and therefore how do we use funding to incentivize them?"

Instead commissioners need to consider and assess carefully from the outset care pathways which include at their core community pharmacy as that can offer access and outcomes at a lower cost.

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful?

Conclusion

Celesio UK acknowledges the concerns of commissioners highlighted in the report in relation to the provision of walk-in centres, and we believe that community pharmacy has a significant role to play, especially in increasing access to primary care and releasing capacity in other, oversubscribed areas of the NHS such as GP surgeries and A & E, given the readymade network in the heart of local communities.

We would welcome the opportunity to work with Monitor to demonstrate how Celesio UK can help deliver solutions in an effective and cost efficient way.

Contact: James Lindsay, Head of Government Affairs and Corporate Communications
Celesio UK
james.lindsay@celesio.co.uk
Tel: 02476 432219

NHS England, East Anglia Area Team Response to Monitor Walk in Centre Report

Question	Response
Reasons given by Commissioners for closing Walk-in-Centres? Has Monitor sufficiently captured the concerns of Commissioners related to WiC?	We are not surprised that there are different reasons offered for local decisions, the key issue is that Commissioners can demonstrate that the decision can be justified in the context of local need, ensuring best use of limited resources and that the decision has been taken openly and transparently. It is for local commissioners to be held to account for their decisions and the rationale. It is regrettable that the report appears to focus on the fact that there have been closures of Walk in Centres, rather that assessing whether the commissioning decisions that have been made and implemented have been progressed in an appropriate manner in the context of the role and remit of Monitor. This is of particular concern given the media focus has now been given to "closure" of WiCs, rather than welcoming the fact that commissioners are critically reviewing how they improve access to high quality services within the resources available. We would suggest that it is unhelpful to suggest that Commissioners have concerns with regard to Walk in Centres – Commissioners have a duty to look at all services and, with stakeholders, critically review services to ensure that they are achieving the outcomes required and offering best value.
What are your views on Monitors analysis and preliminary findings related to the potential impact of WiC closures on patients? What additional information or evidence should Monitor consider	The report highlights the variation that exists nationally, thus making any generalised statements unhelpful, reinforcing potential perceptions that do not reflect local circumstances. It is the responsibility of all Commissioners to understand local needs, undertake Equality Impact Assessments and ensure transparency in decision making.
What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of WiCs may result in drawbacks for patients?	We are confident that Area Teams and CCGs are able to work jointly to support strategic reviews of local services and develop appropriate commissioning strategies to meet local needs, recognising that currently the majority of WiC play a role in delivering "essential" primary care services and as part of an integrated urgent care system. Further change in commissioning responsibility would be extremely unhelpful as the key to delivering for patients will be the building of strong partnership arrangements

What other information of evidence should be considered? What changes would you recommend to the commissioning of WiCs?	and trust between commissioners which requires a period of stability. We would strongly urge that there is no centrally driven directive on which body should be responsible, but rather this should be for local determination to meet local circumstances. The current arrangements facilitate this.
What are your views about our analysis and findings on how the payment mechanism for GP practices and WiCs may not be working in the best interests of patients? What other information or evidence should be considered? Should there be strong incentives for GP practices and WiC to improve quality and efficiency? How could payment mechanisms be adjusted?	We recognise the risks associated with perverse incentives impacting across the health and care system and therefore this issue cannot be considered in isolation and therefore any changes must be considered as part of a whole system review of financial flows. All commissioners should be expected to demonstrate best use of limited resources and be held accountable for this through effective contract management against agreed outcomes to drive quality and efficiency.
Is the description of the key factors that commissioners are likely to need to consider under the PPC&C Regulations helpful? What further advice would be helpful?	The steps set out are appropriate and would be expected as best practice in relation to any service.

[Luton Walk-in Centre: response 1]

2nd December 2013

Corporation and Competition Directorate Monitor
Wellington House
133 -155 Waterloo Road
London
SE1 8UG

Re: Review of the provision Walk In Centre Services in England – Our suggestions and comments

Thank you for allowing us this opportunity to comment on the provision of Walk In Centres and just to note that we were not aware that this review was currently being undertaken but we commend you for having carried out this excellent review and analysis. Local Healthcare Solutions Ltd (LHS) is the provider of the Town Centre GP Surgery, the Luton Walk in Centre and of course we are sorry that you did not choose us as one of the review centres for your analysis but hope we can complement some of the excellent work that has already been completed. Attached is our 2010/11 Annual Report which has covered many of the areas already carried out in your review but just to update; the numbers attending the Walk In Centre and registrations have continued to rise with the numbers seen during 2012/13 was 44,399. We currently are on a par with last year's number but the number of registered patients stands at just over 5000, having started off as zero in 2009.

Below we provide you with some suggestions and comments on the questions raised in the 'Walk In Centre Review Preliminary Report':

Section 6, Page 49

During the past year and with the removal of PCTs and the introduction of the CCG and the NHS England Local Area Teams (LAT) there has been a complete absence of communications with any commissioners in respect of the Town Centre GP (TCGP) Walk In Centre.
As a general overview, however, we feel that commissioners may have a point but the issue is not so much with Walk In Centres as with general practice and the variability of General Practice. At a local level here in Luton we collect the information about the GP registration of the patients who attend the Walk In Centre and can report that the pattern is constantly repeated, week on week. We are unclear as to what the concerns of commissioners nationally are as none has been raised. We have seen no evidence that it is the Walk In Centres that are having a negative effect on access to primary care. Our experience taken from patient word of mouth is that it is the other way around. The patients can't get access to their own GP. We can further evidence that on a number of occasions GP practices have been closed with the sign on their door advising all patients to go to the Walk In Centre. As a provider we had notified the PCT about such incidents but of course the throughput of commissioning staff means that none of these staff are still around and records are scanty.

Section 7, Page 58

Our experience from running the Luton Walk In Centre for the past 5 years is that, had the Walk In Centre not been open then between 35 and 50% of the non-registered patients seen would have turned up at the Accident and Emergency Department. A considerable number of the patients who use the Walk In Centre live in the more deprived areas where the population operate from the old fashioned perspective that they want to see a clinical person; in addition many of them have been referred to the Walk In Centre by local chemists, voluntary sector and an array of statutory service providers. It's as if everyone wants to safety net their decision these days, eg, the pharmacist thinks it's a benign rash but it might be meningitis so the parent is advised to have it checked out at the WIC or the Health Visitor wants the burn on a child's arm seen by a GP. It is our opinion that the numbers attending have been compounded by the introduction of fear factors which has come via:

- the media
- 111 or NHS Direct Service who contribute about 10% of the number of patients sent
- a complicated mix of lack of access in primary care; experience of friends and family who have already used the Walk In Centre
- Added to this the fact that we have noticed a change in the case mix with sicker people now attending the Walk In Centre as non-registered patients requiring same day care.

A recent survey has calculated that 10% of such patients would need to be seen at A&E if the Walk In Centre was not able to cater for them. We would further like to inform this review that during the recent **swine flu epidemic** we were a centre for dealing with swine flu, especially for the children. We were able to respond very quickly especially in the unusual circumstances where the swine flu telephone service was not dealing with children under 16 years; the local A&E Department was not see anyone with swine flu; resulting in the Luton Walk In Centre being turned in to a Tamiflu Centre. Do to the experience and skills mix of the workforce and us being a local provider we were able to cope with extraordinary large numbers of people attending, all of whom were dealt with on site.

Monitor's analysis is a good understanding of the potential impact of Walk In Centre closures on patients but also needs to be aware that during the past 5 years, (the life span of Walk In Centres) GP practices' have come under further pressure with the growth in long term conditions and GP practices having to make decision as to whether they concentrate on same day demand hence reducing resources for specialised clinic run in the main by experienced GPs or reduce capacity for long term condition and meet the demand for same day appointments especially in the afternoons. It is also worth noting that any extra funding that came into General Practice has been earmarked for long term conditions.

Locally our experience has been that few GP practices offer same day appointments in the afternoons, with most same day patient attending the Walk In Centre from approximately 3.30 onwards stating that they couldn't get an appointment with their own GP practice. On a number of occasions when we were full to capacity and rang such surgeries we were either not able to access the surgery by phone or when we did were informed by the receptionist that no further appointments were available on the day and yes the patients had been advised to attend the WIC

We consider that Monitors' unique positions in spanning the spectrum between the Walk In Centres: General Practice and A& E departments will give this final report a powerful voice in an otherwise silo orientated NHS Service planning structure with ring-fenced resources & accountability disjointed.

Section 7.2, Page 61

Agree entirely with your conclusion that the division in responsibility for the commissioning of Walk In Centres (WIC's) has resulted in confusion and may in time result in draw backs for patients. The experience on the ground is that the CCGs are local organisation elected from amongst local independent providers, GPs and chemists, hold open board meetings and are ultimately accountable to its constituents. The status and role not dissimilar to the previous PCTs with local CCGs accountable to local practices to the local population; in turn local GP practices are accountable to the CCG, all of whom have an overarching responsibility for the population health as a whole.

Whilst the CCG have responsibility for urgent care we would propose that Walk In Centres are a key and significant contributor to the overall management of same day conditions and same day urgent care. Removing the contribution of Walk In Centres from the overall provision of urgent care is somewhat illogical and in our experience is not working. For instance, should decision be made to close the Luton Walk In Centre then that decision needs to be made from an evidence base and with those responsible for the provision of urgent care taking responsibility for the decision including the impact and the consequences should this provision no longer be available to the people of Luton.

The experience from the Luton Walk In Centre is unsustainable in so far as that:

1. The commissioning of the WIC & GP Registered patient service is the responsibility of the NHS England LAT.
2. Some of the services carried out here such as LES's, contraception and HIV services are the responsibility of the Public Health Department for Luton Borough Council.
3. Responsibility for the premises, including facilitating extra capacity rests with the NHS Property Company (Prop Co)
4. Responsibility for services such as drugs; access to secondary care: DES's, NES's are the responsibility of the local CCG.

Our experience of having tried unsuccessfully to get the simplest of issues resolved between these four organisations has been that it doesn't work for the provider or for the patients.

It is our considered opinion that the future commissioning of Walk In Centres should be the responsibility of the local CCGs. The Luton Walk In Centre contract is due to expire at the end of February 2014 and we have not had any commissioning meetings during the past year and are totally unaware of the intention of or whether or not the NHS England LAT team are planning to continue; close or re-commission by public procurement this services. If, a decision has or will be made to close the WIC then the Luton CCG will of course feel the impact as will the other local providers of primary and urgent care services.

Section 7.3.2, Page 65

In our opinion the difficulties lie with the variability in GP practice quality and the lack of any performance management carried out to any of the GP contracts, GMS, PMS, or APMS. The payment mechanism in General Practice in there totality doesn't reflect quality and performance. There needs to be much more transparency and a levelling of the playing fields between General practice and Walk In Centres. It could be argued that what is needed is dis-incentives to practices that are not offering the full range of primary care, especially same day urgent patient care and hence the patients having to use Walk In Centres, this would then free up resources.
An important point missing from your analysis and findings is the role that the Immediately Necessary Treatment (INT) played in general practice with the pre new GMS contracts rewarding GP practices for seeing immediately necessary treatment patients under the red book item of service arrangements. The need for immediately necessary treatment has increased in many areas

especially an area such as Luton with a transient population, the majority of who have no experience of using the NHS. If the payment options were adjusted in general practice, regular general practice may be more flexible to see INT patients who at the moment are all referred to the Walk In Centres. There is a strong case especially in an area such as Luton to adjust the award or payment structure to GPs who are operating in a deprived area where demand for same day appointments is disproportionately high and in many cases the per capita funding is disproportionately low.

We consider that this monitor review is an ideal umbrella for considering and making recommendations about inequitable but fair tariffs for patients using Walk In Centres, GP Surgeries and patients attending A&E with a primary care condition. Should such a tariff be identified and a market created linked to quality and performance then this may introduce some competition, choice and subsequently some redistribution into the many services currently providing; or not providing; same day urgent care.

Section 8.5, Acting Transparently, Page 71

There is only one pot of money in the NHS and if a Walk In Centre is currently operating well on a value for money basis delivering good quality care to the local people and to the local health economy then there is little cause for going through the process of re-procurement at open tender. If the current Walk In Centre is providing a good service then there should be no need to destabilise a good system which is working well for local populations. If, it is not broken then why fix it but if however there are performance issues with the current service provision this is an ideal opportunity for the commissioners to proactively performance manage these centres.

As a local provider we would value and welcome some performance management as we feel confident that we can demonstrate:

- what does work well
- the opportunities for profiling some of the services
- varying capacity
- changing case mix and incorporating or integrating some of the same day urgent care services.

As an experienced NHS provider we would recommend that this style of performance and contract management based on cooperation and collaborative working would produce a much better outcome if measured by quality performance and patient experience than what spending money by going out to re-procurement by open tender.

However, as already stated we do not think that poor performance should be tolerated and that this should extend across the whole of primary care including GP practices, Walk In Centres or Out of Hours care provision. Where contract management has not achieved an improvement in quality and productivity then such centres should or could go out to external procurement using the open tender system.

In summary and as number; 164 in Appendix 2 on your List of current Walk In Centres, we are pleased to have this opportunity to comment and make our suggestions.
These comments are based on our experience of providing the service during the past 5 years during a period of significant growth seeing same day urgent care patients who are often sicker than those seen in regular general practice.
We have responded positively to the swine flu; have seen peak performance with the attendance last Sunday of 200 patients within the 12 hour period.

Look after many very needy people including the homeless which we are able to provide long term care for
We have received visits from a number of oversees commissioners or providers: a visit from the UK Treasury Office assessing if we were meeting our objectives to reduce inequalities: in the last month we received a visit from the Cabinet Office who were carrying out a deep dive of urgent same day services in a number of areas across the country.

Please feel free to make contact if you require any further information and I look forward to reading the final report.

Yours sincerely

Bernie Naughton
Director and Management
Luton Walk In Centre.

Town Centre GP Surgery

Annual Report 2010-2011

Local Healthcare Solutions Ltd.

Foreword

Convenient, clinically effective and easily accessible health and care services can have tremendous impacts upon how people best manage and cope with illness and disease. The Luton Town Centre GP Walk in Service has firmly established these benefits for local people. Complementing other primary care led services across the town, the service provides these accessible services 12 hours a day 365 days of the year. I am impressed how the staff make sure they offer a fully flexible appointment system which in turn is especially helping young people to seek and be provided with the treatment and advice they need.

If we are to help people take greater control and responsibility for their own health, we have to make sure that they can receive the right support and back up when they need it. The Town Centre GP Walk in Centre is a growing and developing example as to how this partnership provides exactly the right sort of support in ways that people easily engage with, whether they need to see either a doctor or a nurse. This is helping more and more people to lead healthier lives. I am sure the service will grow and flourish as the team continues to learn and develop what is already a successful resource for local people.

Dr Steve Feast
Deputy CEO and Director of Transformation
NHS Luton

Contents

Executive Summary

In 2008 NHS Luton commissioned (by open tender) Local Healthcare Solutions Ltd. (LHS Ltd.) to deliver a primary care resource for walk-in patients without an appointment and registered patients at the Luton Walk in Centre, 14-16, Chapel Street, Luton.

"The NHS Luton and Luton Borough Council, Annual Public Health Report 2010-2011, describes Luton as a multicultural urban town; with an estimated population size 194,300; younger than that in the East of England and England; approximately 32% of Luton's population is from Black and Minority Ethnic (BME) communities and with 25.9% of Luton residents who are in the worst national quintile of deprivation."

This is the second Annual report which sets out to examine how this Town Centre GP Surgery (TCGPS) is performing including meeting its objectives: foremost of which is providing access to primary care services 8am-8pm, 365 days a year. This service has been operating for over two years, has grown in clinical capacity and reputation and reports the following:

- During the period April 2010 until March 2011 the TCGPS saw and treated 27,302 walk in patients: 42% more than in the same period the previous year.
- Peak demand is in the middle of the day with a similar but delayed pattern at weekends but near full capacity throughout the day.
- Those who attend the walk in service come from across Luton with more residents from LU1 and LU2: which includes areas of highest deprivation
- During weekdays Monday to Friday 11.5% and 14.5% at weekends of users live outside of Luton
- Children 0-15 years are the highest age group users of the walk in service at 26% compared to 21% which is the number of 0-15 year olds in Luton.
- A detailed breakdown of presenting conditions is included but the most common clinical condition at 24% is respiratory distress, especially in children

The reasons why people use the walk in service are varied but in summary **the key factors** include ease of access to primary care: location of the building in central Luton: convenience for those working in Luton: shoppers and visitors to Luton including those using the airport: referrals made from other statutory and voluntary agencies: word of mouth from previous users and the reputation for quality, speed and choice. However, of equal importance why people use this service is that it meets the previously unmet needs of the people who tell us that in the absence of this service they would have attended the Accident and Emergency service as they had no other access to primary care in Luton.

This report also provides a profile of the patients who are on the TCGPS's list of registered patients and shows that 98.5% of those registered are under 65 years of age compared to 88% for the population of Luton or 83% for the rest of the East of England.

This report contains details of what the users of the Walk in centre think of this service for both walk in and registered patients including the results of the national MORI 'GP Patient Survey' and some direct feedback received from patients and their families.

This second Annual Report has sought to focus on activity and service performance and we believe it shows that this service is performing well, has an excellent reputation and meets the needs of the people of Luton and surrounding areas. However, as a leading edge primary care service the TCGPS needs to remain vigilant and respond to the many changing economic and technological forces, patterns of health care especially the desire for individual self care and well being and how we can better target health programmes towards the most disadvantaged in Luton in order to encourage positive lifestyle and behaviour change as an enabler for raising their life chances.

Annual Report 2010 - 2011

1. Introduction

Since opening in February 2009, The Town Centre General Practitioner Surgery (TCGPS) has been providing healthcare services out of the Luton Walk in Centre at Chapel Street Luton. These two related Primary Care services are as follows:

1) A walk-in service where anyone eligible to receive NHS care can walk and be seen by a GP or Nurse whichever is most appropriate to their needs
2) A regular GP service for residents of Luton who want to register with a GP practice.

The walk-in service which gives access to a GP without an appointment is a new concept in primary care and was the brainchild of Lord Darzi's NHS next stage review, 'Vision for Primary and Community Care'. It was never intended to substitute for patients receiving comprehensive primary care from their own registered GP but to compliment it especially during the periods when regular GP surgeries are closed.

Open 8am-8pm on 365 days a year with at least one GP on site at all time, it is set to give patients more rights to control over their own health through greater access to primary care. The majority of patients attending the walk in centre are sick but it is important to note that the role of the walk in centre is also to give immediate access to preventative care such as contraception and providing a holistic service for self help and wellbeing. Visiting dignitaries have commented that on a number of performance and quality indicators the Luton walk-in centre is one of the most successful Darzi walk-in-centers in the country.

The Town Centre GP surgery also provides **registration for patients** who reside within the Luton Unitary Authority boundary. Based at the walk-in-centre, 14-16 Chapel Street Luton, anyone eligible to receive NHS treatment can choose to register and receive access to a comprehensive range of primary healthcare services.

1.1 Purpose

The purpose of this report is to;

- Provide an update and analysis on the performance of the Town Centre GP Surgery service for the past year and review if this new service is meeting the needs of the people of Luton with reference to inequality and public health
- Assess how it is assisting with improving access to primary care as envisaged by Lord Darzi in his founding philosophy.
- Profile in some detail, who the people are who use the walk-in centre, make comparisons with the previous year and highlight any significant changes.
- Make an informed contribution for the necessary future planning, enabling all to realize the benefits that can be extracted from having such a valuable Primary Care resource in the centre of Luton.

2. Profile of Luton

In order to fully comprehend the aims of the walk-in centre as a source of primary healthcare, it is first of all important to set it within the context of Luton as a town.

The NHS Luton Annual Public Health Report 2010 - 2011 contains the following overview of Luton:

Luton is a multicultural urban town situated approximately 30 miles north of central London, and covers an area of approximately 16 square miles. Luton has excellent communication links including its own international airport, and has recently bid for city status as part of the Queen's diamond jubilee celebrations.
Estimates of population size, obtained from the office for National Statistics (ONS), is 194,300 in 2009. However, Luton Borough Council estimates that there are approximately 204,700, that is, 10,400 higher than ONS estimate, with the difference mainly arising from migration.

In general, Luton's population is younger than that in the East of England and England see Table 1.

Age	Luton	East of England	England
Under 15 Years	21%	18%	18%
15-64	67%	65%	66%
65+	12%	17%	16%

Table 1. Displaying Age Breakdown of Luton Population

Approximately 32% of Luton's population is from BME communities, particularly the Pakistani, Bangladeshi, Indian and Caribbean communities. In recent years, the diversity of the population has increased due to an increased number of international students attending the University of Bedfordshire, and the arrival of migrants from European Union countries, notably Poland and other Eastern European countries.

Based on the Index of Multiple Deprivation (IMD), Luton's deprivation score increased from 24.73 in 2007 to 25.78 in 2010 and the rank dropped from 87 out of 354 to 60 out of 326 local authorities (with 1 indicating the most deprived authority).
Over a quarter (25.9%) of Luton residents are in the worst national **quintile** of deprivation, and 58.6% are in the worst two quintiles. Figure 1 map below shows the most- deprived areas in the Borough of Luton which corresponds to the areas with lower life expectancy.

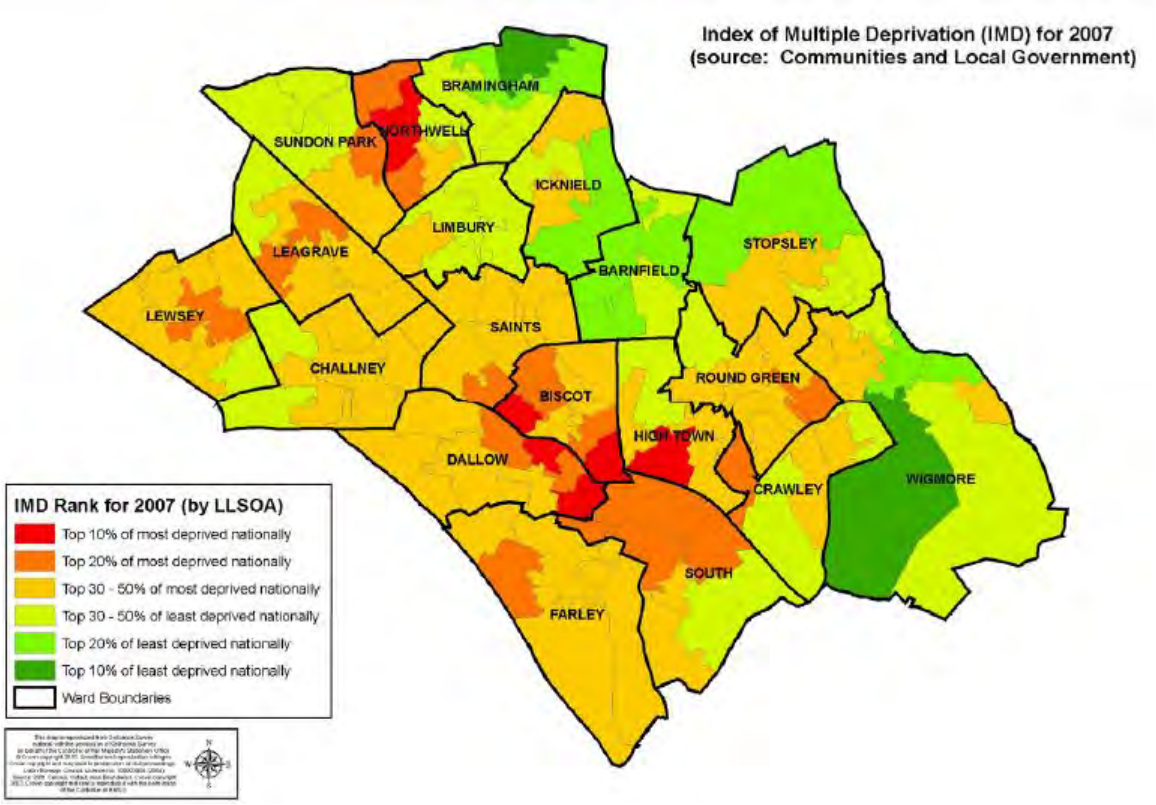

Fig.1 Map of Multiple Deprivation in Luton

3. NHS Luton Walk-in service

3.1 Demographics of Walk in Patients who use the service

The walk-in service is widely used by the population of Luton and people from the surrounding areas. In addition it is also used by people, who work in Luton during the week and due to a number of factors have difficulty in accessing their own GP practice for primary care services. Chart 1 below shows the residency of users, classified by post code, at weekends and during the week.

3.1.1

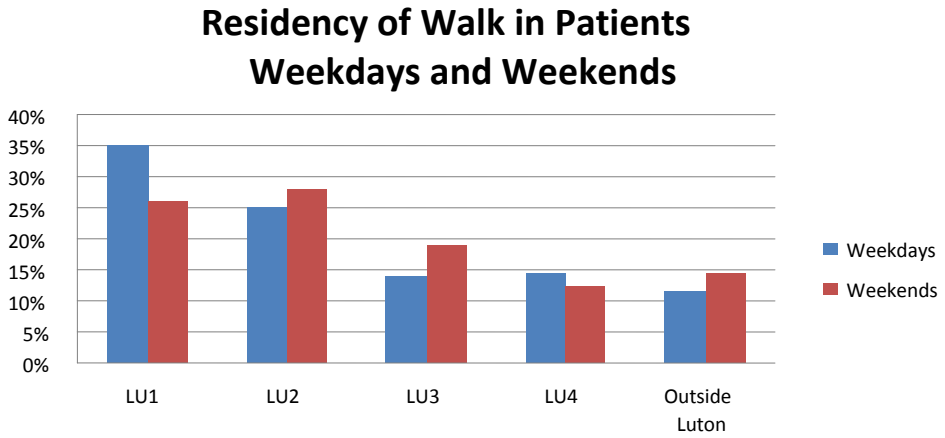

Chart1. Demonstrates the residency of walk in centre users 2010-2011

Residency of Walk in Patients who use the Centre

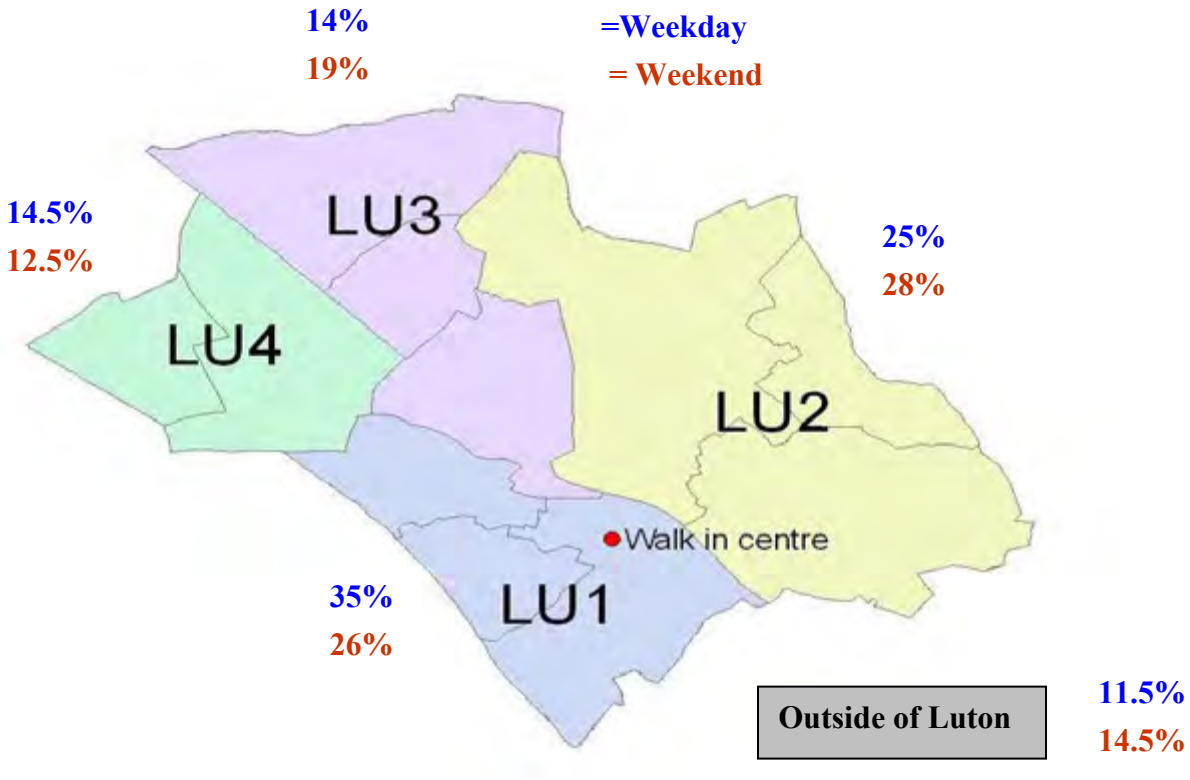

Fig.2 Map displaying the different Luton postal sectors and alongside the percentage of walk in patients who attend the TCGPS

3.1.2 Ethnicity

The Luton Annual Health Report 2010-11 further notes that some ethnic communities are more likely to live in areas which are more deprived especially the wards in and around the centre of Luton town and covering almost the whole of the LU1 postal area. Chart 2 below shows the ethnicity of the walk in patients who use the TCGPS walk in service. The large number classified as 'undisclosed' is due to many users not wishing to have their ethnicity recorded: many even noting that 'the question in itself is a form of racism'

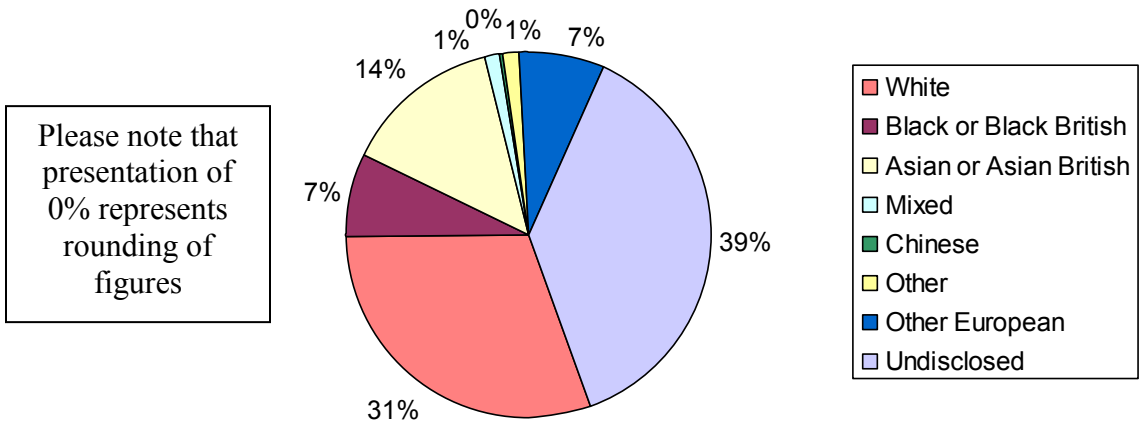

Chart 2. Pie Chart representing the ethnicity of walk-in-patients

3.1.3 Age Gender

Table 2a and 2b shows the age gender profile of those who attend for walk in health care and how these compare with the age profile of Luton generally.

Age range	Female	Male
0-15	2434 **(23.2%)**	2660 **(30.2%)**
16-25	2720 **(26%)**	1581 **(17.9%)**
26-35	2084 **(19.9%)**	1765 **(20%)**
36-45	1198 **(11.4%)**	1137 **(12.9%)**
46-55	901 **(8.6%)**	780 **(8.9%)**
56-65	588 **(5.6%)**	476 **(5.4%)**
66-75	348 **(3.3%)**	269 **(3.1%)**
76-85	168 **(1.6%)**	116 **(1.3%)**
86+	31 **(0.3%)**	29 **(0.3%)**

Age Range	Walk-in-Centre	Luton
Under 15 Years	26%	21%
15-64	69%	67%
56+	5%	12%

Table 2a (left) Showing the age gender profile of the walk in patients and

Table 2b (right) Showing the age range differences between patients using the walk in centre and the population of Luton (comparison with Table 1)

4. The staff who deliver the service at the Walk in Centre

4.1 The Clinical Team:

DR EMILIE HAWORTH B.Sc (Hons), MBChB, DFFP, MRCGP
Interests in Sexual Health, Dermatology, Public Health / Tropical Medicine

DR RAMALINGAM SUGANTH MBBS, MRCP, MRCGP
Interest in Diabetes.

DR RAZA ALAM MBBS, MRCGP
Interests in Mental Health, Health Inequalities and Medical Ethics.

JANE MORTON RGN
Minor Illness Cert

ROSE IRESON RGN, Dip Health Education
Minor Illness Cert, Nurse Prescriber.

4.2 Operational Management Support team

Dr Peter Ward M.B., Ch.B. Medical Director to Local Healthcare Solutions Ltd.
Dr Raj Khanchandani MBBS, M.S., MRCP. Clinical Director
Mrs. Jeannie Szumski RGN. Minor Illness Cert., Nursing Director
Mrs. Bernie Naughton BA, RGN, RM, HV Cert. Management Director
Amanda Philpott On site Operational Manager

4.3 On call back up support

Experience has taught us that in addition to the regular rostered team of staff it is essential to have a back up contingency plan in the event of an unforeseen incident happening at the Walk in centre. Members of the Local Healthcare Solutions Ltd. parent company who are also clinicians provide an on call support service to the frontline staff

The Town Centre GP Surgery has been remarkably successful in recruiting and retaining good quality staff who have worked as a team to initially establish this new service and have ever since concentrated their efforts in sustaining the delivery of quality care and assisting with the development of new projects. This good team spirit has to be set against a background of difficulties with recruiting GP and nurses to work in Luton.

5. Activity and Performance

As noted earlier the initial aim of the walk in service was not to replace the need for a patient to register and attend their own GP, but to complement access to current GP services for patients wishing to see a primary care professional without an appointment. Demand for consultations at the walk in centre has been high and year on year has continues to increase. Feedback from the clinical staff based at the Walk in Centre and the reported evidence shows that most people attending are sick at the time of presenting

and there is a link between the residents of Luton many of whom are migrants and may have limited knowledge of how the standard NHS operates.

5.1 Monthly activity and compared to the previous year

Table 3 below presents the activity figures each year since the opening in 2009 until March 2011

Month	Walk in Appointments Year 1 (2009-2010)	Walk in Appointments Year 2 (2010-2011)
Apr	1248	1910
May	1356	1927
Jun	1704	1892
Jul	1986	2095
Aug	1691	1980
Sep	1393	2007
Oct	1725	2332
Nov	1569	2422
Dec	1657	2809
Jan	1611	2705
Feb	1408	2329
Mar	1914	2894
	19262	**27302**

Table.3 Increase in activity figures between February 2009 and March 2011

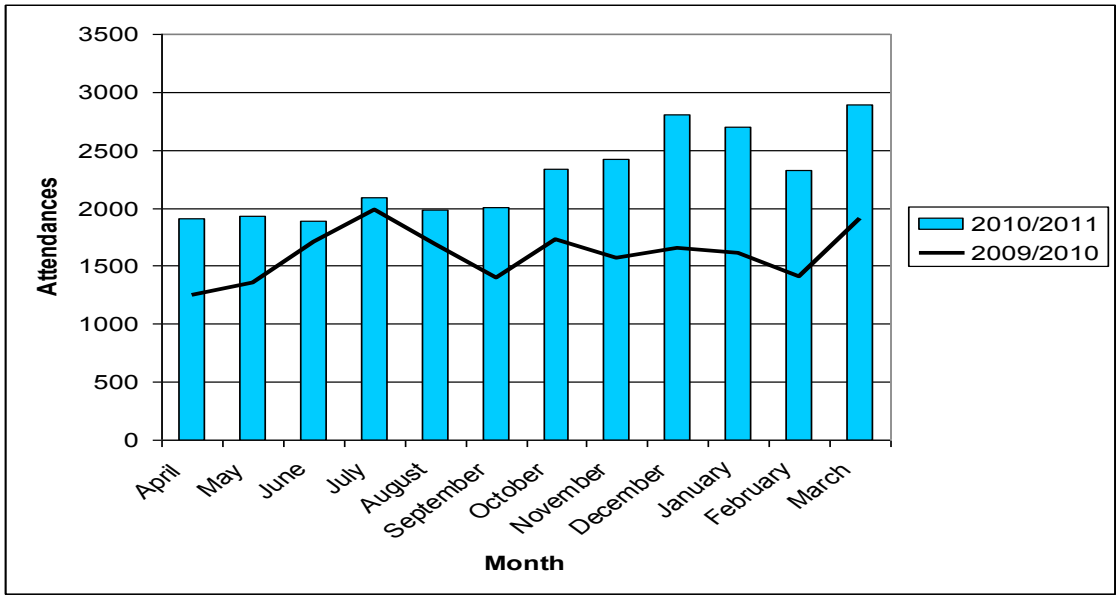

Chart.3 above displays the total number of attendances per month for both 2009/2010 and 2010/2011.

5.2 Times when people present for treatment

Chart 4 below purely gives the times of attendance but also provides a clue as to why people attend and the reasons given for not accessing their own GP surgery. It is also worth noting that these figures do not include visits made by the registered patients but taken together the walk in centre building operates at near full capacity during opening hours.

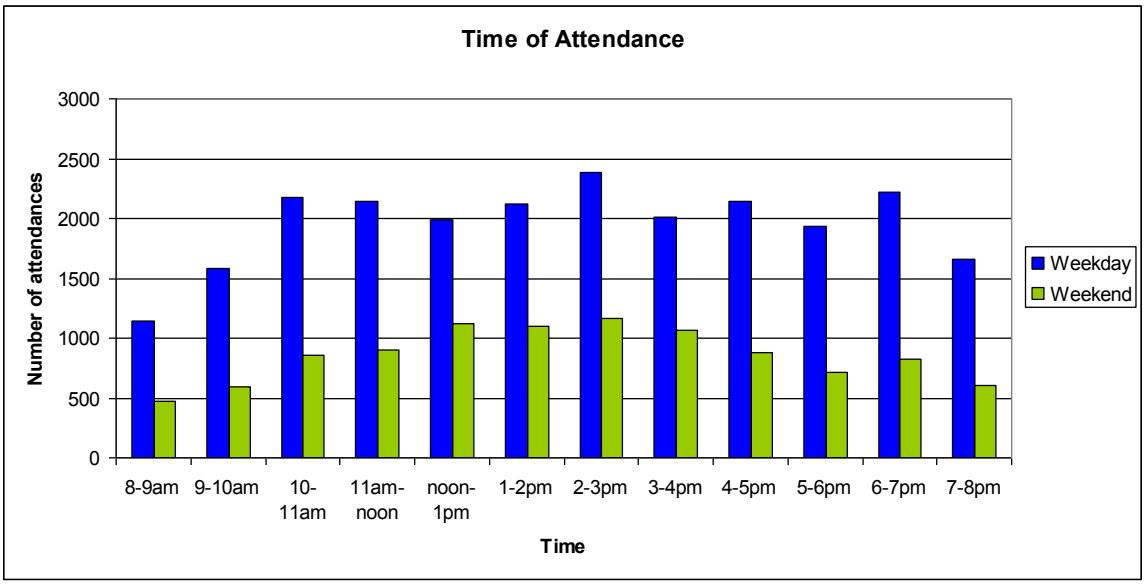

Chart.4 Representing the total number of Walk in Attendances in 2010-2011 by time

5.3 Presenting Conditions

Patients attending the Town Centre GP Surgery for walk in care without an appointment present with the usual range of conditions ordinarily seen in general practice. However, there are many more patients seen with acute minor injuries and there is also seasonal variations when, for example, there are exceptionally high numbers of respiratory distress patients both young and old attending for medical care.

Feedback from the staff on site informs us that they are now seeing and treating many more acutely ill patients who have self presented or have been referred by another community health service. The Town Centre GP Service is working closely with NHS Luton to monitor and evaluate this apparent trend but more needs to be done to address and raise awareness amongst the public, about making better usage of preventative health care rather than delaying access to healthcare until there is a crisis.
Chart 5 below shows the main presenting conditions for patients accessing walk in care in the year 2010/2011

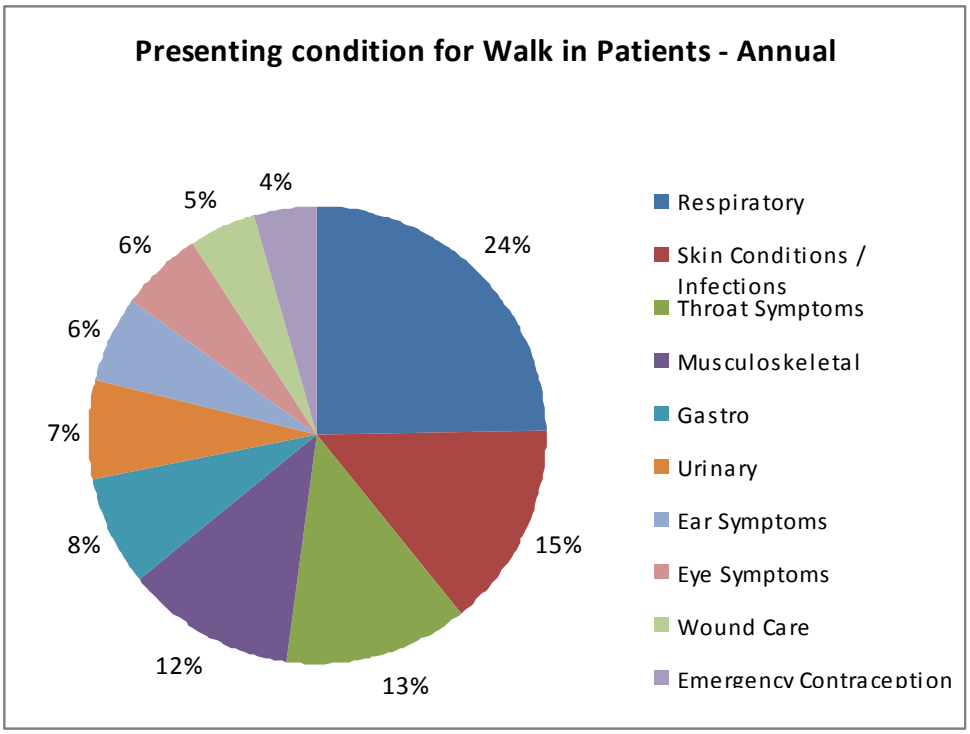

Chart. 5 Displays Presenting Conditions for year 2010/2011

5.4 Access to Contraceptive Care

Demand for emergency contraceptive care and advice, especially at the weekends, has been very high and increased overall by 301 consultations or 226% and by 358% for the age group 13-19 years, between 2009/2010 and 2010/2011

Access to contraceptive care is well provided for in central Luton but information available demonstrates that access to contraceptive care at the Walk in Centre is particularly popular with young girls due to the anonymity of the centre and the speed and ease of access. Feedback from onsite staff can quote young girls coming in with other members of their own family registering at reception with a physical ailment such as: sore ears and when in the privacy of the GP surgery requesting the 'morning after pill'

Age range	2009-2010	2010-2011
13-19	41	147
20-29	142	286
30-39	44	91
40-49	12	12
50-59	0	4
Total	**239**	**540**

Table 4: Figures for Emergency Contraception issued 2010/2011 and compared to 2009/2010

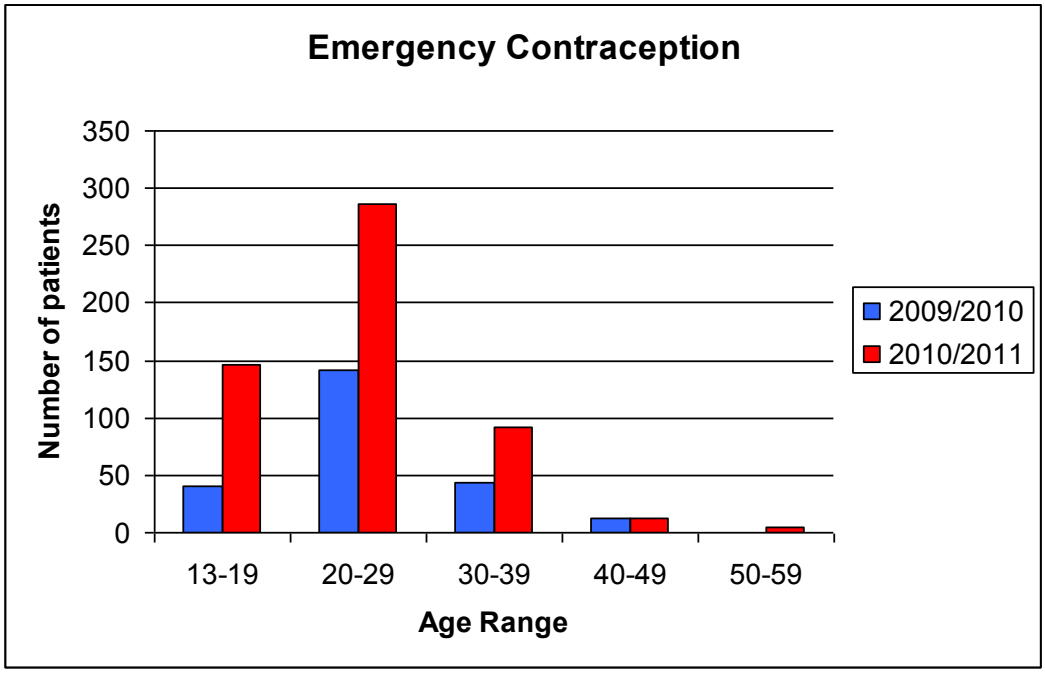

Chart.6 Displays change in Emergency Contraception between 2009/2010 and 2010/2011

5.5 Why do people use the walk-in centre?

Patients attending the town centre walk-in centre report multifactor reasons for using it, but these can be clustered into the following categories:

1. Access to the entire range of Primary Care services
2. Convenience and anonymity
3. Referral from other statutory and voluntary agency
4. Reputation

Access to Primary Care

The most frequent reason given by patients as to why they present at the Walk in Centre is because of their inability to get an appointment at their own GP's surgery or their inability to get access to the surgery due to a number of reasons. This also varies between the time of day and at weekends when most of the surgeries in Luton are closed. Patients in this category also report that had the walk in centre not been open they would have gone directly to the accident and emergency department at the Luton and Dunstable hospital.

This fact is further supported by the number of people who are resident outside of Luton but who choose to attend the walk in centre especially at the weekends. Residence from Dunstable and Houghton Regis who represent the greatest number of frequent attendees from surrounding areas have to pass the Luton & Dunstable A&E department thus dispelling the myth that people present at the accident and emergency service inappropriately because of access location.

Convenience
This is the second most frequently sited reason why patients attend for primary care and the central Luton location makes it an ideal site for people who are shopping, people who are visiting Luton and are suffering from same day or emergency illness's and people often not wanting to take time off work or out of school to go and see a Doctor. Luton's commercial and business sector have become aware of the service on their doorstep and have frequently be known to advise workers to go along and be seen on the day by a GP to reduce absenteeism from work.

Referrals from other Statutory and Voluntary Agencies.
The Luton walk in centre is becoming a 'mini primary care hub' for a number of other agencies that want a second opinion or feel it desirable to have a medical opinion for a patient they have seen.
Such agencies that make direct referrals include: community chemists, other primary care service providers including those providing contraceptive services, NHS Direct and direct referrals made through the 111 service. The walk in service now also provides an out of hours continuity of care service for patients receiving seven day a week care but when their own GP practice is closed at the weekends. Luton and other surrounding General Practitioners regularly use the TCGPS as a 'safety net' for patients who may need further advice, monitoring or treatment over the weekend when they are closed.

During the past year in particular we have become aware that other groups, especially the homeless and those that are socially excluded are able to use the walk-in centre as their main source of primary care provider. Due to the central Luton location and the ease of access, this walk in care is particularly valuable as an urgent medical support service to the voluntary sector especially NOAH who has particular expertise in caring for homeless people.

Reputation
Word of mouth has been a strong influence on how the public have heard about the Luton walk in service and has fuelled the demand for same day without an appointment access to medical care and advice. The majority of people attending the walk in service has already spoken to someone else, personal or professional, about the services and care available, opening hours and how long they are likely to wait to be seen.
As noted above, many of the Luton business and commercial sector community know of this service, its reputation for quality and speed of access, and are able to inform their employees that the service is business friendly and an asset to the Luton economy.

6 Profile of Registered Patients

In addition to the walk in service for patients without an appointment residents of Luton can also choose to register with the Town centre GP Surgery based at the Walk in Centre. During the past year 1090 patients have registered at the Town Centre GP Surgery bringing the total number of patients on the registration list to just over 2000.

6.1 Age gender of registered patients

Below in table 5 are the breakdown of the age and gender of the patients who are registered.

Age range	Female	Male
0-15	181 **(17.4%)**	176 **(18.4%)**
16-25	317 **(30.4%)**	189 **(19.7%)**
26-35	305 **(29.3%)**	335 **(34.9%)**
36-45	116 **(11.1%)**	131 **(13.7%)**
46-55	74 **(7.1%)**	82 **(8.6%)**
56-65	36 **(3.5%)**	34 **(3.5%)**
66-75	6 **(0.6%)**	10 **(1%)**
76-85	5 **(0.5%)**	2 **(0.2%)**
86+	2 **(0.2%)**	0 **(0%)**
Total	1042	959

Table 5. Breakdown of Registered Patients by Age and Gender

6.2 Residency of registered patients

Table 6 below shows the distribution of registered patients across the four Luton postal sectors.

Postcode	Number	Percentage
LU1	988	49.5%
LU2	581	29%
LU3	230	11.5%
LU4	201	10%

Table.6 Spatial distribution of registered patients

6.3 Ethnicity of registered patients

Chart.7 below shows the ethnicity of the registered patients.

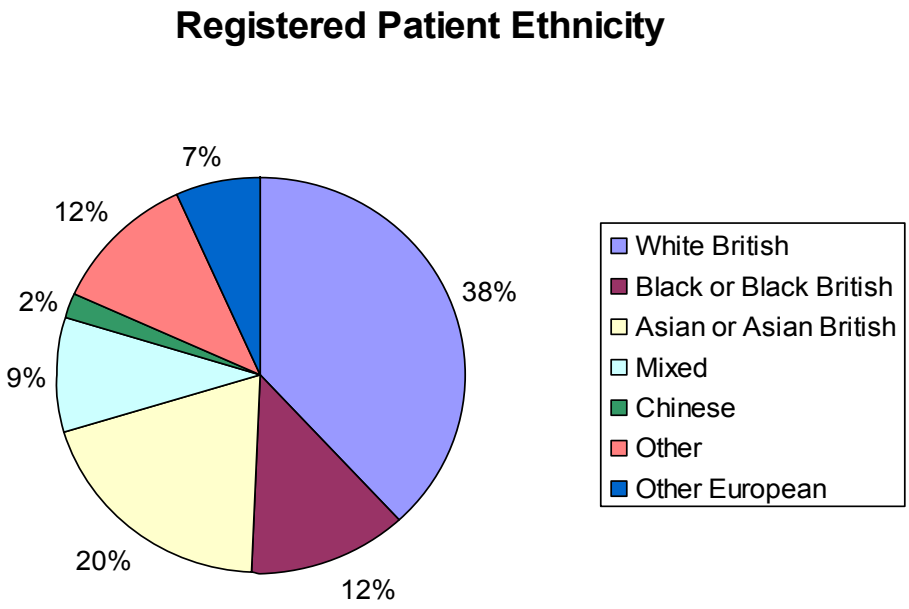

Chart.7 Registered patient ethnicity

7. Healthcare Services Provided

The Town Centre GP surgery provides a comprehensive range of Essential, Additional and Enhanced services to the registered patients.

For ease of presentation the following chart sets out to show the different services offered to registered and walk in patients as this differential in registration status is not always fully understood especially by patients who present for walk in appointments.
Please note that this list is not exhaustive but a summary for example only.

Services provided to: Registered patients and Walk in patients

Service Description	Registered	Walk In
Able to book appointment with GP or GP of choice at a time of choice up to 4 weeks in advance	✓	✖
Able to speak to a healthcare professional by telephone	✓	✖
See a GP or nurse for Immediately necessary treatment	✓	✓
Consultation with a GP and, where appropriate, physical examination for purpose of identifying the need for treatment:	✓	✖
- or carry out further investigations	✓	✖
- as result of investigation results make available such treatment or further investigations as is necessary and appropriate	✓	✖
Book consultation with a GP when:		
- ill with conditions from which recovery is generally expected	✓	✖
- terminally ill	✓	✖
- suffering from a long term condition	✓	✖
Make home visits for the seriously ill and house bound	✓	✖
Prescribe clinically effective medicines for patients:		
- who are acutely ill	✓	✓
- patients with long term conditions	✓	✖
- emergency supply of drugs for long term conditions	✓	✓
- prescribe appliances and surgical equipment	✓	✖
Make referrals to intermediate and secondary care for:		
- planned secondary care	✓	✖
- urgent referrals for suspected cancer under the 2 week rule	✓	✓
- urgent referral to secondary care for acute condition	✓	✓
- Provide patient information about healthy living, health promotion and disease prevention	✓	✓
- Ensure patient with a range of long term conditions receive regular monitoring, measurements and treatment and	✓	✖
- information on effective strategies for self management of their long term conditions	✓	✖
Provide Routine Additional Services including:		
• Vaccinations and immunizations including influenza and Pneumonoccal	✓	✖
• Contraceptive services and sexual health advice	✓	✖
• Maternity medical Services	✓	✖
• Child health Surveillance Services	✓	✖
• Cervical Screening Services	✓	✖
• Minor Surgery Services	✓	✖
• Childhood Immunizations and pre-school Boosters	✓	✖
Provision of Enhanced Care Services which include:		
• Sexual health and gynecological service	✓	✖
• Point of contact HIV Testing, Phlebotomy	✓	✖
• Smoking Cessation, Alcohol Reduction	✓	✖
• Learning Disabilities Health Checks	✓	✖
• Osteoporosis Diagnosis and Prevention	✓	✖

• Chlamydia Screening and treatment • NHS Health Checks for the 40-74 year olds • Diabetes, End of Life Care	✓ ✓ ✓ ✓	✖ ✖ ✖ ✖
Provide Walk in Patients with healthcare information, advice and treatment for: - Urgent initial Treatment relating to suspected meningitis, acute asthma and airway obstruction - minor injuries and illnesses, including:- • Wounds, burns and minor head injuries • Muscular skeletal pain and injuries • Fevers, headaches and dizziness • Upper respiratory tract infections • Eye care including removal of superficial foreign bodies • Dermatology and skin complaint and injures • Stomach and other alimentary problems • Genito-urinary tract infections or problems	 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
Lifestyle/health promotion services including: • Emergency contraception • Pregnancy testing and advice • Sexual health/lifestyle advice • Counselling, Smoking cessation • Weight management and healthy eating advice	 ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓ ✓

8. What do the patients think of this service?

Local Healthcare Solutions Ltd has sought to facilitate feedback about how the patients feel about the service received from a number of sources. To date almost all the feedback and results of surveys etc has been exceptionally positive and highly complementary about how patients experience the services provided. We carry out an annual survey using the nationally recognized CPAQ survey and have found that satisfaction rates with access, courtesy and professionalism of staff and efficient treatment provided was very high.

The Town Centre GP surgery has played host to a number of Luton leaders and dignitaries and they have all praised the centre, noted and remarked on the availability of this service as a contributory to the economic business health of the community.

The NHS Department of Health commissions MORI to carry out 'The GP Patient Survey' quarterly surveys and Figure 3 below shows the published results for the Town centre GP Surgery for the period April 2010 – March 2011

8.1 MORI survey 'Satisfaction with overall care'

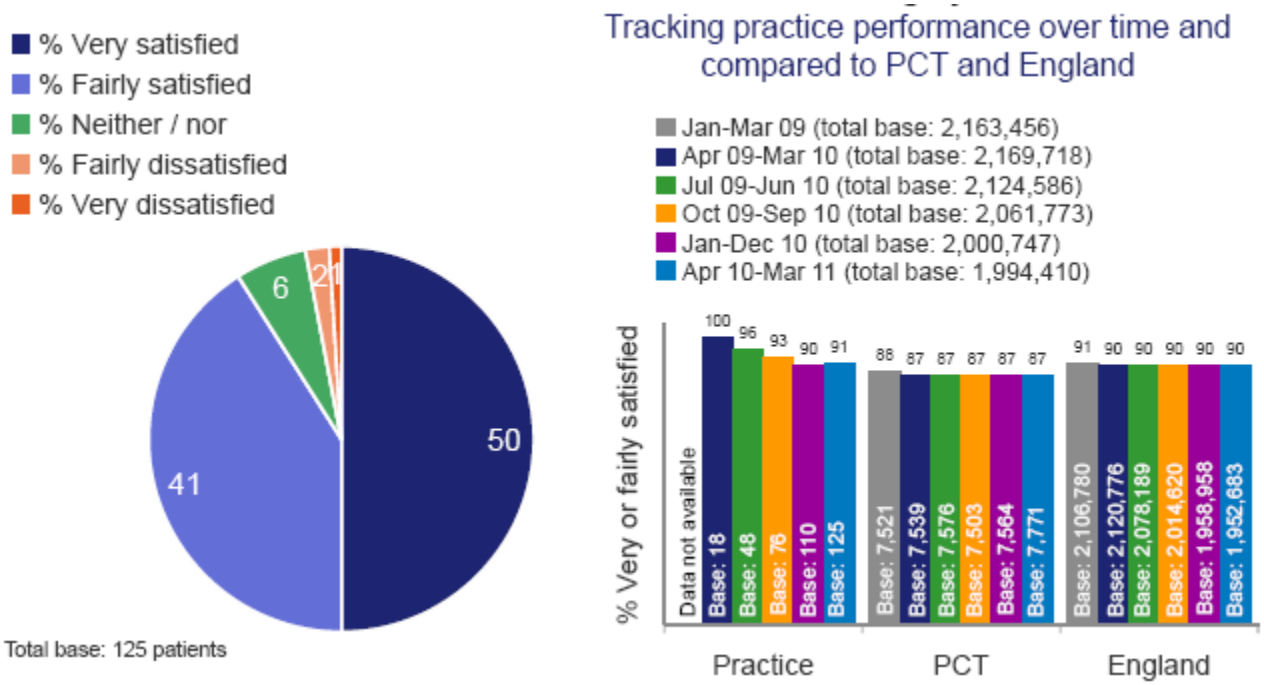

Fig.3 Patient satisfaction with overall care at the walk in centre (Obtained from Ipsos MORI)

8.2 Direct Patient feedback

In addition, the direct verbal and written feedback we have received from patients has included the following quotes:

'I was impressed by the professional, friendly and kind manner of the staff.'
'The doctor made us feel really comfortable and welcome'.
'This is a very good, quick and friendly service'.
'Lovely receptionists, very quick service, ideal for the busy women of this town'
'Surgery is very good; the staff are very helpful and friendly, the waiting time very good.'
'I am very impressed!'
'Excellent service always. Without it I knew my only other option would have been A&E on a number of occasions, so a massive saving to the NHS as well I presume

The lowest scoring area is where patients are not always able to see the same GP for each consultation: an area which presents us with a particular challenge as we aim to offer choice but have to have medical cover across the 84 hours opening hours per week.

9. Success Factors

9.1 Access

The 8 – 8pm 7 days a week opening hours are very popular with the people of Luton and the surrounding villages. The service is operated in an orderly and planned fashion which means that waiting times are minimized

The Commissioning vision present within NHS Luton during 2008 and ever since has provided the funding necessary for this enhanced Primary care health service and without which would put immense pressure on other urgent care services

9.2 The Staff

The clinical and administrative staff has a positive attitude towards working in this type of environment; we have been able to recruit quality staff and retention has been good. The GP's and Nurses are very well qualified and LHS Ltd has sought to incorporate an enriched learning and research environment into every aspect of the organization. They are also well respected by the patients both registered and people who walk in.

9.3 Location

The location in the centre of Luton close to the Arndale and main shopping area is very convenient, albeit without any on site car-parking facilities. In addition, as a very visible NHS building it carries a statement of trust and safety and as we have been informed by the users a large degree of anonymity and lack of stigma.

As shown in Figure 2 above, 14.5% of those who attend the Walk in Centre, especially at the weekends, travel in from the surrounding town and villages to receive urgent Primary Care services.

9.4 Reputation

As mentioned earlier the Town Centre GP Surgery is now highly regarded and its clinical reputation as a provider of quality primary care within Luton and the surrounding villages has increased and has become something of a local 'Primary Care Hub'

The local business community frequently remark upon its contribution to the health of the town center's economy and the Walk in Centre received a mention as a Luton asset, in Luton's bid to become a City.

9.5 General Practice model of Care

This walk-in centre is based upon the traditional general practice, easy-access model of generalist healthcare and therefore meets the needs of the people who use it. This generic holistic style of care is well regarded, represents good value for money and is appropriate for a town such as Luton that has a rich demographic mix and equally rich multiple pathology load.

10 Key areas for further development

10.1 Patient Engagement

The NHS is very keen to assist with the development of patient engagement and we are in the process of developing a patient reference group. This has also been supported by an interactive website and we are aiming to develop a number of interactive feedback sites and surveys, including the enlargement of the patient participation group. Other plans in place include the production of a monthly newsletter and a facebook page.

10.2 Managing Changes

The Town Centre GP Surgery is involved in the now nearly complete amalgamation of the two previous services; that is the nurse-led walk-in centre and the GP-led walk-in centre. This will necessitate an increase in activity but should make patient access simpler and more streamlined.

10.3 Collaborative Working

a) The success of the walk-in service would not be complete without the excellent assistance received from a number of other care providers but in particular the work of the East of England Ambulance service. However, as medical care becomes more complex new ways of working jointly with other urgent care providers need to be designed to ensure access to primary and subsequently secondary care are as seamless and efficient as possible

b) Information and advice from local chemists has meant that patients are properly signposted and the two services are able to compliment each other thus avoiding waste and inconvenience to patients

c) Demand for sexual health services is high and the TCGPS has learned that by working jointly with the Brook clinic and other sexual health providers, users are able to realize benefits from both organizations.

d) The emergence of the 111 telephone service has provided an excellent additional and easy to use telephone service to people whose condition is not serious enough for the 999 ambulance service but who still need access to advice and primary care.

f) The drug and alcohol therapy service is also based at the walk-in centre and is a source for excellent advice and cooperation for the numerous people attending the walk-in centre with drug and alcohol problems, both acute and chronic.

g) NOAH the homeless service who provide a range of services to the homeless and also the night shelter service during the winter months works closely with the walk-in service and both are aware that easy access to the healthcare available at the walk-in centre is often a matter of life and death to some of their most vulnerable and socially excluded clients and users.

h) Access to Primary Care between the hours of 8pm and 8am is often necessary for some patients and the relationship that has grown between CARE UK (the current out of hours

provider) and staff at the Town Centre GP Surgery is based upon good communications, the usage of pathways which both providers are able to use for the mutual benefit of all concerned.

11 Major Challenges & Recommendations

This report has reviewed what progress has been made to date and shown what services the organization has successfully delivered and the very many benefits that have emerged since the GP Led walk in service began in February 2009. However many success's we have had there is no room for complacency or relaxing as the future speed of change and challenges appears daily more daunting. Whilst concluding this Annual Report it is nevertheless essential that the known major challenges in the coming year are highlighted and are presented for urgent attention and recommendations. Amongst the known major challenges that needs to go to the top of the urgent 'to do' list are the following:-

1. Demand management for access to walk in Primary Care in Luton.
2. Promoting and supporting the roll out of the 111 telephone health service.
3. Working with a new Out of Hours service provider and model of care provision
4. The design and delivery of primary healthcare services that better meets the needs of the 'social network generation' and the very transient Luton population with no experience of the NHS but who need access to basic health care.
5. Amending the current model of care so that the TCGPS is also synonymous with the promotion of health and wellbeing and empowering individuals to adopt healthy lifestyles for themselves, their families and their communities.
6. Piloting service delivery methods using technology and interactive healthcare for the 1 in 3 of the population who now live with a long term condition
7. The impact of the economy on people's physical & mental health: the emerging psychology distress load and the importance of working with others e.g. NOAH
8. The Care Quality Commission (CQC) registration of the Walk in Service and the subsequent revalidation of doctors.
9. Positive engagement with the Clinical Commissioning Group (CCG) to ascertain what changes they may want to make to the level or model of care at the Walk in Centre

12. Conclusion

The focus of this Annual Report has been on activity, performance and appraising if this GP Led Walk in Centre if fit for purpose and meeting the needs of the people of Luton. This is the second such report which means that we can measure progress from some of the previous benchmarks and also we have not shrunk away from highlighting some of the major challenges: one of which is the very popularity of this new service and how best to manage demand.

The NHS Luton, Annual Public Health Report 2010 – 2011 has ably demonstrated the extent of deprivation in Luton and also the relative deprivation when compared to the East of England and England. This Town Centre GP Surgery Annual Report has charted the Post Codes of users and their ethnicity and can demonstrate that by this measure the GP Led walk in service is accommodating maximum access to quality Primary Healthcare for the residents of some of the most deprived areas in this region.

By using the measure of acceptance and overall user satisfaction with the service provided, the results of the MORI 'GP Patient Survey' April 2010 – March 2011 has shown that satisfaction with the service is exceptionally high. This is further evidenced by the attendance from people who reside within the Luton Unitary Authority and those from the more affluent surrounding villages who value choice and articulate satisfaction.

LHS Ltd continues to work closely with NHS Luton and the wider community with the expressed intention of making a positive and significant contribution to the health of the residents of and visitors to Luton and to that end have met all our set targets and objectives and look forward to the new challenges of designing and configuring health care in the future to meet the needs of the 'social network generation' whilst achieving easy access to the homeless and socially excluded groups in the true and enduring fashion of NHS healthcare *to all at the point of need.*

Bernie Naughton 2011

References

Annual Public Health Report (2010-2011) "The Health of Luton's ethnic and migrant communities" – Director of Health, NHS Luton and Luton Borough Council

[Response from The Practice]

1. **What are your views on the reasons that commissioners have given for closing walk-in centres?**
2. **Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?**

The Practice understands the views that commissioners have presented in the consultation but feels that many of them may be potentially flawed as they may apply only to a locality and/or may not be based on local evidence.

They are however important and to maximise patient outputs and to minimise risk they need to form part of the pre procurement review of WICs, as part of the wider urgent care system to ensure that all relevant areas have been considered prior to procurement. This will drive up the standard of commissioning practice.

Summary of points underpinning the statement above:

- WICs have developed a bad reputation because the idea that every locality needed one was poorly thought through.
- WICs may well create a level of unnecessary demand in some areas although we see no evidence in our WICs of this. However where it occurs it can be reversed by focused commissioning to deliver specifications that clearly articulate what patients are to be seen and those that are to be redirected back into the community/Primary Care.
- The current payment mechanism means that a local health economy does not align financial incentives between different forms of provision. This is not the same as paying twice but GPs are not being paid or having to provide the resources that their patients require.
- However this is not a valid reason to stop provision. GP consultations have risen at 3.1% a year from 1995 to 2005 but funding has not. Primary care does not have the capacity to take on the current WIC workload. GPs need to focus on LTC, frail elderly and hospital admission avoidance. Other systems need to manage the on the day work.
- Primary care does not currently provide the wide access hours [up to 8pm and weekends] that the WICs do and this is an important factor in patient decisions around where to go for care. Nor are GPs often able to provide convenient access through location which WICs often do. For example our WIC in Birmingham city centre Boots.
- Paying twice only applies if the patient a] attends WIC and then the GP and/or b] if the GPs have capacity and are not using it [in areas where there is poor PC availability then WICS are a great facility for keeping patients well].
- Spending money here can save elsewhere in the system. More focus on long term conditions and better IM&T links are needed to facilitate this.
- Information about the value and impact of WICs has been unreliable. This is an absence of evidence rather than evidence of absence. Impact on AE is difficult to assess due to the fluctuations in their attendance rates.
- Local GP vested interest has impacted on the location, hours of opening, list and activity caps for WICs to protect the status quo. This potential conflict of interest needs to be understood in any decommissioning of WICs.

- The centres are very popular with patients particularly in urban areas and serve a need and segment of the population poorly served by traditional GPs. This is particularly true of the hard to reach patients.
- Properly commissioned WICS that reflect local patient need, promote integration and are a part of the local urgent care provision will deliver good quality care to patients.
- We agree that the complexity and fragmentation of services leads to confusion for patients knowing which access route to use. This affects UCC's, MIUs and ED's and is not specific to WIC provision. This can be reduced by less variability in centre provision, appropriate naming of centres and clear marketing to the general public with consistent opening times that do not change. GPs could play a major part in this.
- The in-equality of access argument can be reduced by thoughtful placement of the WICS in areas that actually require them and improve patient access.
- The WIC model in one way is similar to well delivered GP services that have access on the day for patients, a principle that is already supported, it is not replacing an ED service.

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients? What additional information or evidence should Monitor consider?

The Practice agrees with the report's findings. Our experience is that WICs are very popular with patients and importantly can serve patients with many different needs [e.g. the homeless and patients with chaotic lifestyles that do not conform with the traditional primary care model] which are currently not addressed by traditional GPs.

In addition, access to traditional GPs is increasingly difficult and closing WICs will exacerbate this position and further disadvantage these patient groups, placing a further burden on local ED's. Finally patients will lose access to the much greater opening hours that WICS provide in the evenings and weekends.

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What other information or evidence related to this topic should Monitor consider?

As a provider of multi-site and multi-CCG primary and community care, we have experienced varying levels of commissioning quality both geographically and with CCGs and NHSE. To compound this further with two commissioning bodies for one contract has the potential to slow the process and increase the current quality issues. Conversely though having the two bodies working jointly may positively ensure that the potential conflict for CCG GPs is negated and the links with the urgent care system are in place/maintained.

Access for unscheduled care is a challenge and is likely to get worse, particularly in areas of expanding and transitory population with language, culture and deprivation also having a major impact. The challenge is that some areas desperately need WIC's both for patient safety and quality but also for financial reasons and this requires a whole system approach to unscheduled care. Split commissioning responsibility will encourage silo mentality and will perpetuate local self-interest.

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions

about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care? If so, which body and why?

Our preference would be for a single commissioner [at least until the commissioning process is stronger and can deliver this more complex system] but we do not have a particular view on which body should commission.

The most important elements are the principles they work to as commissioners. The process must be fair, equitable and transparent [negates the CCG GP conflict issue] and that the type of unit [UCC/WIC/MIU] is congruent with local needs [supporting evidenced patient need] and lies within the current/planned urgent care system in that locality with clear links to the community services, including primary care [integrated]. There needs to be consistency, regardless of the point of contact, with patients receiving the same process and quality of care. In relation to decommissioning and due to the negative patient impact any decommissioning of WIC's should be agreed by CCG and NHSE with Monitor approving the process.

Nationally we need WIC's in the right places. This needs local sensitivity as every area will have its own challenges. Our view is that WIC's offer value in unscheduled primary care, improve quality and avoid crisis through better access and reducing the ED burden and cost.

6. **What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients? What other information or evidence related to this topic should Monitor consider?**
7. **Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?**
8. **How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?**

We agree with Monitors assessment of the current payment lack of incentives for collaborative WIC and primary care working.

The current GP contract does not reflect the burden of deprivation and whilst there is an argument for financial penalties for primary care poor access, there needs to be some assessment that those surgeries have resources that reflect the real need.

Payment mechanisms are not aligned and there is no incentive for GPs to see their own patients rather than them going to a WIC or to an ED. GP funding on a capitation basis tends to lead to a management of downwards demand to their services whilst WICs are mostly funded on a cost per attendance and therefore look to drive up attendances [excepting those with activity caps]. A focus on incentivising quality and efficiency would benefit patients. In some areas a WIC will be the most efficient and cost effective way of managing the GP surgery capacity problems.

9. **Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful? Would further advice or guidance be helpful?**

We found the report summary helpful, succinct, complete and accurate.

Commissioners should follow national guidance as suggested and merge this with an evidence based local needs assessment taking due regard to the patient needs, hard to reach groups/needs, current level of primary care provision and access, wider urgent care service delivery/plans and current AE department performance.

Commissioners should ensure that equity, access, specific local initiatives and integration is fundamental to any new service specification, which builds upon the WIC foundation. The local community should be involved and the naming and marketing of services in the locality should be reviewed, updated and re-cascaded to ensure patients know what services are available, for what problems and when they are open. There should be real focus on services that are closer to patients [home or work], improve wellbeing and long term condition management, deliver IM&T integration and are provided in a simple way so that confusion and fragmentation is reduced.

Commissioners should drive this with payment incentives which encourage both the WIC and primary care providers to be joined up and more effective which in turn delivers improved patient outcomes. These principles need to be in place prior to procurement so that providers can respond to the service specification, contractual requirements and KPIs and design and deliver a needed and focused service that is right for commissioners and patients in the local area.

West Midlands Ambulance Service NHS
NHS Foundation Trust

Ambulance Service Headquarters
Waterfront Business Park
Waterfront Way
Brierley Hill
DY5 1LX

Tel: 01384 215555
Website: www.wmas.nhs.uk

4 December 2013

Review of The Provision of Walk-In Centre Services
Cooperation and Competition Directorate
Monitor
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Dear Sir/Madam,

Thank you for providing stakeholders with the opportunity to submit submissions to the facts, analysis and preliminary findings presented in Monitor's recently published ***Walk-in Centre: preliminary report***. WMAS welcomes this report from Monitor and supports the findings and issues outlined in the report. Our specific responses to the questions posed are set out below:

Q: What are your views on the reasons that Commissioners have given for closing walk in centres?

A: Whilst WMAS recognises the reasons given for the **failure** of Walk in Centres as being accurate, these are not necessarily reasons for **closure**. WMAS believes that appropriate commissioning of Walk-in Centres, along with the matching of the needs of the local population to the capacity and capability in the Walk-in Centres would lead to better outcomes for patients and better uptake of the facilities.

Q: Has Monitor sufficiently captured the concerns of commissioners related to walk in centres? Is there any other additional information that should be considered?

A: In the West Midlands, WMAS is commissioned by CCGs to develop and maintain the Directory of Services (DoS). The DoS hold information about all Walk in Centres including the opening hours, capability and capacity of the centre. WMAS is able to provide 'gap' information for commissioners which identifies where a patient calling either 999 or 111 could be clinically appropriate to be referred to a Walk in Centre but where a Walk-in Centre is not available.

This data can be used to:

- target areas of under provision
- establish where Walk-in Centres have been commissioned inappropriately in terms of availability or services provided
- where Walk in centres are provided but not used as a result of over provision or lack of information for patients.

WMAS would therefore advise that Commissioners across the country are made aware of such initiatives and use data from the Directory of Service to inform their needs assessments.

Q: What are your views on Monitor's analysis and preliminary findings related to the impact of walk-in centre closures on patients?

A: WMAS supports and agrees with this analysis and preliminary findings. WMAS also believes that the closure of Walk in Centres in areas where patients cannot easily access other services will result in increased demand for Ambulance services.

Q: What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What changes would you recommend to the way the commissioning of walk-in centres is organised.

A: The analysis seems accurate although WMAS knowledge of the specific commissioning arrangements is limited. WMAS has found that a number of CCGs have been active in reviewing their provision in this area and in considering options for the future. CCGs have responsibility for shaping local provision and ensuring integration of services and therefore it would seem appropriate for CCGs to have the responsibility for commissioning WICs. It would also seem appropriate for commissioners to provide incentives for Walk in Centres to work jointly with other providers to ensure an integrated service is provided for patients.

In addition to the specific responses set out above WMAS would like to see further consideration of the deployment of paramedics in walk in centres, minor injury and urgent care services. This would see paramedics in alternative locations alongside other health professionals as part of multi-disciplinary teams. Paramedics are able to triage effectively and have the skills and training to treat a wide range of illness and injury. This issue has been raised in the Keogh report and the WMAS Trust Board would like to see further consideration of:

- Review of the variability in service provision, opening hours, staff capability and clinical equipment: the current arrangements make it difficult for our paramedics to confidently refer patients to Walk-in Centres.

The specification of services could provide either a more standardised approach or a requirement for closer working and information to be provided. A further option for consideration may be centres that are jointly staffed by medical, nursing and paramedic staff. This would ensure better integration with the wider health economy and also promote skills transfer between professionals for the benefit of patients.

- Integration of the Directory of Services (or other mechanism) to support referrals to/from Walk-in Centres – WMAS feels the promotion of the DoS should be a key feature in reforming Walk-in Centre services. The preliminary report highlighted barriers to referrals between A&E departments and Walk-in Centres and the DoS could be utilised to achieve effective referrals between services.

- Paramedic access to Walk-in Centres during night-time closures: One of the issues experienced by ambulance services is the variable nature of services with variable opening and closing times. Walk-in Centres are closed are often closed at times of peak demand for ambulances but it may be possible for conveyance to A&E to be reduced if paramedics were able to use the facilities available at the Walk in Centre to treat a patient.

In summary WMAS is supportive of the findings detailed in the Preliminary Review and wishes to thank Monitor for the opportunity to submit this response. WMAS wishes to offer further support to inform the final recommendations and action as outlined in this letter.

Yours faithfully

Kate Barber
Strategy and Business Development Director

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

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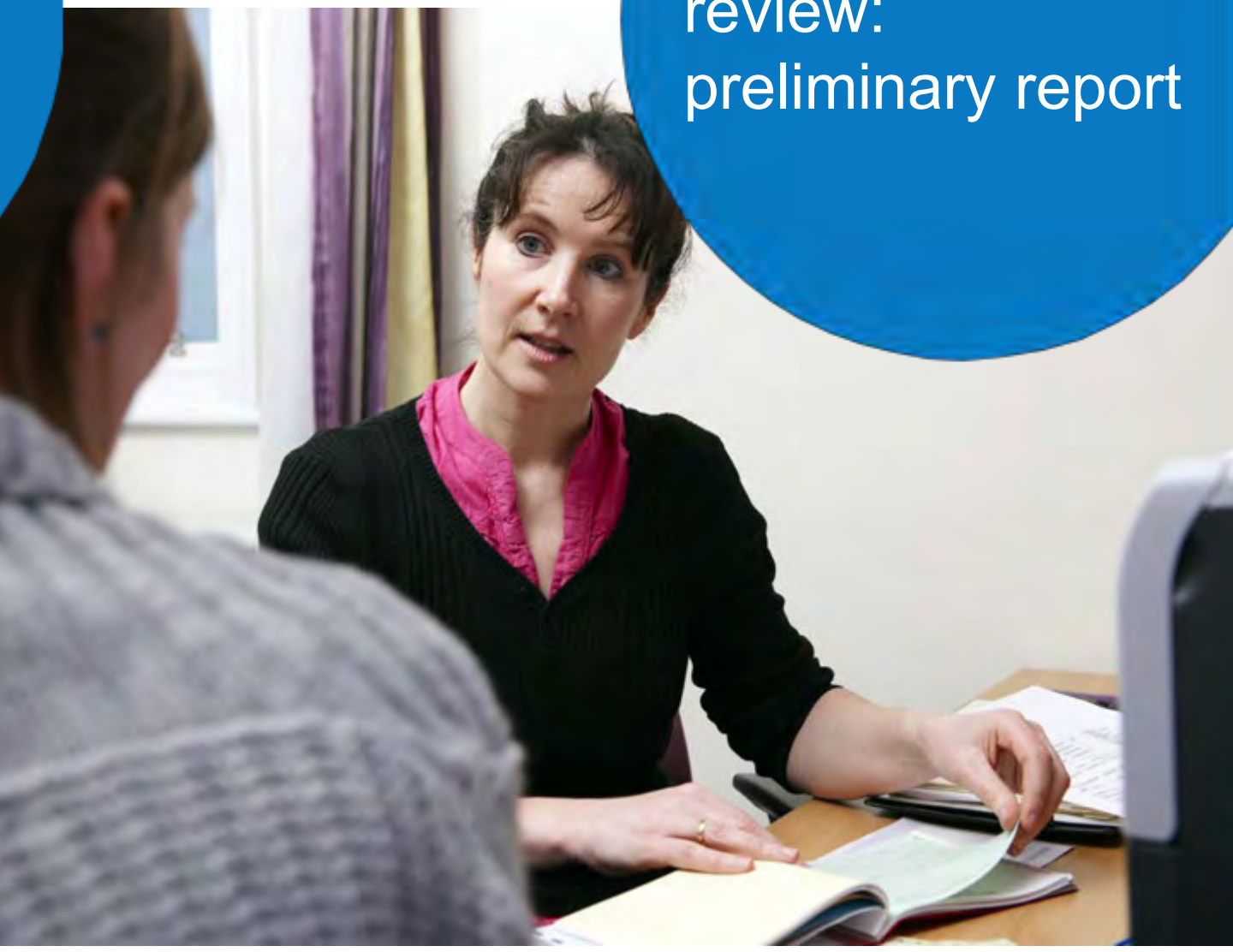
Monitor

Making the health sector work for patients

Walk-in centre review: preliminary report



www.monitor.gov.uk

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

We exercise a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences we issue to NHS-funded providers.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are run well, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Find out more: www.monitor.gov.uk

Contents

Executive summary

In the decade from 2000-2010, the NHS opened more than 230 walk-in centres across England. The aim was to improve patients' access to primary care, modernise the NHS to be more responsive to patients' busy lifestyles, and offer patients more choice.

The centres delivered primary care differently from the traditional way in which general practitioners (GPs) provide primary care services to patients who register with their practice. The walk-in centres allowed patients to access care from a GP or a nurse with no need to register or to pre-book an appointment. The centres were open for longer hours than the typical GP practice, including after normal working hours and on weekends.

Walk-in centres proved to be popular with the public. Attendances at many centres have exceeded expected levels.

However, from the start, the centres have stirred debate. Proponents say that walk-in centres are important in providing easy access to primary care, particularly when some patients have difficulties getting timely or convenient appointments with a GP practice or accessing primary care more generally. Others believe that walk-in centres create demand for care for self-limiting, minor conditions. They say that the resources used to provide walk-in centres would be better spent on other priorities.

In the last few years, more than 50 walk-in centres have closed across England. In many localities where walk-in centres still operate, commissioners are reviewing contractual arrangements and are considering closing the centres or making changes to services or locations.

Following reports of walk-in centre closures, Monitor decided to review the provision of walk-in centre services in England. As the sector regulator for health services in England, our primary duty is to protect and promote the interests of patients. We aim to enable providers and commissioners of NHS-funded care to deliver the best possible outcomes for patients today and tomorrow by creating the right incentives, providing information they need, and enforcing rules where necessary. The questions about walk-in centres that we sought to understand are:

- Why are walk-in centres closing?
- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?
- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

We undertook a broad range of research, including a survey of almost 2,000 patients using walk-in centres. We received 65 responses to a call for submissions and we gathered evidence from walk-in centre providers and commissioning bodies. We also gathered views from more than 20 stakeholders.

This report contains our preliminary findings developed as a result of this research.

We found that the provision of walk-in centre services varies greatly by location. The range of services on offer, the settings where the centres are located, the skill mix of clinicians, opening hours, the degree to which they are integrated with other providers, the types of patients attending – all of these factors can vary from centre to centre, reflecting local health economies and populations. Likewise, the reasons for a particular closure and its impact on patients largely depend on local circumstances.

Despite these variations, our review revealed some common themes in the key areas that we examined.

As to why walk-in centres are closing, commissioners who have closed centres often cited concerns that the centres were generating unwarranted demand for services; that they led to duplication because some patients used them in addition to other services for the same problems; and that they caused confusion among patients about where to go for care. Commissioners also commonly said they felt they were "paying twice" for patients who attend walk-in centres. This was because most patients attending a walk-in centre are registered with a GP practice elsewhere that is already being paid to provide their primary care under the current list-based remuneration mechanism for primary care.

We also identified some common issues in the other key areas that we explored: the potential impact on patients of walk-in centre closures; whether commissioning practices are working in patients' interests; and whether features of walk-in centre provision related to choice and competition are operating in patients' interests. Our examination of these areas has led us to the following preliminary findings:

- **In some cases, walk-in centre closures may adversely affect patients' access to primary care**

  Our research indicates that closures may adversely affect some patients by:

  - making it more difficult for them to access primary care services where there are problems with access to local GP practices; and
  - limiting the ability of primary care to reach particular groups of people who find it difficult to engage with the traditional model of GP services or whose uptake and interaction with primary care has traditionally been poor.

- **The division of commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision**

  Walk-in centres play a role in both primary and urgent care provision. The split in commissioning responsibilities between NHS England and clinical commissioning groups (CCGs) in this area, with NHS England broadly responsible for primary care and CCGs for urgent care, has led to confusion about which commissioning body is chiefly responsible for overseeing walk-in centre provision. This lack of clarity can lead to some drawbacks for patients, including: a lack of clear accountability for decision-making; lack of transparency as to who key decision-makers are; and the potential for decisions to not take a system-wide view of patients' needs and the impact of changes to walk-in centre services.

- **Walk-in centres would work better for patients if payment mechanisms were reformed**

  Current payment mechanisms for GP practices and walk-in centres discourage commissioners from offering walk-in centres, even where these may represent a high quality, cost-effective model for delivering services. In addition, the payment mechanisms do not strengthen incentives for GP practices to improve the quality and efficiency of their services so that their patients are more likely to choose their services rather than a walk-in centre.

Increasing demand for services and finite resources create significant challenges for the NHS. In taking decisions about whether to continue to procure walk-in centre services, commissioners will want to assess the benefits of walk-in centres and those of other models of care in areas including ease of access, quality of care, efficiency and affordability. It is for local commissioners to decide what is best for patients in their areas having engaged with relevant stakeholders, including people in their communities.

Taking these challenges into account and recognising commissioners' independence, in this report we set out some factors for commissioners to consider when deciding whether to continue to procure walk-in centre services. These factors are reflected in commissioners' obligations under the Procurement, Patient Choice and Competition Regulations and are drawn from the themes that have emerged in our review. They include:

- assessing patients' needs in the local area and understanding what role the walk-in centre may play in meeting those needs;

- deciding what services to procure and from whom where the contract for a walk-in centre is due to expire and the centre is identified as meeting particular needs;
- considering whether services can be delivered in a more integrated way;
- managing conflicts of interest; and
- ensuring transparency in decision making.

Assessing walk-in centres in this way should ensure that local patients' needs are met as well as they can be.

Feeding in your views

This report sets out the facts and analysis underpinning our preliminary findings. We welcome submissions from readers that respond to the facts presented and our analysis and preliminary findings, and that offer any additional information that we should consider.

Specific questions on which we invite responses are set out in Section 9.

Please submit suggestions and comments by **5pm, Tuesday 3 December 2013**. There are a number of ways to send us feedback.

By email

You can email your feedback to walkincentresreview@monitor.gov.uk

By post

Send your comments to:

Review of the provision of walk-in centre services

Monitor
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Confidentiality

We intend to publish all responses to our preliminary findings on our website, so please clearly mark any information for which confidential treatment is requested.

As we are a public body, please note that information provided in responses may be the subject of requests from the public for information under the Freedom of Information Act 2000 (FOIA). In considering such requests for information we will

take full account of any reasons that you provide in support of confidentiality, the Data Protection Act 1998 and other relevant legislation.

What we will do next

We intend to publish a final report taking into account the responses we receive; in it, we may include recommendations for commissioners, providers, or government related to walk-in centre provision. We will endeavour to publish the final report in January 2014.

1. Introduction

1.1. What are walk-in centres?

There is no standard definition of an NHS walk-in centre.[1] We define an NHS walk-in centre as a site that provides routine and urgent primary care for minor ailments and injuries with no requirement for patients to pre-book an appointment or to be registered at the centre or with any GP practice.

While all walk-in centres provide basic advice and treatment for minor conditions, the full range of services on offer vary greatly by location. In Section 4, we discuss in more detail the services that walk-in centres provide and alternatives for those services that may be available to patients.

1.2. Why is Monitor reviewing walk-in centres?

Our decision to review walk-in centre provision is grounded in our main duty as health care sector regulator: to protect and promote the interests of patients by promoting the provision of health care services that is effective, efficient and economic and that maintains and improves the quality of services.

We have a range of functions to enable us to carry out our duty. This review is based on our functions of ensuring that commissioning, choice and competition are working in the best interests of patients.[2]

We launched this review, following reports of walk-in centre closures, to understand the nature of walk-in centre provision in England[3] as well as to understand:

- Why are walk-in centres closing?
- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?

[1] For purposes of setting out commissioning responsibilities, regulations define a walk-in centre as "a centre at which information and treatment for minor conditions is provided to the public under arrangement made by a relevant body." National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.
[2] To carry out these functions, Monitor has the power to: enforce the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013; enforce the provider licence; enforce provisions of the Competition Act 1998; to make market investigation references to the Competition Commission; to review mergers between NHS trusts; and provide advice on merger benefits to the Office of Fair Trading for mergers involving foundation trusts.
[3] See *Review by Monitor of the provision of walk-in centre services in England*, Scope of review, 31 May 2013, www.monitor.gov.uk/sites/default/files/publications/ToPublishReviewWalkinCentreServicesMay2013.pdf.

- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

Some issues related to walk-in centre provision fell outside the scope of our review. We did not investigate, for example, how the quality of care at walk-in centres compares to other primary care services. We also did not assess the underlying costs of providing care in walk-in centres compared to the costs in other settings.[4] Commissioners are best placed to consider these issues locally when evaluating which models of care are best to meet the needs of their patients.

Further, some of the issues we identified in our review of walk-in centres relate more broadly to the provision of GP services. In July 2013, Monitor issued a call for evidence to better understand how GP services may or may not be working in the best interests of patients.[5] As part of that exercise, we may consider some of the issues raised in this review that relate more broadly to general practice provision. We have flagged in this report those issues that are beyond the scope of our review, but may fall within the scope of our broader look at GP sector services.

1.3. Our key pieces of research

- **Call for submissions:** we issued a call for submissions and received 65 responses from service users, commissioners, walk-in centre providers (both independent and public), GPs, and several local and national organisations.
- **Patient survey:** to better understand who uses walk-in centres and why, we commissioned a survey of 1,886 patients at 20 centres across England. The patient survey report has been published alongside this report.[6]
- **Stakeholder meetings:** we met with more than 20 stakeholders, mostly walk-in centre providers and commissioners, and we spoke to some academic experts who have studied walk-in centres.
- **Information and data from providers and commissioners:** in addition to gathering publicly available information, we sought information and data from walk-in centre providers and commissioning bodies.

1.4. Topics covered in this report

Section 2: The history and policies behind walk-in centres

Section 3: The policy context today

[4] Comparing costs to deliver services in different setting is complex and subject to the reliability of underlying data. Monitor is working on improving costing as part of its role in setting prices for NHS-funded services. See www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-10.
[5] See www.monitor.gov.uk/gpservices
[6] See Accent, *Patients' use of walk-in centres*, Report, October 2013 [Monitor's patient survey report].

2. Walk-in centres were introduced to improve access to primary care, modernise the NHS, and offer patients more choice

Between 2000 and 2010, the government launched initiatives to establish NHS walk-in centres throughout England as part of efforts to achieve three major health care policy goals:

1. **Improving access to primary care**

   The government wanted to improve access to primary care because of concerns that people sometimes found it difficult to access health care quickly from general practice. The requirement to register with a GP practice close to home, in particular, was thought to present barriers to access for certain groups, including commuters, the homeless, tourists and travellers.[7] Later in the decade, the Department of Health's public consultations raised concerns that:

   "*many people are seeking the opportunity to access routine primary care from a GP in the evenings or at weekends. And a quarter of patients still report that they cannot book advance appointments at their GP practice. It is also significant that young working males and black and ethnic minority communities are more likely to report difficulties in accessing GP services.*"[8]

   The walk-in centre model was introduced to lower the barriers to accessing primary care.

2. **Modernising the NHS to make it more responsive to patients' lifestyles**

   The government wanted to modernise the NHS to meet the needs of people with busy schedules, such as parents and workers who have difficulty taking time off work to visit their GP.[9] Walk-in centres were to offer conveniently-located services with extended hours including weekends, and fast access to an appointment. Many centres were expected to keep waiting-times to within 15-30 minutes for a triage assessment or a full consultation.[10]

[7] C. Salisbury, M. Chalder, et al, *The National Evaluation of NHS Walk-in Centres*, Final Report, July 2002, p.1.
[8] Department of Health, *NHS Next Stage Review Interim report*, October 2007, p.25.
[9] See press release, 1999/0226, *Up to £30 million to develop 20 NHS fast access walk-in centres*, 13 April 1999.
[10] L. Mountford, R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, The King's Fund, 2001; Department of Health, *Contract for Primary Medical Care Services* [for use with health centres as per EAPMC criteria], 11 July 2008, Schedule 2, p.13, available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086657.

3. Offering more choice to patients

> The government has sought to expand choice in both secondary and primary care to give patients more control over their care and to strengthen incentives for providers to improve services in order to attract patients. Walk-in centres, particularly those introduced later in the decade, were intended to give people greater choice from a range of primary care services.[11]

While walk-in centres were established primarily to provide and improve access to primary care, our conversations with stakeholders and other evidence suggests that many in the sector view the main purpose of walk-in centres as reducing pressures on A&E departments.[12]

Most walk-in centres in England were established through the three national initiatives described below. The centres reflected local commissioners' decisions about where, how, and what services were to be provided.[13]

2.1. 1999-2004: Nurse-led walk-in centres

In April 1999, Prime Minister Tony Blair announced plans to establish a number of nurse-led walk-in centres that would provide information and treatment for minor conditions.[14] Services were to be provided without the need for a pre-booked appointment for extended hours, typically 7am to 10pm, 365 days a year. The centres were to be sited in easily accessible locations, such as town centres or adjacent to A&E departments.[15]

An additional goal of the nurse-led centres was to maximise the role of nurses in primary care. Beginning with pilot sites, the Department of Health eventually established about 72 nurse-led walk-in centres throughout England.[16] This included a final wave of centres established in 2004 that were mostly co-located with A&E departments as way to reduce pressure on A&E services.[17] The centres had to be managed by an NHS body (such as an NHS trust) or GP co-operatives and were expected to build on, rather than duplicate, existing services, and to have links with

[11] Department of Health, *NHS Next Stage Review: Our vision for primary and community care*, June 2008, p. 28.
[12] See, eg, NHS Office of the Strategic Health Authorities, *Emergency Services Review, Good practice in delivering emergency care: a guide for local health communities*, July 2009, p.13 (urgent care centres, walk-in centres, and minor injury units "are intended to provide alternatives to Emergency Department attendance").
[13] In addition to walk-in centres that started as part of these national initiatives, our research suggests that there are a small proportion (we estimate less than 10% of all centres) that started as part of local initiatives or evolved from existing local services.
[14] See press release, 1999/0226, *Up to £30 million to develop 20 NHS fast access walk-in centres*,13 April 1999.
[15] NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/116, 11 May 1999.
[16] *The rise of the walk-in centre*, Nursing Times,18 August 2008. Other sources gave a slightly different number of nurse-led centres that opened as part of the national initiative.
[17] Salisbury et al, *The impact of NHS walk-in centres on A&E services*, February 2006.

local GP practices.[18] Some centres had access to a GP for patients who needed one.[19]

GPs and other health professionals initially voiced concerns that the walk-in centres would adversely affect continuity of care or that the centres would increase demand.[20] However, in later years, some GPs began referring their patients to the centres for services such as blood pressure checks and dressings.[21]

Although walk-in centres were new to the NHS, minor injuries units had already been established in several towns in the UK to serve patients with urgent care needs on a walk-in basis. And walk-in centres were already operating in a number of other countries, including the US, Canada, Australia and South Africa.[22]

2.2. 2005-2007: Commuter walk-in centres

Building on the policies behind the first walk-in centre initiative, the government established six GP-led walk-in centres between 2005 and 2007 aimed at commuters in London, Manchester, Leeds and Newcastle.[23]

The commuter centres were introduced as part of the Independent Sector Treatment Centres programme launched in 2002. The programme sought to increase independent sector involvement in the NHS to increase capacity to reduce waiting-times as well as offer patients greater choice of services to stimulate improvements in quality through competition.[24]

At the time, walk-in centres were viewed as part of a broader vision for primary care, as set out in Table 1.

[18] NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/116, 11 May 1999.
[19] L. Mountford, R. Rosen,
[19] L. Mountford, R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, The King's Fund, 2001.
[20] A walk-in? Now you're talkin', *Health Service Journal*, 4 May 2000.
[21] The rise of the walk-in centre, *Nursing Times*,18 August 2008.
[22] C. Salisbury, J. Munro, Walk-in centres in primary care: a review of the international literature, *British Journal of General Practice*, January 2002; pp.53-59.
[23] Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, June 2004, paragraph 5.8. The government pledged to open more so-called "commuter centres" in 2006, but these openings did not occur.
[24] Department of Health, *Independent Sector Treatment Centres*, Report to the Secretary of State for Health, 16 Feb. 2006.

Table 1: The government's vision in 2004 for primary care

THE NHS IN 2000	THE NHS IN 2008
Patient has to make an appointment with a registered GP for advice, diagnosis and referral	Patient chooses whether to make an appointment with a GP or practice nurse, visit an NHS Walk-in Centre or Pharmacy Service Centre, or contact NHS Direct for advice and diagnosis
Patient may wait several days for an appointment with their GP	Patients see a primary care practitioner within 24 hours when they need to or a GP within 48 hours
GP makes decision about how, when and where patient is treated	Patient chooses how, when and where they are treated – from a range of providers funded by the NHS and accredited by the Healthcare Commission

Source: Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, June 2004, p.33.

The commuter centres were to be open from 7am to 7pm, 365 days a year and were to offer treatment for minor illness and injuries, prescriptions and pharmacy services, and other services such as physiotherapy and blood pressure checks.[25] Six centres were contracted from independent providers using five-year contracts at a total cost of about £9 million a year.[26] However, by December 2011, all six commuter centres had been closed upon contract expiration, mainly because they saw fewer than expected patients,[27] were poorly located, or were not thought to represent value for money.[28]

2.3. 2007-2010: The Next Stage Review and the emergence of GP-led health centres

In October 2007, as part of his *Next Stage Review*, health minister Lord Darzi announced new investment to develop 150 GP-led health centres that offered both:

- a list-based GP practice at which patients could register if they chose; and
- a GP-led service open to any member of the public, including those registered at GP practices elsewhere or those not registered with any GP practice. The

[25]Department of Health, *New surgeries offer commuters fast-track to treatment*, Press release, 4 November 2004.
[26] Bureau Investigates, *Get the data: Commuter walk-in centre closures*, May 2011.
[27] /www.ncbi.nlm.nih.gov/pubmed/2087525
[28] http://alternativeprimarycare.wordpress.com/2011/06/16/the-light-nhs-leeds-walk-in-centre-to-close/

service was to allow any member of the public to access GP services through pre-bookable appointments or walk-in appointments that did not require pre-booking.[29]

Under the Equitable Access to Primary Medical Care (EAPMC) programme, each Primary Care Trust (PCT) was expected to commission at least one GP-led health centre in their area.[30,31]

The centres were to be open between 8am and 8pm, 7 days a week, and were to be situated in easily accessible locations. They were intended to be responsive to local needs and, to foster integrated care, they were to be co-located where possible with other community-based services such as diagnostic, therapeutic (eg, physiotherapy), pharmacy and social care services.[32]

The GP-led health centres – commonly referred to as "Darzi centres" – were commissioned between 2008 and 2010. PCTs procured the centres primarily through competitive tender for Alternative Provider Medical Services (APMS) contracts, which allowed bids to provide the services from the independent sector, GP-formed companies, traditional GP practices, social enterprises and NHS trusts.[33] The Department of Health raised PCTs' baseline funding to pay for the centres.[34]

The centres were controversial from the start. For example, the British Medical Association (BMA) stated in a submission to our review that it "*supported establishing these centres where there was a proven need for the services they offered*" but it did not support the blanket approach requiring every PCT to open a centre. The BMA also stated: "*the resources invested in walk-in centres would be better targeted at existing GP services, which have been stretched for many years.*"[35] Several stakeholders also told us that some PCT commissioners felt they were being forced to procure a service that they did not need.[36]

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[29]. Department of Health, *NHS Next Stage Review Interim report*, October 2007, p 25.
[30] We identified 150 GP-led health centres that opened under the EAPMC programme (including those that have now closed). Our research suggests that a few PCTs out of 150 did not commission any centres at all, while a few commissioned more than one. The EAPMC also provided funding for 113 new standard GP practices (with no walk-in requirement) in the most under-doctored (and often the most deprived) areas of the country. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm
[31] Department of Health, *NHS Next Stage Review Interim report*, October 2007; Department of Health, *High Quality Care For All: NHS Next Stage Review Final Report*, June 2008.
[32] Department of Health, *Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs*, Version 3, August 2008.
[33] See J. Ellins, C. Ham, & H. Parker, *Choice and Competition in Primary Care: Much Ado About Nothing?*, University of Birmingham Health Services Management Centre, November 2008.
[34] Department of Health, *Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs*, Version 3, August 2008, p. 9.
[35] BMA submission to Monitor review, June 2013.
[36] Reflecting last year on how the GP-led health centres were established, Lord Darzi wrote that while he still believes the centres are "a good idea," "the initiative's credibility was badly damaged by its top-

On the other hand, we were told that some commissioners welcomed the walk-in centres and the opportunity to design the services around local needs.

However, soon after (or in some instances even before) the centres opened, some PCTs began to renegotiate contracts to change the services provided by the centres, moving away from initial policy guidance, such as by reducing opening hours or dropping the option of patient registration. (See Section 6 for a description of changes to walk-in centre provision).

We refer throughout this document to the walk-in centres established as a result of the EAPMC programme as “GP-led health centres.” These have both a registered list GP practice and a walk-in service that is available to patients who are registered or not registered with the practice.

down nature” and did not always reflect local needs. A. Darzi and P. Howitt, Integrated care cannot be designed in Whitehall, *International Journal of Integrated Care*, 18 May 2012.

3. Since 2010, policy objectives have evolved to focus on improving access to 24/7 care and better managing demand

The policy context and the economic climate have changed since walk-in centres were established. In 2010, the government's whitepaper, *Equity and excellence: Liberating the NHS*, provided a blueprint for the Health and Social Care Act 2012. Among other reforms, the Act abolished PCTs and transferred commissioning responsibilities to NHS England and to clinical commissioning groups (CCGs) (which are made up of local GPs). *Equity and excellence* also reaffirmed the government's commitment to offer patients greater choice of service providers.[37]

Financial pressures are a key focus of policymakers, commissioners, and providers today. The Quality, Innovation, Productivity and Prevention (QIPP) programme was launched to achieve £20 billion in savings to be reinvested in the NHS. Monitor recently published a report on the challenge of closing a predicted £30 billion funding gap by 2021.[38]

There also are efforts underway to better manage demand for services. For example, NHS England is reviewing how urgent and emergency care are organised. The review aims to develop a framework for better managing demand while ensuring that people have access to 24/7care for urgent medical needs.[39] Urgent Care Review Boards are also being formed in every community to review and develop local plans to improve urgent and emergency care.[40] The National Audit Office recently published a report looking at the causes behind increased emergency admissions, how well emergency admissions are managed and what might be done to better manage demand.[41]

Improving access to primary care also continues to be a major policy goal. In early October 2013, the Prime Minister announced a proposal to implement seven-day 8am-8pm GP access to "help thousands who struggle to find GP appointments that fit in with their family and work life."[42] Under the proposal, nine GP groups will operate pilots to provide extended and flexible access, including email, Skype and phone consultations, as well as online registration and choice of practice. The groups will apply to a £50 million fund for support for the pilots.

NHS England also intends to develop a national strategic framework for commissioning of GP services that addresses key challenges facing the sector: an ageing population, growing co-morbidities and increasing patient expectations;

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[37] *Equity and Excellence*, p.45.
[38] See: www.monitor.gov.uk/home/news-events-publications/latest-press-releases/monitor-sets-out-how-secure-the-future-the-nhs.
[39] www.england.nhs.uk/2013/01/18/service-review/
[40] http://cms.pulsetoday.co.uk/Uploads/2013/05/09/d/u/x/Final-A-and-E-Improvement-Plan.pdf.
[41] www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/
[42] https://www.gov.uk/government/news/seven-day-8am-8pm-gp-access-for-hard-working-people.

increasing pressure on NHS financial resources; growing dissatisfaction with access to services and persistent inequalities in access and quality of primary care; and growing workforce pressures.[43]

The Department of Health's recent consultation on its Mandate to NHS England also stated: *"we want to improve people's access to primary care through new forms of provision including rapid walk-in access."*[44]

[43] NHS England, *Improving General Practice – A Call to Action, Slide Pack*, August 2013.
[44] Department of Health, *Refreshing the Mandate to NHS England: 2014-2015*, Consultation, p.9.

4. Walk-in centres today: service features vary by locality

While walk-in centres were largely established under national initiatives, local commissioners often tailored the centres to reflect local needs and priorities. As a result, many key features of walk-in centres, such as where they are sited, opening hours, skill-mix of staff, the range of services provided, and the degree of co-location with other health and social care services vary by walk-in centre.

The names of walk-in centres also vary and are not necessarily indicative of the services provided. Labels include NHS walk-in centre or simply walk-in centre, GP-led health centre, equitable access centre, open access centre, 8 to 8 centre, same day centre, health centre, medical centre, and primary care centre.

There is no central repository containing data and information about all walk-in centres in England.[45] In this section, we provide an overview of walk-in centres that is based on our compilation of publicly available information, data and information received from commissioners and providers, and conversations with stakeholders.

We also provide an overview of services that might be considered an alternative to walk-in centre services. While services labelled as urgent care centres and minor injuries units often look very similar to a walk-in centre, the nature of services can be different to walk-in centre services and many offer a suitable alternative only for certain health care needs (see Section 4.3).

4.1. Numbers and locations of walk-in centres in England

Our research identified 185 walk-in centres operating throughout England.[46] A list of these is provided in Annex 2. This number includes 135 walk-in centres that are GP-led[47] and 50 that are nurse-led.

Walk-in centres exist in most areas of England (see Figure 1), and are present in all of the (former) Strategic Health Authority (SHA) areas of England.[48] We found that

[45] The Department of Health collects data about walk-in centres operated by NHS trusts and NHS foundations trusts (Department of Health, National Schedule of Reference Costs 2011-12 for NHS trusts and NHS foundation trusts, available at https://www.gov.uk/government/publications/nhs-reference-costs-financial-year-2011-to-2012); however, trust-run centres represent a small fraction of the total number of walk-in centres. Likewise, NHS England A&E statistics include attendance figures for some NHS trust-run and independently-run walk-in centres but not the full universe of walk-in centres (NHS England, Weekly A&E SitReps, available at www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/).

[46] This figure reflects centres that were in operation in England at the time of our review and centres fitting our definition of walk-in centre, as described in Section 1.1. Our list of walk-in centres was developed using information from the Care Quality Commission, the Health and Social Care Information Centre, submissions from providers and commissioners, CCG information request responses, and our own web research and conversations with stakeholders.

[47] Of the 135 GP-led walk-in centres that we identified, 124 are GP-led health centres (known as "Darzi" centres) that opened under the Equitable Access to Primary Medical Care programme. The other 11 GP-led walk-in centres appear to have developed from local initiatives.

centres are more prevalent in the North East and North West, London and West Midlands compared to other areas of England (see Table 2). We identified 81 CCGs out of 211 total that do not have a walk-in centre in their geographical boundaries. Nineteen CCGs told us that they have no walk-in centres, no urgent care centres and no minor injuries units located within their geographical boundaries.[49]

[48] Although SHAs no longer exist, they are a convenient way of dividing England into smaller regional areas. SHAs were also responsible for overseeing health care services in each region when the latest wave of walk-in centres was established. The SHA areas adopted are those that were formed in 2006. The 10 SHA areas are: North East, North West, Yorkshire & Humber, East Midlands, East of England, West Midlands, South Central, South East Coast, South West, and London.

[49] This figure is most likely an underestimate as approximately half of the 211 CCGs in England did not respond to our request for information. See section 4.3 and Annex 1 for a description of these other services.

Figure 1: Map of walk-in centres in England

Source: Monitor analysis

Table 2: Number of walk-in centres by (former) SHA areas

Strategic Health Authority	Number of walk-in centres	Population mid-2012 ('000)	Number of walk-in centres per million residents
North East	19	2,602	7.3
London	42	8,308	5.1
West Midlands	25	5,643	4.4
North West	31	7,084	4.4
Yorkshire and the Humber	15	5,317	2.8
South East Coast	11	4,514	2.4
South West	12	5,340	2.2
East Midlands	10	4,568	2.2
East of England	12	5,907	2.0
South Central	8	4,211	1.9
Total	**185**	**53,494**	

Sources: Monitor analysis; ONS Population Estimates mid-2012

Walk-in centres are often located within areas of relative deprivation. Our research suggests that 28% of walk-in centres are located within the 10% most deprived areas, whereas 1% of walk-in centres are located within the 10% least deprived areas (see Table 3).[50]

[50] This has been calculated using the Index of Multiple Deprivation (IMD), a combination of 7 indices that measure aspects of deprivation including income, employment, health and crime. Indices are calculated by Lower Layer Super Output Areas (LSOAs), of which there are 32,482 in England. Source data and more information about the IMD are available here: https://www.gov.uk/government/organisations/department-for-communities-and-local-government/series/english-indices-of-deprivation.

Table 3: Deprivation levels of walk-in centre locations

Percentile of deprivation	Number of walk-in centres	Percentage of total walk-in centres
10th	2	1%
20th	9	5%
30th	6	3%
40th	10	5%
50th	12	6%
60th	12	6%
70th	26	14%
80th	23	12%
90th	34	18%
100th	51	28%

Least deprived areas

Most deprived areas

Sources: Monitor analysis; The English Indices of Deprivation 2010

At a local level, our research indicates that walk-in centres are generally sited in one of five types of locations:

- in urban city/town centres such as in a central shopping area or close to a train station;[51]
- within suburban locations, for example, close to or within large residential estates;[52]
- within or on the fringes of commercial/industrial areas, sometimes close to residential estates;[53]

[51] There are many examples of walk-in centres in urban/town centres including Reading Walk-in Centre, Liverpool City Walk-in Centre, Brighton Station Health Centre, Worcester Walk-in Health Centre, Soho Walk-in Centre, Walsall Walk-in-Health Centre, Birmingham NHS Walk-in Centre and Swindon Walk-in Centre.

[52] Examples of walk-in centres located within residential areas include Battle Hill Health Centre, Dudley Borough Walk-in Centre, The Practice Loxford (Loxford Polyclinic), and Putnoe Medical Centre.

[53] For example, Barkantine Practice, Cardrew Health Centre, and Quayside Medical Centre.

- in community hospitals or other community health care hubs;[54] and
- at acute hospital sites, with or without an A&E.[55]

4.2. Overview of services provided

Most walk-in centres are open seven days per week for extended hours, such as from 8am to 8 pm, or 7am to 10pm.[56] Services provided vary and may depend on whether a walk-in centre is nurse-led or GP-led; however, walk-in centres commonly provide advice and treatment for minor illnesses and injuries including:

- coughs, colds and flu-like symptoms;
- skin conditions or skin infections;
- stomach upset or pain;
- breathing problems (such as asthma);
- back pain;
- urinary tract infections;
- ear, eye and throat infections;
- cuts, strains and sprains; and
- insect and animal bites.

Beyond advice and treatment for these and other minor conditions, the services provided depend on the centre and local commissioning priorities.

Nurse-led walk-in centres

Nurse-led centres often provide health promotion and advice and some provide information such as opening hours and contact numbers for other local health services. Several offer assessment, diagnosis and initial therapy for deep vein thrombosis (DVT) upon referral from GPs. Some centres provide blood tests, emergency contraception or travel vaccinations. Nurses or other staff who are qualified prescribers can issue prescriptions, and the centres may be authorised to offer certain medications within set guidelines.

[54] For example, Solihull Healthcare & Walk-in Centre, Finchley Walk-in Centre.
[55] For example, Royal Devon & Exeter Walk-in Centre.
[56] A number now operate with reduced opening hours. (See Section 6 for a description of changes to walk-in centre provision.)

Some centres provide wound care such as the removal of sutures and dressings; others do not. Some centres have access to x-ray services, although these may be offered for limited hours and may be operated by a separate provider.

Generally, nurse-led centres provide a single episode of care – they do not provide ongoing care for patients with chronic conditions although they may treat patients with symptoms of such conditions. However, some providers of nurse-led centres said they are looking to develop joint pathways for certain services. For example, 5 Boroughs Partnership NHS Foundation Trust is working with commissioners and other providers to develop pathways for people with chronic conditions to go direct from a walk-in centre to specialist care, including one for patients with chronic obstructive pulmonary disease.

GP-led health centres

GP-led health centres can offer many of the same services as nurse-led centres, however, services available may depend on whether the patient is registered with the practice or not. The original EAPMC template contract for the GP-led health centres[57] required them to offer, at a minimum, "essential services" for registered patients. These are services that a traditional GP practice would offer and include care for patients "who are, or believe themselves to be":

(a) ill, with conditions from which recovery is generally expected;

(b) terminally ill; or

(c) suffering from chronic disease.[58]

In addition, PCTs could choose to contract for a host of additional or enhanced services[59] for registered patients, which could include a range of nationally-defined or locally-defined services, such as cervical screening, contraceptive services, vaccinations and immunisations, minor surgery, weight loss or smoking cessation clinics, anticoagulation monitoring and others.

For non-registered patients, PCTs could exclude some essential services, so long as the centres provided care for a list of minor conditions for non-registered patients.

[57] The Department of Health issued a contract template for PCTs to use, and (other than with respect to terms mandated under the APMS Directions) tailor locally when procuring the GP-led health centres. We refer to this as the "EAPMC template." We examined the template dated 7 January 2009 that is available in Department of Health online archives at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086657

[58] The definition of essential services comes from the National Health Service (General Medical Services Contracts) Regulations 2004, which govern General Medical Services (GMS) contracts for GP services.

[59] The additional services that could be on offer are defined in the EAPMC contract template. For a definition of enhanced services, see: www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices.aspx.

PCTs also could choose which additional, enhanced or specialist services (if any) the GP-led health centre was required to offer to non-registered patients.

Our review of several GP-led health centre contracts suggests that some PCTs contracted their centres to offer non-registered patients close to the full range of services provided for registered patients. Some went even further to try to target certain high need populations. For example, the Walsall GP-led heath centre in West Midlands was commissioned to provide special services for homeless patients, violent patients, nursing home patients, alcohol misusers, and people with learning disabilities as well as "street-doctoring" and sexual health services.[60]

Providers told us that, in practice, the main difference between services offered to registered and non-registered patients is in the ongoing nature of care for registered patients. Non-registered patients do not, for example, receive regular treatment for chronic conditions, but may be encouraged to see their GP practice or to register with the centre's GP practice for further care.

GP-led health centres were supposed to offer both bookable and non-bookable (walk-in) appointments to both registered and non-registered patients. We found that some centres have a greater proportion of bookable appointments, while others more often provide walk-in appointments. Some services at some centres are available only by booking an appointment in advance.

Although walk-in centres are typically described as "nurse-led" or "GP-led," in practice, a walk-in patient is likely to see a nurse-practitioner at either type of centre, and will have access to a GP if needed.

4.3. Alternative service options to walk-in centres

Based on the types of services available at different services, a number of alternatives to walk-in centres may be available within a locality for people needing advice or treatment for minor illness or injury. These include:

- urgent care centres;
- minor injuries units;
- A&E departments;
- NHS Direct and NHS 111 services;
- GP services (in hours);
- out-of-Hours GP services;

[60] The PCT closed the registered list practice at Walsall in December 2011; however, the walk-in element and full range of services are still available for unregistered patients.

- community pharmacy services; and
- self-care and self-management.

These alternatives are described in detail in Annex 1.

Like walk-in centres, the service features for each of these alternatives can also vary widely by locality. However, broadly, walk-in centres typically differ to other services across certain features, including:

- whether services are only available to patients with urgent care needs;
- whether services are available on a walk-in basis;
- whether services are available to unregistered patients;
- the time and day of week that services are available;
- where services are located within a local area; and
- who is responsible for leading delivery of services (for example, a nurse, a GP, or consultant).

An overview of how the services vary is provided in Table 4. The table illustrates a number of distinctions between walk-in centres and alternative services. Urgent care centres and minor injuries units, for example, while offering services with extended hours and on a walk-in basis, will sometimes turn away patients with non-urgent needs (instead sign-posting them to their registered GP practice) (See Annex 1 for further discussion).

Likewise, services such as the new 111 initiative and out-of-hours GPs are not accessible on a walk-in basis (they are telephone-based); they also refer patients back to their registered GP practice if their needs are assessed to be non-urgent. GP services (in hours) typically offer more restricted opening hours compared to walk-in centres; also services generally are not available on a walk-in basis and patients must first register before using services.

Table 4: Features of different health care providers offering routine and urgent primary care

Service options	Routine primary care	Urgent primary care	Services accessible on a walk-in basis	Opening hours[1]	Service lead
Walk-in centre	✓	✓	✓	Extended	Nurse or GP
Urgent care centre	?[2]	✓	✓	Extended or 24/7	GP
Minor injuries unit	X[3]	✓	✓	Extended or 24/7	Emergency Nurse
A&E department	X[4]	✓	✓	24/7	Consultant
NHS Direct / 111 services	X	✓	X	24/7	Nurse / GP / non-clinical adviser
Out-of-hours (OOH) GP services	X[5]	✓	X	OOH	GP
GP services (in hours)	✓	✓	?[6]	Core[7]	GP
Community pharmacy	✓	✓	✓	Extended[8]	Pharmacist
Self-care and self-management	✓	X	X	24/7	-

Notes: (1) Opening times are defined as either: Core, OOH, Extended, or 24/7. Core is 8:00 to 18:30 weekdays (not including bank holidays); OOH is 18:30 to 8:00 weekdays, 24 hours on weekends and bank holidays; Extended will vary by location, eg, 8:00 to 20:00 or 7.00 to 22.00 every day of the week (including bank holidays). (2) Not all urgent care centres treat routine primary care cases, eg, some centres will direct non-urgent cases to other services (such as patients' registered GP practice). (3) Minor injuries units only treat minor injuries and will often re-direct patients with routine care needs to other services. (4) A&E departments are not intended for patients with routine needs, however these patients are often accepted if they present. (5) Services are accessible by telephone; after a clinical assessment, the caller will be directed to a service that best suits their needs (eg, an OOH GP appointment may be booked for patients with urgent needs). (6) Some GP practices offer walk-in appointments for their registered patients. (7) Some GP practices offer extended hours one or two evenings a week or on the weekend; similarly other practices may offer more restricted hours (eg, they may also be closed one or two afternoons during the week). (8) Some pharmacies may have more restricted opening hours, eg, some high street community pharmacies.

4.4. Providers of walk-in centres

There are many different providers of walk-in centres in England. Large independent sector companies (such as Care UK and Virgin Care) operate about 17% of walk-in centres; acute and community NHS trusts and foundation trusts operate 25%; and 58% are operated by other providers including GP-formed limited companies (such as Malling Health, The Practice, Danum Medical Services), mid-to-small size GP partnerships (such as GTD Primary Care, Brisdoc), partnerships between GP practices and NHS Trusts (such as Freeman Clinics), social enterprises (Local Care Direct) and individual GP practices.

Walk-in centre providers tend to also offer other NHS services such as out-of-hours services or GP practices.

Table 5: Providers with the largest number of walk-in centres

Provider	Number of walk-in centres	Proportion of total walk-in centres
Care UK[(1)]	14	7.6%
Virgin Care[(2)]	13	7.0%
Malling Health	8	4.3%
The Practice	6	3.2%
Liverpool Community Health NHS Trust[(3)]	4	2.2%
The Hurley Group[(4)]	4	2.2%
Central London Community Healthcare NHS Trust	4	2.2%
Primecare	4	2.2%
South Tyneside NHS Foundation Trust	4	2.2%
5 Boroughs Partnership NHS Foundation Trust	3	1.6%
Bondcare Medical Services	3	1.6%
Bridgewater Community Healthcare NHS Trust	3	1.6%
Danum Medical Services	3	1.6%
DMC Healthcare	3	1.6%
GTD Primary Care	3	1.6%
Local Care Direct	3	1.6%
One Medicare	3	1.6%
Wirral Community NHS Trust	3	1.6%
Total	**88**	**47.6%**

Source: Monitor analysis.
Notes: (1) includes walk-in centres formerly operated by Harmoni; (2) includes those formerly operated by Assura in partnership with local GPs; (3) The Liverpool Community Health NHS Trust operates an additional walk-in centre for children only; (4) The Hurley Group provides 3 GP-led Health Centres plus one branch site which also offers a walk-in service.

4.5. Links and relationships with other providers

Delivering care in an integrated way means that patients have a person-centred, well-co-ordinated experience when accessing different providers or services to get the care they need.[61] As noted in Section 2, the government intended walk-in centres to be well-integrated with other services and providers, but the extent of their actual links and relationships varies. Some walk-in centres appear to be well integrated, while others operate mostly in "isolation," according to stakeholders. Several walk-in centre providers told us that they seek to build stronger relationships with other health and social care providers. Other providers emphasised that walk-in centres can be quickly adapted to provide rapid response services, such as for flu outbreaks, or to deliver evolving urgent care strategies.

We observed how walk-in centres link with other providers or services across several areas:

Co-location

Reflecting the original intent that walk-in centres foster integrated care, many are co-located with other health or social care services. Some have a pharmacy on site;[62] some are co-located with diagnostics, such as x-ray services.[63] Some are housed in a facility with a range of other services such as other GP practices, GP out-of-hours, and dental services. Walk-in centres may also operate or may be co-located with a variety of community clinics, such as sexual health or family planning. Co-location in some instances has led to stronger links between providers, such as shared working among staff.[64]

Relationships with GPs

Walk-in centres tend to have a relationship with GP practices because often they are contractually required, with a patient's permission, to send a report of an attendance to the patient's GP practice.

In addition, walk-in centre providers say that some GP practices advise patients to attend walk-in centres when they have no same-day appointments available.[65] Some

[61] See National Collaboration for Integrated Care and Support, *Integrated care and support: Our shared commitment*, May 2013.
[62] Some walk-in centres are located within the pharmacy itself (for example, Birmingham NHS Walk-in Centre, Yeovil Health Centre, and Bristol City Walk-in Centre are located within a Boots chemist); others have a pharmacy onsite (for example, St Andrew's Health Centre).
[63] For example, Garston Walk-in Centre and Smithdown Children's Walk-in Centre operated by Liverpool Community Health NHS Trust; Battle Hill Health Centre.
[64] See, eg, Lattimer et al, *The impact of changing workforce patterns in emergency and urgent out-of-hours care on patients experience, staff practice and health system performance*, March 2010, p.92 (shared working of staff from walk-in centre and co-located out-of-hours).
[65] See also BMG Research and Communications and Engagement Team, NHS Central Midlands CSU, *Understanding people's use and experience of the Birmingham and Solihull walk-in and urgent*

walk-in centre providers suggested that this might work better for patients if the centres could work with GP practices to enable GPs to use phone triage to direct appropriate patients to walk-in centres (those with one-time minor conditions) instead of using a "first-come, first-served" approach to scheduling same-day appointments. This would prevent patients who need care for chronic or complex conditions from being directed to a walk-in centre. GP practices may also direct their patients to walk-in centres for certain services, such as blood tests or DVT services.

Two walk-in centre providers told us that they have entered into subcontracts with local GP practices to provide phone answering services or out-of-hours services during afternoon closing hours or for holiday cover.

Relationships with A&E

Walk-in centres send patients needing emergency care on to A&E departments, although evidence indicates that the proportion of walk-in patients sent to A&E is low.[66] Some A&E departments will direct patients with minor conditions to a walk-in centre during times of pressure; however, several stakeholders told us that A&E departments can be reluctant to redirect patients and do not refer as many patients as they could to walk-in centres or other primary care services.[67]

Some walk-in centres, such as Solihull Healthcare and Walk-in Centre, have agreed with ambulance services to receive their non-emergency patients, or patients with minor injuries that can be treated in primary care, directly into the walk-in centre. In another example of walk-in centres building relationships with emergency services, Malling Health has agreed to station a GP and a nurse from one of its walk-in centres at a nearby A&E department to provide triage and treatment for less serious conditions.

Referrals to secondary care and joint pathways

Evidence suggests that most walk-in centres have limited ability to refer patients on to secondary care services (unless patients are registered with a GP-led health centre practice).[68] Patients needing a referral to secondary care are typically told to see their GP for a referral, as GPs are the traditional gatekeeper. However, some commissioners have developed referral pathways (such as for DVT services) for

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care centres, 2012, p.51 (GPs sometimes signpost patients to the walk-in centre); see Section 7.1 of this document for further discussion of issues related to access to GP practices.

[66] In our patient survey, less than 1% of respondents said they would go to A&E. Monitor patient survey report, p.51. Other sources indicate that referrals can be up to 5%.

[67] See also NHS Nottinghamshire County, *Walk-in Centres Review Business Case*, NHS Nottinghamshire County Board Meeting, 24 March 2011, p.14, available at: www.nnotts.nhs.uk/board/default.aspx?recid=2083.

[68] GP-led health centres are able to refer their registered patients in the same way that a GP practice can, and the EAPMC template called for the centres to offer registered patients Choose and Book for specialist services.

both nurse-led and GP-led walk-in centres. For example, clinicians at the Reading Walk-in Centre are able to refer patients on to secondary care services.

Access to patients' records

Commissioners and health professionals sometimes raise concerns that walk-in centres do not provide continuity of care, particularly because they do not have access to patients' general practice medical records. This may be changing somewhat, as it appears that most walk-in centres are able to access patients' nationally-held summary care records, which show medications, allergies and adverse reactions.[69] In addition, the Department of Health intends to give patients access to their records online by 2015 – this could facilitate access for walk-in centres if patients agree to make the records available to them.[70]

In some areas, walk-in centres and other providers share access to urgent care records. For example, St Andrews GP-led Health Centre in London shares a database with a local out-of-hours provider and other area walk-in centres. The providers also have shared access to a database of all children subject to a child protection plan to make this information visible to clinicians.

But shared access to patients' full medical records continues to present a challenge to the NHS in part because providers may use different technology platforms.[71] Even where walk-in centres use the same system as other GP practices or urgent care providers (such as SystmOne), stakeholders told us that the centres do not always have the required access permissions from the providers holding the records.

Some stakeholders said, however, that continuity of care is not a large concern for patients attending walk-in centres because many feel they have an urgent one-time need and simply want to see a doctor or nurse.[72] Younger people, in particular, are less likely to have a preferred GP.[73]

4.6. Pricing for walk-in centre services

Walk-in services generally are paid for on a per-attendance basis or through a block contract (a contract for a fixed value that does not vary with the volume of activity).

[69] See www.nhscarerecords.nhs.uk/. So far about half the population of England have a summary care record; www.nhscarerecords.nhs.uk/havescr. Patients have the ability to opt out.
[70] See www.pulsetoday.co.uk/patients-given-access-to-full-gp-record-by-2015/13131402.article#.UmLrA3Nrrlc.
[71] Some GPs are switching to a common system to enable shared access to patients' records. See, eg, *West London GPs start switch to SystmOne*, EHI ehealth insider, 1 August 2013. www.ehi.co.uk/news/EHI/8798/west-london-gps-start-switch-to-systmone.
[72] See also The King's Fund and Nuffield Trust, *Securing the future of general practice: new models of primary care*, July 2012. ("sometimes speed of access will trump the desire to see the same person or team, and this can be mitigated by a shared record.")
[73] See 2012-13 GP Patient Survey, question 8.

Evidence suggests that nurse-led centres are often paid on a block contract basis and that services were commissioned through various contractual arrangements, such as through the NHS Standard Contract for Community Services or through an APMS contract.[74]

GP-led health centres were commissioned under APMS[75] contracts, procured through a competitive tender process. The typical duration of contracts was five years.

Because the contract included two elements of service, a registered-list GP practice and a service available for any member of the public, including those not registered with the practice, the EAPMC template developed by the Department of Health recommended that PCT commissioners divide the payment structure accordingly:

- **For registered patients**, PCTs could pay a set price for each contract year to cover essential and any included additional services for each patient on the practice's registered list, and could top that up with a national tariff-based payment for national enhanced services (NES) or directed enhanced services (DES) and a locally-negotiated payment for local enhanced services (LES). (See Section 4.2 for a definition of these types of services).

  This is similar to the way that traditional GP practices are paid under the general medical services (GMS) contract – by capitated payment based on the number of patients on their registered list, and by an add-on payment for enhanced services. One difference, though, is that for the GP-led health centres, providers could submit a bid price, per-patient, whereas for traditional GP practices the per-patient price is set by national negotiations (for GMS contracts) or local contract negotiations with GPs (for personal medical services contracts).[76]

[74] As noted in Section 2.1, nurse-led walk-in centres were introduced as a pilot programme in which GPs, GP co-operatives, or other NHS bodies (such as trusts), could operate the centres through primary care groups, which were precursors to PCTs. See NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/16, 11 May 1999. Following the pilot, the Department of Health funded the opening of additional centres. Some of these centres were operated by PCTs, which then transferred them to other providers, such as NHS trusts, social enterprises, or community foundation trusts, through the Transforming Community Services programme. We found other examples of nurse-led walk-in centres co-located with GP practices that were contracted under local initiatives with APMS contracts.

[75] APMS contracts are Alternative Provider Medical Services contracts for primary medical services. They place minimum requirements on APMS contractors which broadly reflect those for Personal Medical Services agreements (which along with GMS contracts are the traditional categories of contracts for providing primary medical care services) but otherwise allow the remainder of the contract to be negotiated between the commissioner and the contractor or, more commonly, stipulated by the commissioner during the course of a tender process. NHS England, *Managing Regulatory and Contract Variations*, June 2013. www.england.nhs.uk/wp-content/uploads/2013/07/mng-reg-con-vari.pdf.

[76] Another slight difference is in how additional services are handled. Under the GMS contract, additional services are included in the per-patient price, but GP practices may opt out of them in

As an alternative to this more traditional payment structure for registered list patients, PCTs could combine essential, additional, NES and DES together in the per-patient price, with only LES priced separately. The price for the combined services could be paid for based on a bidder's price, or according to a weighted capitation price formula. LES were to be priced separately.

- **For unregistered patients**, the Department of Health recommended that PCTs use a price per attendance, with providers to bid on the price.

Our analysis of several GP-led health centre contracts and our conversations with stakeholders suggest that most providers are paid according to one of the Department's recommended approaches and a minority are paid using a block payment structure instead.

In addition to these payments, some GP-led health centres were paid a minimum income guarantee for the first two years while the practices were building their list size.[77]

The GP-led health centres can also receive performance-based Quality Outcomes Framework (QOF) payments, like traditional GP practices.[78]

Moreover, at GP-led health centres, providers often are not paid on a per-attendance basis for walk-in attendances by registered patients (as those payments are deemed to be covered under the capitated payment for the registered list).

Some commissioners also have used marginal payments for walk-in attendances. In these instances, providers are paid a marginal rate for walk-in attendances exceeding the contractual targets, in some cases gradually declining to no payment.

The EAPMC contract template called for GP-led health centres to have up to 25% of their total payment for services provided tied to their performance against key performance indicators (KPIs). We have seen some local modifications of the amount tied to KPIs. The KPIs are quality measures designed around indicators regarding access, quality (which may be based on the centre's QOF score), service delivery, value-for-money and patient experience. Commissioners have tailored KPI measures to meet local priorities. Evidence suggests that some, but not all, commissioners have separated KPIs applying to the registered patients from those applying to non-registered patients.

The GP-led health centre contracts include some demand management tools for both the registered list and unregistered list elements. The EAPMC template and

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exchange for a slight income reduction. See National Health Service (General Medical Services Contracts) Regulations 2004, Part 5, Section 17.

[77] See EAPMC contract template, Schedule 3.

[78] For a description of the QOF, see: www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx.

several contracts we examined require providers to obtain consent from PCTs before registering new patients or seeing walk-in unregistered patients who came close to or slightly exceed target numbers of patients set in the contract.[79]

As demand in many cases has exceeded contractual targets, particularly for walk-in services, providers told us that they have gone to commissioners to seek additional payment. This has happened under both block and per-attendance contracts. Our evidence suggests that in some cases, commissioners have agreed to provide more funding; in others they have not. Where they have not, it appears that some providers do not turn patients away, but some do.

[79] See EAPMC contract template, Schedule 2, Part 2, Section 2.3 and Part 5, Section 2.2.

5. Demand for walk-in centre services is strong

Providers and commissioners say demand for services at many walk-in centres is rising year-on-year. In this section, we look at who is using walk-in centres and how often.

5.1. Who uses walk-in centres?

The types of people using walk-in centres will vary by locale; however, evidence on the use of walk-in centres suggests that:

- younger people are the predominant users, with people between 16 and 45 attending at higher rates than other age groups;[80]
- there are slightly higher proportions of women attending, compared to men at most centres (some centres in our survey show higher proportions of men attending, for example at the Putnoe Medical Centre);[81]
- people from lower socio-economic groups tend to be the most common users of walk-in centres;[82]
- the majority of patients attend on their own behalf, although people often attend on behalf of their child particularly at some centres;[83] and
- populations served often depend on locations. City centre sites often cater to working people. Sites on residential estates often serve young families. Some centres see high numbers of university students, who tend not to be registered with a GP in the area in which they are attending university.

We also found that the needs of most patients attending a walk-in centre are being met at the centre. For example, our patient survey found that 84% of patients did not intend to use the services of another health care provider following their visit to the walk-in centre.[84] A small minority of patients (1% or 13 patients) had already seen their GP before coming to the walk-in centre. Five of these 13 patients had wanted a

[80] The age breakdown of patients from our patient survey shows those in the 25 to 34 year age bracket (23%) and the 16 to 24 age bracket (16%) were the most commonly attending patients. Monitor patient survey report, p.23.
[81] In our patient survey, for example, almost three-fifths of patients were female (59%) and just over two in five were male (41%). Monitor patient survey report, pp.21-22. This is consistent with information submitted by walk-in centre providers.
[82] Our patient survey suggested that 36% of patients attending walk-in centres were from social grade DE, with a further 19% from C2 and 30% from C1 (see pp.24-25 of the Monitor patient survey report, including definitions of each grade).
[83] Our patient survey indicated that up to 23% of people attended on behalf of their child at some walk-in centres. Monitor patient survey report, pp.21-22.
[84] There were 14% of patients that indicated they would use the services of another health care provider following their visit to the walk-in centre: 7% indicated they would see their GP; 2% indicated they would visit a pharmacy; and a further 1% indicated that they would go either to A&E or another walk-in centre. Monitor patient survey report, pp.50-51.

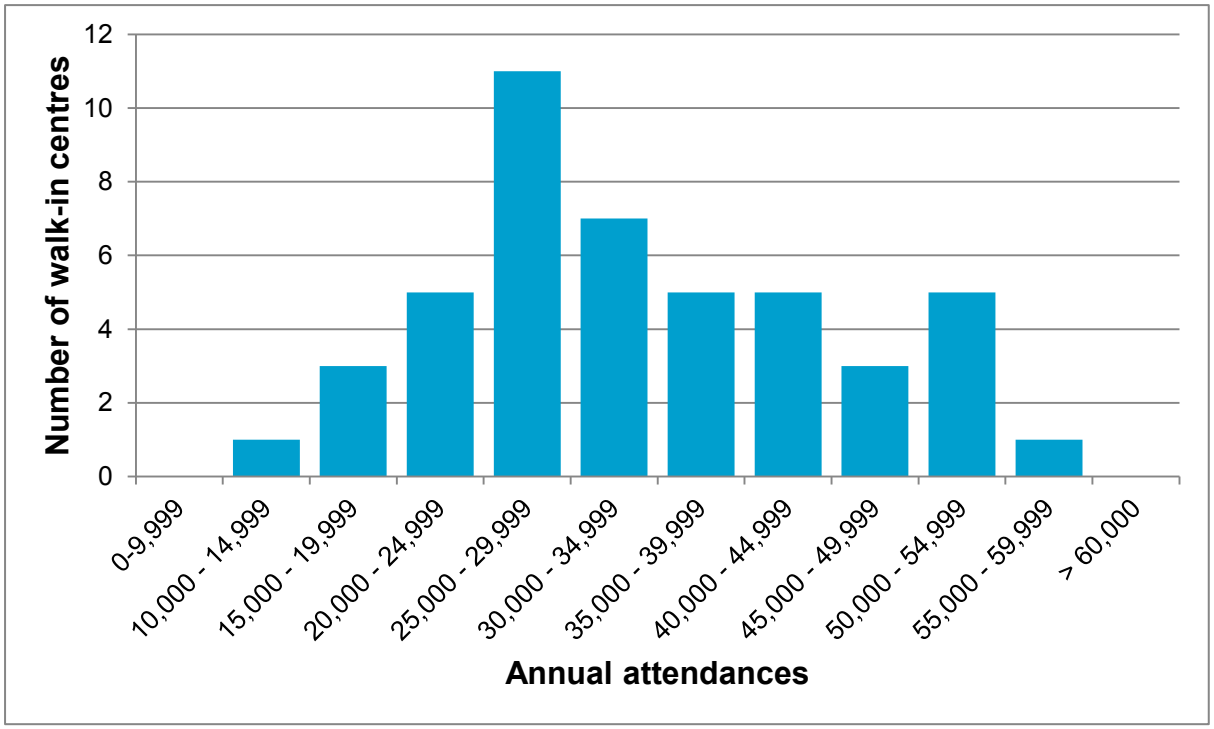
second opinion and a further four patients had wanted treatment or medication that their own GP would not prescribe.[85]

Evidence also suggests that the majority of people would have gone to a GP practice or an A&E department if the walk-in centre was not available. Very few people indicate that they would stay at home and attempt self-care.[86]

5.2. Numbers of walk-in attendances

Evidence supplied by providers indicates that walk-in attendances can range from 12,000 to 60,000 attendances per year, depending on the centre. Figure 2 shows the range of attendances at 46 walk-in centres. Over 70% (33 walk-in centres) provide between 20,000 and 45,000 walk-in appointments per year, with 24% (11 walk-in centres) providing between 25,000 and 30,000 walk-in appointments per year.

Figure 2: Current annual walk-in attendances in a sample of 46 centres



Source: Data submitted to Monitor by providers of walk-in centres

Notes: Figures reflect walk-in attendances at 46 walk-in centres in England over the last 12 months or financial year. Estimates do not include pre-booked appointments.

[85] Monitor patient survey report, pp.72-73.

[86] In our patient survey, when patients were asked spontaneously what option they would choose in place of the walk-in centre they had attended, 34% indicated they would go to a GP practice (eg, their own GP practice or a different practice, depending on where the patient was registered), 21% said that they would go to A&E, and 16% indicated that they would go to a different walk-in centre. Only 8% indicated that they would stay at home or attempt self-care. Even fewer people indicated that they would visit a pharmacist (5%) or call an NHS helpline (4%). Monitor patient survey report, pp.74-75. This result is consistent with survey results we received from several walk-in centre providers, which typically indicate that around 20-40% of patients would attend a GP practice and 20-30% of patients would visit an A&E department if the walk-in centre was not available.

Walk-in attendances at some walk-in centres exceeded the levels originally anticipated when they were initially opened.[87] Attendances anticipated (or targeted) in commissioning contracts were typically in the range of 12,000 to 24,000 attendances, rising to 35,000-60,000 in years four and five for some contracts.

Providers report that when walk-in centres first opened, in some cases excess demand strained resources, staffing, and facilities. Press reports also suggest that some centres were forced to close for temporary periods while capacity was extended or reconfigured to meet the volumes of patients attending.[88]

NHS England reports that attendances at walk-in centres and minor injury centres have increased by around 12% per year since data was first recorded in 2003.[89]

Increased demand for walk-in services is part of a larger trend of increased demand for other NHS services. The average number of GP practice consultations per patient rose from 3.9 to 5.5 per year between 1995 and 2008.[90] Attendances at major and single specialty A&E departments have also increased, by about 18 per cent between 2003 and 2011 (or 2% per year).[91]

Patterns of walk-in attendances by time of day and week vary by walk-in centre. Most report Mondays or Saturdays as their busiest days. Some walk-in centres report, on average, higher attendances during weekday regular business hours,[92] and others report peak times during GP closure hours in the evenings and on weekends and bank holidays.[93]

Figure 3 shows average attendance patterns over the week for six walk-in centres.[94] It shows that on weekdays, centres are typically busy from 9am, with surges in

[87] See, eg, www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/; www.thestar.co.uk/what-s-on/out-about/walk-away-from-walk-in-centre-1-2965911; www.thetelegraphandargus.co.uk/news/8763859.___Walk_in_medical_centre_a_success___/

[88] For example, Trafford Health Centre closed temporarily so that capacity could be reconfigured to handle the large number of patients attending. See: www.traffordpct.nhs.uk/Latest_News/NHS_walk_in_service.aspx and www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/

[89] NHS England, Evidence Base from the Urgent and Emergency Care Review, 17 June 2013, p.18 [NHS England, Evidence Base] www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf; see also John Appleby, *Pressures on accident and emergency service*s, The Kings Fund, 4 June 2013. www.slideshare.net/kingsfund/john-applebyqmrjune13; www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing

[90] Health and Social Care Information Centre, *Trends in consultation rates in general practice 1995/1996-2008/2009: Analysis of the Q research database*, 2009.

[91] NHS England, Evidence Base from the Urgent and Emergency Care Review, 17 June 2013, p.18.

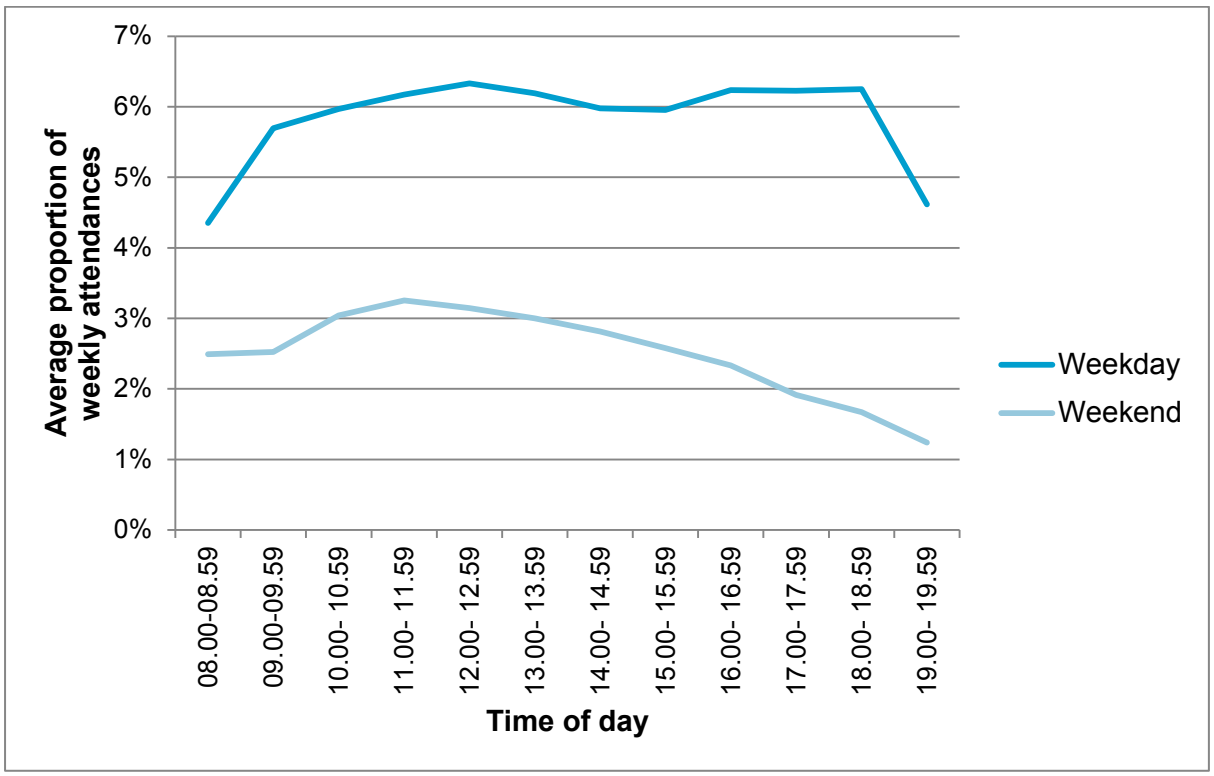
[92] See, eg, Barking & Dagenham consultation documents: 70% of attendances during GP opening hours.

[93] See, eg, NHS East London and the City, Pre-Consultation Business Case, Jan. 2012 (peak times weekdays from 4pm-8pm); NHS Southhampton City PCT consultation (64% used WIC during evenings or weekends); Solihull Director's Report 2012/13; Putnoe response to Monitor's review.

[94] We received (descriptive and quantitative) data on attendance patterns for almost 40 walk-in centres. A lack of data compatibility meant that we had to restrict our graphical presentation to only 6

activity between 11am and 1pm and between 3pm and 7pm. A higher proportion of attendances are earlier in the day during weekends than during weekdays.

Figure 3: Walk-in attendances by time of day and week in a sample of six centres



Source: Data submitted to Monitor by providers of walk-in centres

5.3. Registration with GP-led health centres

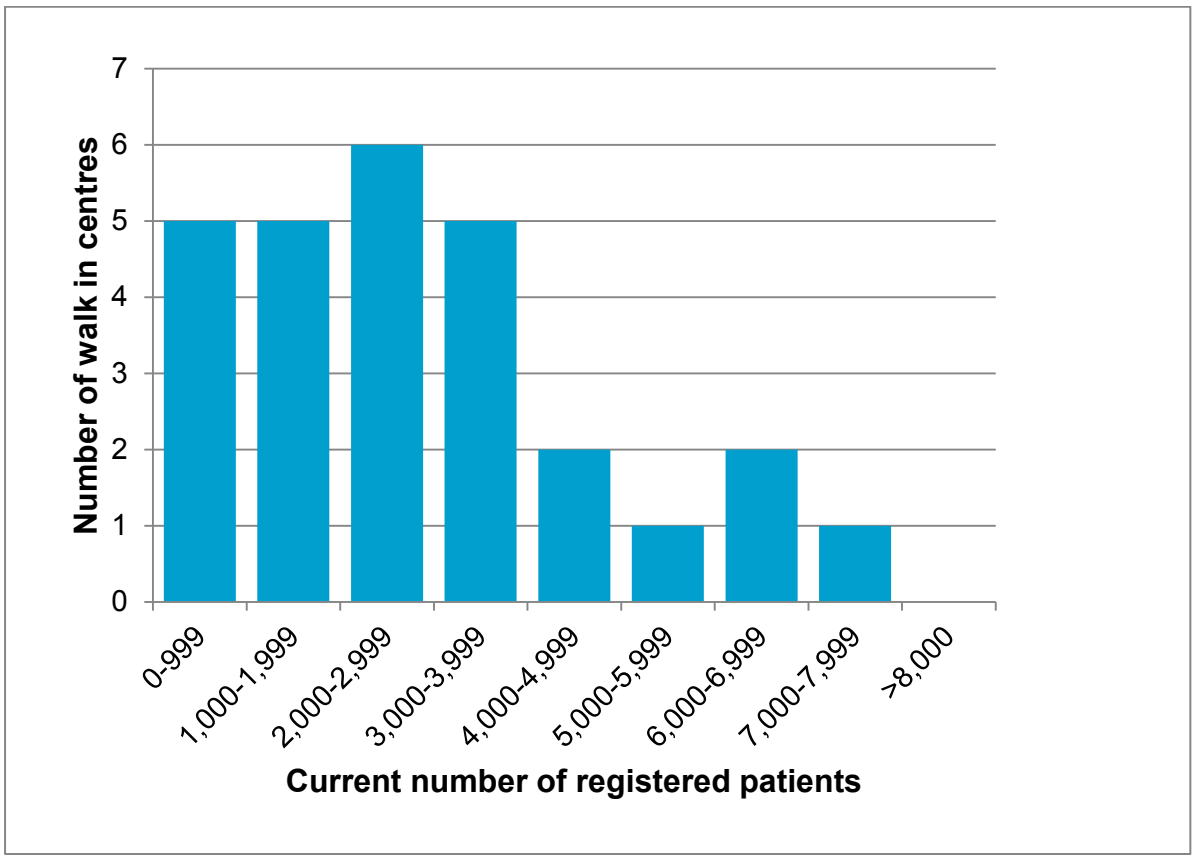
As noted, GP-led health centres offer a registered-list GP practice as well as walk-in services open to any member of the public. The take-up of registration at the GP practices of GP-led health centres has been more modest compared to the numbers of walk-in attendances seen. Most centres started without any registered patients.

With many now in or approaching their fifth year of operation, our research shows that registered list sizes for these practices tend to be between 1,000 and 3,000 patients, although we observed several centres with a registered list of between 5,000 and 6,000 patients. This compares to an average list size for a GP practice of

walk-in centres. The data is broadly consistent with the attendance patterns described by providers for other walk-in centres.

6,891 in 2012.[95] Figure 4 shows the distribution of current list sizes for 27 GP-led health centres for which we have data.

Figure 4: Current number of registered patients in a sample of 27 GP-led health centres



Source: Data submitted to Monitor by providers of walk-in centres.
Notes: figures shown are only for GP-led health centres that started with no patients on their lists.

Data on registered lists size over time indicates that, for most walk-in centres, registered patient numbers have grown at a steady rate. Provider data indicates that growth in list sizes ranges from between 200 to 2,000 patients per year depending on the location of the walk-in centre. Across all GP practices, average list size grew by about 1,000 patients in total over the 10 years from 2002-2012.[96]

As noted in Section 4.6, list size tended to be contractually limited, requiring providers to seek the commissioner's consent to go beyond the targets.

The practice boundaries for registered patients at GP-led health centres were set through negotiations between the provider and the PCT, often with input from local

[95] See Health and Social Care Information Centre, *NHS Staff – 2002-2012*, General Practice, Selected Practice Statistics.
[96] Average list size grew from 5,833 in 2002 to 6,891 in 2012. Average list size varies between 5,993 in the North West and 8,760 in South Central England. See Health and Social Care Information Centre, *NHS Staff – 2002-2012, General Practice*, Selected Practice Statistics.

GPs. The practice boundaries usually overlapped with some other GP practices. (The centres generally have no practice boundaries for walk-in patients who are not registered at the centre's GP practice, and they can and do treat walk-in patients who are registered with a different practice.)

Our patient survey indicates that of all patients choosing to register with a GP-led health centre, about half were previously registered with a different GP practice locally;[97] a further 25% were registered previously in another area and the final 25% had not been registered with a GP practice before. Patients who had not been registered with a GP practice before were more likely to be female; aged between 25 and 34 years of age; working full-time; and/or from a lower socio-economic group .[98]

[97] A few walk-in centres had a very high proportion of patients stating that they had previously been registered with another GP locally, including Battle Hill Health Centre (79%), Shropshire Walk-in Health Centre (76%) and The Skelton Medical Centre (76%).
[98] See Monitor patient survey report, pp.54-56.

6. There is a trend to close walk-in centres

Of the 238 walk-in centres that we estimate originally opened, we found that 53 walk-in centres have closed in the past three years. Of these closures, about one-third were part of reconfigurations to replace the walk-in centres with urgent care centres co-located with A&E departments at hospital sites,[99] or with models that integrated primary care staff within an A&E department.

Of the 53 closures, 22 were nurse-led centres, six were commuter centres, and 25 were GP-led health centres. One-third of the GP-led health centres that closed ceased to provide walk-in services for non-registered patients but continue to operate as a GP practice. Around one-fifth of the nurse-led walk-in centres closed at around the same time as a new GP-led health centre opened in the PCT. See Annex 3 for a list of walk-in centre closures; see Figure 5 (below) for a map of open and closed walk-in centres in England.

[99] Some of these were already located on a hospital site, but as separate walk-in centres.

Figure 5: Open and closed walk-in centres in England

Closed walk-in centres
Open walk-in centres

Source: Monitor analysis

We are aware of a further 23 walk-in centres that have had their service reduced or modified in some way. These modifications include:

- discontinuing the registered list element of a GP-led health centre;
- reducing the hours or days the walk-in centre is open;
- reducing the volume of activity commissioners will pay for;
- reducing the range of services;
- moving from being GP-led to nurse-led; and
- restricting the service to patients with urgent conditions.

We reviewed PCT and CCG documentation underlying a number of closures and changes in walk-in centre services as well as submissions to our review from commissioners. We also spoke to several commissioning groups involved in decisions to close centres. Our aim has been to understand the reasons why commissioners have closed walk-in centres or made changes to the services; in this report, we are not seeking to challenge or endorse particular decisions.

In deciding not to continue walk-in centre services, commissioners have given the following reasons (often not one, but several, of these reasons are behind decisions to close a walk-in centre):

- **Funding pressures**

  Many centres have seen greater numbers of walk-in patients than commissioners initially anticipated (see Section 5). In some cases, this has led to higher payments to walk-in centre providers than expected.[100] Commissioners have cited annual costs for a walk-in centre as being between £450,000 and £1.5 million.

  > *"We are spending far too much money on treating people in walk-in centres and in A&E with primary care type conditions which could be managed by the GP practice*."
  > Barking and Dagenham CCG, *Urgent care – the case for change* (issued as part of the CCG's decision to close a walk-in centre)

  Alongside these unpredicted costs, commissioning budgets as a whole have been under growing pressure. Some commissioners told us that they felt they could no longer fund the convenience that walk-in centres offer and others

[100] See The Bureau of Investigative Journalism, *NHS forced to close walk-in health centres because they are 'too popular'*, 23 June 2011, www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/. We also are aware of cases in which the provider chose to withdraw from a walk-in centre contract because it had become financially unviable. See for example, walk-in services at the Laurels Healthy Living Centre, www.haringeyindependent.co.uk/news/8927389.Health_trust_will_not_restore_walk_in_service/

have closed walk-in centres as part of efforts to achieve savings and contain costs.[101]

- **Failure to reduce A&E attendances**

  Some stakeholders viewed reducing A&E attendances as a key purpose of walk-in centres. (See Section 2 for a discussion of the policies behind walk-in centres.) One commonly cited reason for closures is that the centres have not reduced A&E attendances.[102] The focus of many commissioners is on improving the availability and configuration of urgent care services in the hope of reducing pressure on A&E departments. As a result, a number of commissioners have closed or plan to close walk-in centres to reconfigure services alongside or within A&E departments, with the intention of reducing A&E attendances.[103]

- **"Paying twice" or duplicating services**

  A commonly-cited concern among commissioners is that they are "paying twice" for walk-in centre services because most patients attending are registered with a GP practice elsewhere, and those GP practices are already paid to provide those patients with primary care services through the capitated payment structure. Commissioners argue that walk-in centres duplicate services already provided because patients attend the centres for the same reasons that they would see their GP, often during GP core hours. They believe that patients should see their GP as a "first port of call."[104] (See Section 7.3 for further discussion on concerns about paying twice).

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[101] See, eg, NHS Salford, Trust Board Meeting paper, *Urgent Care, Report of Strategic Commissioning / Interim Deputy Chief Executive*, 31 August 2010, p.4 and Appendix 3.

[102] For example, the Stockport walk-in centre opened in October 2009, and the PCT had hoped that the centre would help reduce numbers at Stepping Hill's A&E for non-emergency treatment. But reports suggest that numbers attending A&E had increased by about 5% and commissioners felt they could not justify the amount spent on the walk-in centres; www.pulsetoday.co.uk/darzi-centre-closes-due-to-duplication-in-services/11042967.article and http://alternativeprimarycare.wordpress.com/2010/10/27/walk-in-centre-to-close-stockport-pct/; See also NHS Salford, Urgent Care Engagement, 30 September 2010.

[103] Several commissioners cited a King's Fund study recommending that commissioners should evaluate walk-in centres "rigorously" and, where possible, "co-locate and integrate" them with emergency departments. The King's Fund, *Urgent and Emergency Care: A review for NHS South of England*, March 2013. We spoke to several commissioners who have experience with a model of integrating walk-in or urgent care services or primary care services with A&E departments. They discussed challenges in the model meeting its goal to reduce A&E attendances in part because of a reluctance of some A&E departments to redirect patients to primary care services. They told us that this may stem from A&E triage clinicians being more risk-adverse or from concerns about loss of revenue to A&E departments. The Primary Care Foundation has pointed to similar challenges with the model.

[104] See, eg, NHS Barking and Dagenham CCG, *Walk-in centres in Barking and Dagenham*, consultation on proposals to close walk-in service, 2013.

- **Walk-in centres create demand**

  The convenience and accessibility of walk-in centres, as well as the relatively minor clinical nature of conditions they treat, has led some commissioners to take the view that walk-in centres create demand unnecessarily.[105] Some commissioners and even some walk-in centre providers said walk-in centres cater mostly to the "worried well" who could otherwise self-manage or go to a pharmacy, rather than serving patients who previously had unmet needs.

- **Concerns over confusion and duplicative use of services**

  In some communities, commissioners closed walk-in centres in part due to concerns that the various points of access to urgent care, and the variation in types of services provided, has created confusion among patients about where to seek appropriate treatment. In some cases, commissioners said, this confusion may result in mistrust of the system and fragmented care, in which the patient is referred onwards to another service such as their GP practice or A&E. Some commissioners said it also may introduce clinical risk if patients requiring emergency services attend a walk-in centre instead. [106]

  In addition, commissioners have cited concerns that walk-in centres result in duplicative use of services based on evidence that some patients use walk-in centres and other services for the same problem, for example, in seeking a second opinion.[107] (See Section 5.1 for the proportion of patients in our survey who used or intended to use more than one service for the same problem.)

- **"Inequity" of access**

  A few commissioners said that their walk-in centres created inequity of access because they were mostly used by people who lived close by, rather than by groups from areas of high deprivation or those with significant health needs.[108] (See Section 5.1 for a discussion of the types of patients using walk-in centres.)

Finally, we found a few examples in which commissioners cited high numbers of attendances by out-of-area patients or insufficient use of walk-in centres as reasons for closure.

Although in many areas commissioners favour closing or changing walk-in centre services, several commissioners we spoke to said that their walk-in centres play an

[105] See Pulse, *Darzi centres are fuelling PCT deficits*, 21 Jan 2011, www.pulsetoday.co.uk/darzi-centres-are-fuelling-pct-deficits/11051000.article#.UnnZZXNR7lc.
[106] See, eg, NHS Bolton CCG, Public Board Meeting paper, *Walk-in Centre Implementation – Urgent and emergency care for the future*, 4 May 2012.
[107] See, eg, NHS Bolton CCG, Public Board Meeting paper; NHS Barking and Dagenham CCG, Walk-in centres in Barking and Dagenham, consultation on proposals to close walk-in service, 2013.
[108] See, eg, NHS Nottinghamshire County, *Walk-in centres review* (public consultation document).

important role in meeting health needs and provide value for money. We were told that some have extended walk-in centre hours, or are looking to expand services and establish stronger links between walk-in centres and other providers. In some places, community members, often with support from local politicians, have lobbied successfully to keep a walk-in centre open.[109]

Many commissioners are currently reviewing walk-in centre provision or will begin reviews shortly. The reviews are being driven in part by the five-year contracts for the GP-led health centres, procured in 2009 or 2010 and set to expire in 2014 or 2015. In addition to this, many CCGs are reviewing walk-in services as part of wider reviews of urgent care services.

What are your views on the reasons that commissioners have given for closing walk-in centres?

Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?

[109] For example, the strong views of the local community is said to have influenced the commissioner in its pre-engagement phase regarding its decisions on the future of the Bitterne walk-in centre in Southhampton; NHS Southhampton City, *Consultation on the future of the walk-in service provided at Bitterne Health Centre, Public Consultation Feedback Report*, February 2011.

7. Analysis and preliminary findings

As the preceding sections indicate, walk-in centre provision and the issues surrounding decisions about whether to continue to procure these services depend largely on local circumstances. However, we were able to draw out some common themes from our review of evidence from various locales that relate to the key factors we examined in our review:

- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?
- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

This section describes our analysis and preliminary findings on these questions.

7.1. In some cases, walk-in centre closures may adversely affect patients' access to primary care

Walk-in centres were intended to improve access to primary care both in and out of normal GP practice hours. Government policies establishing walk-in centres sought to offer patients a service model believed to be more flexible and better suited to the needs of those most likely to find access difficult (see Section 2).

We find from our review that walk-in centre closures may have the potential to affect patients adversely by:

- making it more difficult for people to access primary care services where there are problems with access to local GP practices; and
- limiting the ability of primary care to reach particular groups of people who find it difficult to engage with the traditional model of GP services or whose uptake and interaction with primary care has traditionally been poor.

Our findings and analysis, described below, suggest that local commissioners must carefully consider the extent to which these patients' needs for access to primary care (or for other needs that walk-in centres may be meeting) are present in their communities when taking decisions about walk-in centres. We are seeking readers' views on these preliminary findings as well as additional information or evidence.

7.1.1. Access to GP services

Access to GP services is still frequently cited as a problem. The recent call to action by NHS England to improve general practice, for example, identifies growing dissatisfaction with access to GP services as a key challenge for the sector.[110]

Evidence also indicates that patients' experience of GP services, particularly when related to ease of access, affects their uptake and interaction with primary care, which in turn can affect quality of care and clinical outcomes. Ease of access to GP services can affect quality of care and outcomes through its impact on a patient's attendance rates, continuity of care, communication and engagement with clinical staff, compliance and adherence with treatment, and out-of-hours access.[111]

Results of the 2012-13 GP Patient Survey show:

- 10% of people were not able to get an appointment to see or speak to a GP or nurse last time they tried (varying from 5% to 21% across the country by CCG); and
- of those that were able to get an appointment (87% of all respondents), only about half were able to get an appointment either on the same day or on the next working day (49%); 33% had to wait a few days and 15% had to wait a week or more.[112]

We found that people routinely cite difficulties, and perceived difficulties, in getting an appointment with their GP practice or being seen at a convenient time as a reason for attending walk-in centres. In our patient survey, the majority of patients attending the walk-in centres (62%) were registered with a GP practice elsewhere. Of those patients:

- 22% said that they had tried to contact their GP practice before attending the walk-in centre, but either found that no appointment was available (14%), or not available at a convenient time (4%) or within a suitable waiting time (3%), or they simply could not get through (1%);
- 24% said they did not try to contact their GP practice because of perceptions that they would not be able to get an appointment that was convenient; and

[110] NHS England, *Improving general practice – a call to action*, 2013, www.england.nhs.uk/ourwork/com-dev/igp-cta/.
[111] The King's Fund, *Data briefing: improving GP services in England: exploring the association between quality of care and the experience of patients*, November 2012, www.kingsfund.org.uk/publications/improving-gp-services-england.
[112] 2012-13 GP Patient Survey results, available at http://results.gp-patient.co.uk/report/6/rt3_result.aspx; NHS England, *Improving general practice – a call to action evidence pack*, 2013, www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf.

- 6% had been directed to the walk-in centre by their GP.[113]

For patients who had chosen to register with a GP-led health centre (34% of those surveyed), 19% said they registered because of "not having to phone ahead to book an appointment'"[114] and 18% indicated "time of day or week that appointments are offered" as the reason for registering.[115]

Other surveys of people attending walk-in centres show similar results.[116] For example, more than two thirds of patients surveyed at eight walk-in and urgent care centres across Birmingham and Solihull indicated they had attended because of an access-related issue, such as they could not get an appointment with their GP or would have had to wait to be seen.[117] Patients in that survey also expressed concern over the opening hours of their GP practices, wanting them to be open earlier in the mornings, later in the evenings and on weekends.

> *"I am absolutely horrified to hear that there are plans to close the walk-in centres as I believe they are a vital health resource in our community. I have personal experience of the [local walk-in centre] having used it two or three times with various family members with excellent results to deal with the medical issue and returning home. I feel it provides an essential service for those people who cannot get in to see their doctor but need medical attention for whatever reason."*
> Angela, submission to Monitor

There is wide variation in how well GP practices manage demand for appointments.[118] For example, the Primary Care Foundation's survey of 150 GP practices found that some had fewer than 10% of their appointments available for same-day appointments, while others had well over 70%.[119] In addition, while many practices appear to offer appointments during core or extended hours, some

[113] See Monitor patient survey report, pp.72-73.
[114] Not having to phone ahead to book an appointment was particularly important for patients choosing to register at Cardrew Health Centre, Reading Walk-in Centre, and Shropshire Walk-in Health Centre.
[115] Time of day or week that appointments are offered was particularly important for patients choosing to register at Reading Walk-in Centre. Monitor patient survey report, p.57.
[116] We reviewed patient survey information covering around 12 walk-in centres and Healthwatch Barking & Dagenham, *A response from the public: consultation on proposals for urgent care services and the Broad Street walk-in service*, 21 May 2013; Barking and Dagenham LINk, *Patient survey of walk-in services, Upney Lane Walk-in Centre and Broad Street Walk-in Centres*, December 2012; Arain Mubashir, Jon Nicholl and Mike Campbell, *Patients' experience and satisfaction with GP led walk-in centres in the UK*; a cross sectional study, BMC Health Services Research, 2013, 13:142.
[117] The survey was conducted on behalf of NHS Central Midlands CSU in 2012; a total of 1,106 patients were interviewed. BMG Research and Communications and Engagement Team, NHS Central Midlands CSU, *Understanding people's use and experience of the Birmingham and Solihull walk-in and urgent care centres*, 2012.
[118] See Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, 2009.
[119] See Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, 2009, p.17. The Foundation recommends that one-third of appointments be reserved for same-day access.

practices close for some afternoons each week or for stretches in the middle of the day.[120]

Patients and other community members also have raised concerns about access to GP services when commissioners have proposed closing a walk-in centre. In response, many commissioners pledged to improve access to existing local GP practices to mitigate the impact.

In some cases, commissioners analysed walk-in centre data to determine which local GP practices had high numbers of their registered patients attending the walk-in centre. One commissioning body found "broad correlation between satisfaction with GP access and use of the [two local] walk-in centres, with some of the most represented practices having received low MORI patient satisfaction survey scores."[121]

In another example, commissioners found that a local practice was having difficulties matching resources to peak demand times and was leaving phone calls unanswered because staff members were too busy with other tasks.[122] Another commissioner told us that the CCG found that a practice was not making arrangements to cover periods when the practice was closed for holidays or training amounting to several weeks each year. Commissioners worked with these practices to improve services.

However, in some cases, city or borough council leaders have expressed concerns about walk-in centres closing before GP access problems were adequately addressed.[123] In Manchester, for example, the City Council Health and Wellbeing Overview and Scrutiny Committee contested NHS Manchester's decision to close three community-based walk-in centres due to concerns that commissioners had not demonstrated that all GP practices in the city were providing "genuine same day access to GP appointments."[124]

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[120] NHS Nottinghamshire walk-in centre review documents, Appendix 17, available at www.nnotts.nhs.uk/board/default.aspx?recid=2083; NHS Choices spot research; The GMS contract requires GP practices to be open during core hours, 8:30 – 6 pm, however, we understand that GP practices may close for surgery appointments during those hours so long as phone lines are open.

[121] NHS East London and the City, Pre-consultation business case, Appendix C, Patient profiles, attendance and clinical outputs, January 2012, p.9. The MORI scores refer to the GP Patient Survey by Ipsos MORI.

[122] NHS Nottinghamshire walk-in centre review documents, Appendix 17, available at www.nnotts.nhs.uk/board/default.aspx?recid=2083.

[123] See for example, Letter from The London Borough of Barking and Dagenham to Barking and Dagenham CCG, 21 May 2013, available at www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/consultation-report-and-associated-documents.htm

[124] The city council committee twice referred their concerns to the Independent Reconfiguration Panel (IRP) of the Secretary of State for Health. See IRP letters to Secretary of State for Health, 22 Nov. 2011 and 26 Oct. 2012. In its first letter of advice, the IRP determined that the centres should remain open until assurances of same-day access to GP services were provided. In the second, almost one year later, the IRP urged the parties to settle differences and move forward with the proposals to close the centres and develop urgent care centres co-located with A&E departments.

Several GPs told us that it is difficult, within the bounds of current primary care funding, for some smaller practices to offer extended hours or to invest in improvements that would lead to better access for patients. Practices are looking at new organisational models to meet demand and improve services.

Some commissioners have discounted the possibility of an adverse impact of walk-in centre closures on patients' access because they found unused capacity in the system, such as local GP practices with open lists or reports of same-day appointments being unused. However, while open lists or appointments may be factors to consider, other features of GP practices might make access difficult, such as demand that is beyond the capabilities of phone-answering systems or a lack of extended hours.[125]

Some commissioners have said that the cohort of patients using walk-in centres are attending for minor conditions that could be handled instead by a pharmacist or through self care.[126] But, while self-care or a pharmacy may be suitable for certain medical needs, the public often can lack awareness or confidence in these options.[127]

We spoke to commissioners who said they saw no increases in demand for GP services in the wake of walk-in centre closures, although we found no post-closure studies evaluating the impact on patients' access to primary care and whether patients' needs are being met elsewhere or not. However, walk-in centre closures are occurring at a time of increasing demand for GP services overall.[128]

Some commissioners have reported a lack of complaints as an indication of no or minimal impact on patients. A lack of complaints from patients is unlikely to be sufficient evidence of no or little impact on patients. Patients can be reluctant to complain about a lack of access to service, for example, due to a lack of awareness

[125] See, for example, Section 8.1 of this document describing types of needs related to access that patients may have.
[126] Some stakeholders said they perceive a cultural change among service users. For example, they suggested that some patients, particularly those of younger generations, have higher expectations of services including wanting more immediate advice, care, or reassurance for self-limiting minor conditions, whereas in the past patients were more willing to self-care or "wait-and-see".
[127] NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013, www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf.
[128] The King's Fund and Nuffield Trust, *Securing the future of general practice: new models of primary care*, 2013, p.9, www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice-_full_report_0.pdf.

about who to complain to or because they fear it will affect the quality of service they might receive in future.[129]

7.1.2. Reaching people who find it difficult to access primary care

As well as filling a gap where easy and convenient access to GP services may be lacking, some walk-in centres appear to be successfully reaching people who ordinarily would find access to GP services difficult and for whom uptake and interaction with primary care has generally been poor. This is perhaps unsurprising given that some walk-in centres, particularly GP-led health centres, were explicitly contracted to offer health promotion and disease prevention services for "hard-to-reach" or "equality target groups".[130] Overall, we found that walk-in centre closures can risk increasing health inequality if suitable alternatives are not put in place.

We found few studies evaluating whether walk-in centres have improved access to primary care for certain groups. An early evaluation of the first nurse-led walk-in centres found that the centres improved access primarily for younger, more affluent people, including young and middle-aged men who had been relatively low users of general practice.[131] The authors concluded that walk-in centres may not improve access to health care for those who may need it most.

> *"We treat around 100 homeless patients and many others who are not registered with any other practice, we see substance misusers that other practices don't want to see, and during times of peak demand such as Christmas, or the recent failed NHS 111 launch, we are able to quickly increase capacity to ease pressure on appointments generally."*
> Malcolm Sampson, Director, Worcester Walk-in Centre

However, our research suggests that the characteristics of patients using walk-in centres have changed somewhat since the centres were first introduced, at least in some locations. While younger adult groups are still the predominant users of walk-in centres, women and those from lower socio-economic groups often account for a higher percentage of users than men and those of affluent status (see Section 5.1).

[129] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 1: Analysis of evidence and lessons learned*, chaired by Robert Francis QC, February 2013, Chapter 3, p.245; Patients' Association, *Primary Care: Patients and GPs – Partners in Care?*, September 2012, p.6.
[130] See EAPMC contract template. "Hard to reach" or "equality target" groups were defined to include: those who do not understand English; those who cannot hear, see or have other disabilities; working single parents; asylum seekers or refugees; those who have no permanent address; black or minority ethnic communities; adolescents; elderly and/or housebound people; those who have mental illness; those who misuse alcohol or illicit drugs; and those who belong to a lower socio-economic class or who are unemployed.
[131] Salisbury, C., et al, *The National Evaluation of NHS Walk-in Centres*, Final Report, July 2002.

In addition, we found examples of walk-in centres serving:

- People who can find it difficult to schedule and keep GP appointments, such as homeless patients, traveller communities, substance misusers and ex-offenders. GP-led health centre providers told us that over time, some of these patients could be persuaded to register at the practice ensuring more consistent care, particularly for chronic conditions.

- Asylum seekers, refugees, and other groups facing language and cultural barriers. Stakeholders told us that these groups typically find it difficult to access GP services, or would use A&E for their primary care needs instead, because of a lack of understanding or experience of the NHS or the process of registering with a GP practice. Some providers of GP-led health centres told us that, in areas with high migrant populations, they sought to reach out to these groups and educate them about the NHS and the benefits of registration to ensure continuity of care.

- Workers and students. Accessing traditional GP practices often requires people to take time off work,[132] yet this can be difficult or simply not possible for some.[133] The extended and weekend opening hours of walk-in centres, as well as the locations of some in city or town centres, allow those finding it difficult to take time off work to attend to primary care needs, including seeking preventative services and routine checks for chronic conditions. Walk-in centres located near universities tend to serve high numbers of students who are living away from home and are often unregistered in the locales where they are studying. Our patient survey indicates that about 6% of patients attending walk-in centres work or study near the centre but do not live near it, rising to between 19% and 31% for some centres.[134]

- Minority ethnic groups. Our patient survey indicates that some walk-in centres serve high proportions of minority ethnic groups relative to the local population.[135] Also, of those choosing to register at GP-led health centres, patients who previously had not been registered with a GP practice are more likely to be from black and minority ethnic groups.[136] The Birmingham and Solihull survey found that the eight centres they studied are “particularly

[132] In a recent survey by the Patients’ Association, I in 5 (21.7%) of working age respondents said that they had to take time off to attend an appointment with their GP. Submission to Monitor from Patients’ Association, Call for Evidence for GP services, July 2013.
[133] The 2012-13 GP Patient Survey indicates that, of those in part or full-time work, 32% could not take time away from work to see a GP.
[134] For example, the Urgent Care Centre Guys’ Hospital and Liverpool City Walk-in Centre. See Monitor patient survey report, p.27.
[135] For example, 23% of patients surveyed at Derby Open Access Centre were Pakistani (which compares to 1% of local population), Monitor patient survey report, p.23.
[136] Of patients who were not previously registered with a GP practice, 38% were from black and minority ethnic groups. Monitor patient survey report, p.59.

popular with black and Asian communities, with a disproportionate percentage of these groups using them."[137]

- Patients not registered with a GP practice. While only 3% of all patients attending walk-in centres in our survey are not registered with a GP practice,[138] this number rises to up to 12% at some centres.[139] Other sources report that up to 28% or even up to 50% of patients attending some centres are unregistered with a GP practice.[140,141]

At a June meeting of the National Inclusion Health Board, the Department of Health reported improvements in registering homeless people and travellers with a GP practice, but noted that "homeless people, asylum seekers, and other transient groups are still frequently being refused registration by GP practices. Information suggests registration is a particular barrier for migrants or those with perceived 'irregular' immigration status." The Department also reported that "current models of primary care usually require patients to conform to patterns of access which assume certain characteristics and resources. For those with additional needs or whose circumstances make it difficult to meet these expectations, engagement in traditional models of care can be problematic and can lead to exclusion from any mainstream services."[142]

Our evidence suggests that while walk-in centres mostly serve people with minor conditions, some centres are providing an important route into primary care for high-risk groups. Lower socio-economic status is associated with poorer health outcomes and less healthy behaviours, and lifestyle risk factors in the young in particular have been identified as a key challenge for the NHS.[143] Both of these groups are being served by walk-in centres.

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[137] BMG Research's Birmingham study for NHS Central Midlands CSU, p.28. The study found that the ethnicity of patients at five centres was roughly proportionate with residents within a 3-mile radius of the centres, but the other three centres had much higher proportions of non-white patients than their local populations. Results of all centres combined showed a disproportionately high number of non-white groups using the centres compared to the ethnic make-up of Birmingham and Solihull counties. Appendix 1 of Birmingham study.

[138] Not including non-UK residents who are temporary visitors to England or those who stated that they did not know or were unsure or refused to say. Monitor patient survey report, p.54.

[139] For example, New Cross GP Walk-in Centre, the Urgent Care Centre at Guys' Hospital, Brighton Station Health Centre, Putnoe Medical Centre, and Reading Walk-in Centre.

[140] For example, NHS North East London and the City, Pre-Consultation Business Case (28%); Mountford, L. and R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, Kings Fund, 2001, Executive Summary (up to 45%).

[141] This compares to a figure of 1% for the population as a whole. NHS England, *Improving general practice – a call to action*, slide pack, August 2013, p.6, www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf.

[142] *Sixth National Inclusion Health Board Meeting Notes*, 4 June 2013. The Department of Health statements were based on an internal report that has not been published.

[143] NHS England, *The NHS belongs to the people: A call to action*, July 2013, p.14, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf.

Walk-in centres that were carefully thought out in terms of their locations and services on offer appear to have been most successful at reaching these groups.

Overall, the evidence we collected suggests that walk-in centre closures, or possibly relocations/reconfigurations, can risk increasing health inequality if suitable alternatives are not put in place. Commissioners are conducting Equality Impact Assessments in some cases before closing or reconfiguring walk-in centre services, but it is not clear whether they are adequate to determine the needs of certain populations and what is being done to mitigate the impacts of changes.

The potential impact on patients' access to primary care highlights the need for commissioners to do a careful needs assessment as a first step in any decision about whether to continue to procure walk-in centre services (see Section 8 for more about needs assessments in commissioning decisions).

What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients?

What additional information or evidence should Monitor consider?

7.2. The division of commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision

Divisions in commissioning responsibilities between NHS England and CCGs have created confusion about which body is responsible for deciding whether to continue to procure walk-in centre services. In locations where this is the case, it has drawbacks for local patients. We find that clarifying responsibility for reviewing and commissioning walk-in centres is likely to benefit patients and we seek readers' views on this finding as well as your ideas for the next steps.

Responsibility for commissioning walk-in centres

Since April 2013, responsibility for commissioning secondary care, including urgent care, generally lies with CCGs (made up of local GP practices), whereas the commissioning of primary care lies with NHS England. But the division is not so clear-cut and the commissioning of walk-in centres, which provide both routine and urgent primary care, straddles the boundary.

Based on this rough division of responsibilities, CCGs have taken responsibility for managing the nurse-led walk-in centre contracts and deciding whether to continue to procure walk-in centre services, as these centres are considered to provide urgent care. For GP-led health centres, the Department of Health has said that NHS England should manage and monitor the contracts until a decision needs to be made

about whether to continue services. At that time, CCGs are to decide whether to continue to procure the walk-in element of the contracts and NHS England will decide whether to continue the registered list practice. [144]

We found that, in practice, walk-in centre contracts are being handled differently in different locations. In some cases, CCGs are leading reviews about whether to continue to procure walk-in centre services, while in other cases NHS England local area teams are leading reviews. It was not always clear how the separate bodies are working together in these decisions, and some commissioners said they were unsure about what would what happen if there was disagreement between the two commissioning bodies about what to do..

In some areas, we found commissioners adhering strictly to the Department of Health's direction about splitting responsibilities by trying to split the GP-led health centre contracts into two: one being a contract for a registered list practice and one a contract for walk-in services. However, the Department also noted in its direction that "it would not be practicable to separate out the 'open access' element of the contract from the registered patient element."[145]

The picture is further complicated by other divisions of responsibility between NHS England and CCGs, and the involvement of other newly created entities. For example:

- While CCGs are responsible for commissioning urgent care, NHS England is responsible for commissioning urgent care from GP practices, to the extent that such care falls within the GP contract.[146]

> *"…there has been confusion in some areas over responsibility for future commissioning of walk-in centres. Local commissioners require greater clarity around the respective roles of CCGs and the local NHS England Area Team and would welcome further guidance as to how commissioning of the services is to be divided."*
> BMA submission to Monitor

- While NHS England is responsible for commissioning primary care, CCGs generally are responsible for monitoring quality of primary care, which they do in part by overseeing QOF measures and monitoring whether GP practices, including GP-led health centre practices, have achieved QOF indicators.[147]

- CCGs are responsible for commissioning out-of-hours services and other primary care services that are not included in GP contracts.[148] This means

[144] Letter from Dame Barbara Hakin, Department of Health, 3 February 2011.
[145] Letter from Dame Barbara Hakin, Department of Health, 3 February 2011.
[146] NHS Commissioning Board (NHS England), *Commissioning fact sheet for clinical commissioning groups*, October 2012.
[147] NHS England response.

that CCGs are empowered to procure new services from their member GP practices, including services currently being provided by walk-in centres.

- It is unclear which commissioning body holds the budget for the walk-in centres or how funds will be allocated if GP-led health centres are split into two contracts for future procurement.
- Urgent Care Review Boards and Health and Well Being Boards, made up of local stakeholders, also are involved in reviewing walk-in centre provision in some areas as part of their review of wider urgent care services.

The various divisions in responsibilities appear to have created confusion. Several stakeholders told us of concerns about the lack of clarity around commissioning.

The split and, in some cases, overlapping responsibilities related to walk-in centres may make it difficult for commissioners to achieve the system-wide approach they need to take when considering changes to the provision of walk-in centre services. Any change in the provision of walk-in centre services has the potential to affect patients' needs and demand for services across primary care and urgent/emergency care. In particular, a needs assessment related to walk-in services must look at the availability and quality of other services across the system, including whether the community has good provision and access to high quality GP practice services.

Our conversations with some stakeholders raised concerns that because the walk-in element is considered to be part of urgent care, commissioners may not be fully considering the relationship between the walk-in services and other primary care services.

Possible drawbacks for patients

The lack of clarity around commissioning responsibilities and the attempted strict division of responsibilities in some locations has potential drawbacks for patients, including:

- lack of clear accountability for decision-making;
- lack of transparency as to who key decision-makers are; and
- potential for decisions to not take a system-wide view of patients' needs and impact of changes.

There also is some evidence that the timing of the commissioning reforms and the split in responsibilities have led to delays in reviewing walk-in centre contracts that are set to expire in 2014.

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[148] NHS England, *Primary medical care functions delegated to clinical commissioning groups: Guidance*, 26 April 2013. These services would include those formerly commissioned as local enhanced services (LES). PCT funds used LES were transferred to CCG budgets.

Making one body responsible for deciding the future of walk-in centres

Commissioning of walk-in centres may work better for patients if one commissioning body is responsible for leading reviews of walk-in centres and taking decisions about their future, and at the same time ensuring that decisions take all stakeholders' views into account and examine needs and potential impact across the system.

We seek views on which commissioning body – NHS England or CCGs – should take lead responsibility. We found that, on the one hand, some stakeholders raised concerns that NHS England Local Area Teams are, in some areas, understaffed and already overburdened with managing numerous contracts and therefore may not be able to take on more responsibilities for the walk-in centres than they already have. Many walk-in centre contracts expire in 2014 and require immediate attention.

In addition, providers consistently raised concerns that some CCG members have conflicts of interest when taking decisions about walk-in centres (see Section 8.4). We seek views on whether one commissioning body – NHS England or CCGs – should take lead responsibility.

What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients?

What other information or evidence related to this topic should Monitor consider?

What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care?

If so, which body and why?

7.3. Walk-in centres would work better for patients if payment mechanisms are reformed

Even where the walk-in centre model works well to improve patients' access to primary care and provides high-quality, efficient services, current payment mechanisms:

- discourage commissioners from using the walk-in centre model; and
- do not strengthen incentives for GP practices' to improve quality and efficiency of their services so that their patients are more likely to choose to their services instead of using a walk-in centre.

7.3.1. Payment mechanisms are discouraging commissioners from offering walk-in centre services

As discussed in Section 6, the payment mechanisms for GP practices and walk-in centres has led commissioners to view attendances at walk-in centres as "paying twice" for patients who are registered at a GP practice.

Some commissioners have tried to address their concerns by requiring a GP-led health centre to encourage frequent attendees to register with the centre's practice or to use their own registered GP. For example, a commissioner in Reading required an arrangement in which the GP-led health centre would not be paid for patients registered elsewhere who visited more than six times, other than in exceptional circumstances.

> "*The NHS is paying for care for these patients twice due to the capitated payment to GPs and activity payment to other care settings. It may well be worth exploring changes to the primary medical service contracts. Considering the possibility of rebates on the capitated payment for activity in other settings and more flexibility to commission a mix of access choices for patients would seem a helpful improvement on the current situation where these options are at the discretion of the provider.*"
> Jill Matthews, Head of Public Health and Primary Care, NHS England (Midlands & East), submission to Monitor

However, some commissioners told us that they have not been able adequately to address their concerns about paying twice through local contract arrangements. Other stakeholders, including a few commissioners and some walk-in centre providers, were sceptical of in concerns about "double-payment," noting that the same concern could be raised with respect to patients attending urgent care centres or A&E departments for primary care needs.

We found that concerns about "double payment" are not new. At the time of the EAPMC initiative, the Department of Health issued a set of FAQs for local commissioners regarding procurement of the GP-led health centres. One question was: "*Isn't there a risk of paying twice for the same patient if these health centres are able to see local patients who are already registered with a local practice?*" The Department answered: "*The White Paper 'Our Health Our Care Our Say' committed the Department to review the funding arrangements for walk-in services. This review is currently underway is expected to make recommendations shortly.*"[149] Other than a statement in the cited white paper, we could find no additional evidence of the referenced review or recommendations.

[149] Equitable Access to Primary Medical Care, Local Procurements of GP Practices and GP-led Health Centres FAQs.

Our research suggests that concern about "double-payment" is a key factor driving decisions to close walk-in centres as commissioners seek to address funding pressures. There is a risk that this factor distracts commissioners from an analysis of the merits of the walk-in centre model itself in meeting patients' needs and in providing value-for-money in comparison to other services. Commissioners might find it more practical to support and enable the easy-access walk-in centre model if payment structures were different.

7.3.2. Payment mechanisms do not strengthen incentives for GP practices to improve quality and efficiency so that their patients are more likely to choose their services instead of using a walk-in centre

Choice and competition are tools that commissioners can use to create stronger incentives for providers to improve quality and efficiency of services, thereby benefiting patients. Commissioners can do this by allowing providers to compete to provide services or by allowing patients to choose between competing providers. For example, offering walk-in centres to patients as a choice for certain primary care needs could encourage GP practices to improve their services so that their patients would choose them instead of using a walk-in centre. However, the payment mechanisms currently in place do not always reinforce the right incentives for choice and competition among walk-in centres and other providers of primary care to generate benefits for patients.

This is because GP practices receive the majority of their income through payments that are based on the number of patients registered on their lists; their income is not directly affected when their patients choose to attend a walk-in centre (or another service offering primary care) instead of using their practice. Thus, where their patients have a choice to use a walk-in centre, GP practices have little incentive to improve their services so that their patients will choose to see them instead of attending the walk-in centre.

For example, several walk-in centre providers and commissioners told us that some GP practices point their patients to a walk-in centre when they are unable to offer a same-day or otherwise convenient appointment slot.[150] This suggests that some practices are using the centres to meet the needs of some patients for whom they are paid to provide primary care, rather than responding to what these patients want by, for example, accommodating more same-day or convenient-time appointments for these patients. The payment mechanism creates little incentive for GP practices

[150] We also received some results of patient surveys taken by walk-in centre providers showing that between 4% and 25% of patients attending the walk-in centre indicated that they heard about the centre through their GP practice, although it is not clear what portion of these patients were referred by GP practices for particular services offered by the walk-in centre, such as blood tests or a DVT service (see Section 4.5).

to respond in this way because they are still paid to provide primary care for those patients, even when they direct them to a walk-in centre.

If payment mechanisms created stronger incentives for GP practices to encourage their patients to choose their services instead of using a walk-in centre, this competition for patients could drive GP practices and walk-in centres to continually improve their own services. Such improvements might include delivering services in a more innovative way, such as with telephone or online consultations, improving quality of customer service features like telephone systems or receptionist skills, better prioritising the needs of patients when they ring for appointments, extending hours or offering walk-in appointments. GP practices and walk-in centres could also work harder to improve clinical quality or to offer a broader range of services.

We note that payment mechanisms limit incentives for GP practices to improve services only with respect to walk-in services, including the walk-in element of GP-led health centres, but not the registered list practice of GP-led health centres. Current payment mechanisms do create an incentive for GP practices to improve their services in order to retain patients that might otherwise prefer to register with a GP-led walk-in centre because GP practices' income is affected if their patients choose to switch their registration. We did find some evidence suggesting that the introduction of the registered list element of GP-led health centres caused some GP practices to "raise their game."[151]

There are some other financial incentives for GP practices to improve services, including access, such as QOF measures and the nationally-sponsored enhanced service, the Extended Hours Directed Enhanced Services Scheme, which offers additional payments for practices that open beyond core hours.[152] However, it appears that some enhanced services schemes merely encourage additional opening hours and not better practice management of in-hours appointments, or utilisation of those appointments. In addition, commissioners' additional payments to

[151] For example, by practices responding by extending opening hours. See, eg, A. Coleman, et al, *The limits of market-based reforms in the NHS: the case of alternative providers in primary care*, BMC Health Services Research, 24 May 2013. *Ten ways to face down competition from a Darzi centre*, Pulse, 12 Feb. 2010. However, other evidence we received suggested that, in some areas, when GP-led health centres first opened, commissioners placed advertising restrictions on them or decided not to let them register patients (we were told this was in response to concerns existing GPs in those areas). Also, original procurement guidance from the Department of Health recommended that PCTs define the centres' target population and area "as widely as possible (within reason) to stimulate competition" but at the same time recommended that PCTs adopt the principle of "nil detriment", which meant the new providers had to demonstrate that their services would not negatively impact "existing services in the locality or in near proximity…from a patient perspective." PCTs were to define "protected areas" where the principle would apply. See Department of Health, EAPMC Commercial Strategy, Framework and Provisions Guidance for PCTs, August 2008. In addition, some people told us that they thought primary care was not always working in the best interests of patients. We are considering these views as part of Monitor's call for evidence in GP services.

[152] For GMS practices, core hours are from 8:00am to 6:30pm Monday to Friday excluding Good Friday, Christmas Day and bank holidays.

GP practices for enhanced services may or may not represent better value for money than walk-in centres.[153]

What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients?

What other information or evidence related to this topic should Monitor consider?

Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?

How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

Any approach to payment reform must carefully consider all incentives arising from different payment models. The goal should be to create payment mechanisms for GP practices and walk-in centres that provide stronger incentives for them to respond to patients' needs. Primary care payment mechanisms should enable and encourage providers to deliver both higher quality and value for money. They also need to align with payment structures in secondary care, including urgent and emergency care, so that the entire system offers incentives that continually create more benefits for patients within the limits of NHS funding.

[153] Walk-in centre providers have raised an additional concern about conflicts of interests where CCGs decide to close walk-in centres and commission similar services from member GP practices. See Section 8.4 of this document for a discussion of conflicts of interest.

8. Steps for taking decisions about whether to continue to procure walk-in centre services

Walk-in centres are most valued today where they were introduced following a careful assessment of local needs, were located in an area of the community where the services could be conveniently accessed by those who need it, and were procured using a sound process that resulted in value for money.

Good commissioning will continue to be critical. The Procurement, Patient Choice and Competition Regulations[154] provide the framework for taking decisions about what services to procure and how to procure them. They are designed to ensure that commissioners secure high quality, efficient services for patients that meet their needs. There are a number of factors that commissioners are likely to need to consider to be confident that the decisions that they take are consistent with patients' needs and can achieve quality and efficiency improvements. We have set out below the factors likely to be particularly relevant to decisions about the future of walk-in centres, based on the themes that have emerged from our review.

In practice, what is best for patients will depend on local circumstances. Commissioners will need to consider the Procurement, Patient Choice and Competition Regulations in the round and should refer to Monitor's substantive guidance for more detail on how to apply the regulations in practice.[155]

8.1. Assessing patients' needs

Commissioners are expected to act with a view to securing the needs of health care service users, and this is set out in Regulation 2.

We recognise the financial constraints that commissioners face and that some commissioners consider that some services provided by walk-in centres treat illnesses and injuries that could be dealt with through self-care or by other existing services.[156]

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[154] The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the "Procurement, Patient Choice and Competition Regulations"). The regulations replaced the Principles and Rules for Cooperation and Competition and the Procurement Guide for Commissioners of NHS Funded Services.

[155] Monitor's has published draft substantive guidance for consultation, available here.

[156] NHS England notes that increases in attendances at walk-in centres and minor injury units since they were introduced could mean the services are meeting previously unmet demand or are creating unwarranted demand or a failure to meet needs earlier in the system. NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013, p.18. http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf. While our evidence suggests that most of people use walk-in centres for needs that are not clinically urgent, almost half of the patients in our survey viewed their conditions as urgent. More than 80% said they would try to use other services if the walk-in centre was not available, with the majority saying that they would seek advice from a GP or A&E. Very few would have self-treated or not sought advice (8%). This suggests that most demand would not "go away" in the event of closure.

However, before taking any decisions about the future of a walk-in centre a commissioner will need to develop a clear understanding of the health care needs of the particular population for which it is responsible and the role of the walk-in centre in meeting those needs.

Our findings suggest that issues concerning access to care are likely to be highly relevant to patients in most areas.[157] The commissioner may have to consider in particular:

- The needs of people who find it difficult to access primary care services. These might include particular populations, such as those with language barriers, travellers or homeless people, who may have difficulties registering with a GP or booking and keeping appointments.
- The need for primary care services to be available at different times, such as during evenings and at weekends and when GP practices are closed in areas where there are large numbers of workers who cannot afford to be absent from work for a GP appointment.
- The extent to which there is a need in the area for better access to same-day or immediate care for conditions that are urgent or that patients view as urgent.
- The need for primary care services to be available across different locations, including, for example, whether a walk-in-centre currently provides services in an area of high deprivation that might otherwise lack primary care services, or in a rural area where hospital or urgent care services are far away.
- Overall primary care and urgent needs, including whether a walk-in centre is helping to meet general demand for primary care services.

8.2. Choosing a service model and provider

Where the commissioner has identified that a walk-in centre is meeting particular health care needs in its area, it will need to decide what services it should procure and from whom to ensure that those needs continue to be met when the contract with the walk-in centre expires.

[157] Commissioners are also subject to the public sector equality duty (PSED) in the Equality Act 2010. The PSED requires public authorities to have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people who share a protected characteristic (including, for example, age, disability, race, religion or belief) and those who do not; and foster good relations between people who hare a protected characteristic and those who do not. The Equality and Human Rights Commission has published guidance on procurement and the Equality Act 2010: Buying better outcomes.

Regulation 3(3) requires commissioners to procure services from the provider or providers most capable of securing patients' needs and improving services, and that provide best value for money. Regulation 3(2) also requires commissioners to treat providers equally, which includes giving all potential providers of a service a fair opportunity to provide them. These two requirements are closely linked. By giving full consideration to the relative ability of a wide range of different providers to deliver services, a commissioner is more likely to end up securing services from the provider that will achieve the best outcome for patients.

Our review suggests that, when a contract for a walk-in centre expires, commissioners may not always be considering the full range of options available to them when deciding what services to procure and from whom. The purpose of this review is not to investigate whether individual commissioners have acted consistently with the Procurement, Patient Choice and Competition Regulations. If stakeholders have concerns that a commissioner may not have acted in accordance with the regulations, they may wish to make a formal complaint to Monitor.[158]

A commissioner will need to consider what models of care may be appropriate in light of the health care needs that it has identified and which providers would be best placed to deliver those models of care.

It may be that the needs that are currently being met by a walk-in centre in the area could be secured through a variety of different models of primary and urgent care. These might include, for example, relocating or reconfiguring the services provided by an existing walk-in centre, or procuring additional services from GP practices to provide extended hours or out-of hours care instead. In some circumstances there may be a more limited number of models that would be suitable. If, for example, the service needs to cater primarily to unregistered people or others with specific needs, it may be that extended or out-of-hours cover from GP practices would not be an appropriate choice.

Once the commissioner has chosen a particular model of care, there are a number of ways in which it might go about selecting a future provider. What is appropriate will depend on local circumstances. For example:

- A commissioner may decide to procure services through a competitive tender process. This may be appropriate, for example: if the commissioner plans to commission a single provider of walk-in services; there are a large number of potential providers (for example, some providers may have contacted the commissioner to express an interest in providing a walk-in service in the area); or it is five years since services were last reviewed and the commissioner has concerns about the quality of existing provision but is

[158] Details of how to do so are set out in Monitor's enforcement guidance, available here. Decisions on whether or not to investigate complaints that we receive are taken in accordance with the prioritisation criteria set out in our guidance.

unsure about which alternative provider is most likely to deliver the best outcome for patients.

- The commissioner may decide to announce its intention to extend or renew the contract with an existing provider some time before reaching a final decision. This may be appropriate, for example, where the commissioner is satisfied that the existing provider is delivering a high quality service and good value for money and is unsure about whether there are other providers that might be interested in providing the service. The commissioner could make this announcement on its website and supply2health a reasonably long time before the contract is due to expire, for example, 12 months. This would enable other providers to express interest. If other providers do express an interest, the commissioner would need to consider whether those providers might be capable of delivering a better service or not.

- The commissioner may decide to extend or renew the contract with the existing provider. This may be appropriate, for example:

    - where the commissioner wants to procure a very specific type of walk-in centre, following its assessment of local needs;

    - the fact that the contract is coming to an end is well known;

    - the existing provider is performing well, with high levels of patient satisfaction; and

    - the commissioner has a good understanding of who the potential providers of the service are and has identified that the current provider has experience and expertise that other providers do not have that is necessary for delivering an effective service (for example, expertise in treating particular categories of patient or delivering particular types of service).

Whatever process the commissioner decides to follow, it will need to consider how best to run that process to ensure that it is sufficiently robust to identify the most capable provider without being unnecessarily burdensome.

8.3. Improving services by providing them in a more integrated way

Commissioners are expected to consider ways of improving services, including through services being delivered in a more integrated way (This is covered by Regulation 3(4)(a) of the Procurement, Patient Choice and Competition Regulations.)

Some commissioners raised concerns that walk-in centres may be contributing to the fragmentation of care because, for example, walk-in centres generally do not have access to patients' medical records and may not be able to refer patients on to

secondary care services. However, we found that the strength of links between the walk-in centres and other services in the local health economy varies by locality (see Section 4.5).

Whenever commissioners are considering what services to procure and how to do so, they must consider whether services could be improved by being delivered in a more integrated way with other health and social care services.

Commissioners should not discount a walk-in centre model simply because an existing walk-in centre does not have strong links with other services in the local health economy. Rather, commissioners should consider whether practical steps could be taken to ensure that care is delivered in a more integrated way by creating better links between different services (including those provided by a walk-in centre). This might include, for example, establishing care pathway protocols between the centre and other primary and secondary care providers, developing more and stronger links with social care services, introducing access to shared patient records, integrating walk-in centre clinicians into multi-disciplinary teams, and addressing any confusion that might exist in the community about the different services that are available in the area (including by making clear what services are on offer at a walk-in centre). As some stakeholders pointed out, such a model would also support policies designed to move care into communities and out of hospital settings.

8.4. Managing conflicts of interest

Commissioners are required to comply with a number of rules designed to ensure that conflicts of interest are appropriately declared and managed. These include Regulation 6(1) of the Procurement, Patient Choice and Competition Regulations, which prohibits commissioners from awarding a contract for NHS services where conflicts or potential conflicts between the interests involved in commissioning such services and providing them affect, or appear to affect, the integrity of the award of that contract.[159]

Conflicts of interest may materialise in a number of different ways when decisions are being taken over the future of a walk-in centre. A CCG may decide, for example, to close a walk-in centre and use those funds to buy additional services from member GP practices (such as services that were previously known as LES). Member GP practices of CCGs may therefore have a direct financial interest in decisions about whether or not to continue to procure services from a walk-in centre.

[159] CCGs are also required to comply with section 14O of the National Health Service Act 2006, which includes rules on registers of interests and managing conflicts of interest. Members of commissioners that are registered doctors must also comply with their professional obligations in so far as they concern conflicts of interest. These are set out in the General Medical Council's guidance Good Medical Practice (see paragraphs 77 to 88 "honesty in financial dealings") and Financial and commercial arrangements and conflicts of interest.

Some stakeholders raised concerns with us that these and other potential conflicts of interest may lead to flawed procurement decisions that are motivated by financial interests rather than the interests of patients. As explained above, the purpose of this review is not to investigate whether individual commissioners have acted consistently with the Procurement, Patient Choice and Competition Regulations. However, if stakeholders have concerns that a CCG may have breached Regulation 6 by awarding a contract for services to replace a walk-in centre without appropriately managing a conflict of interest, they may wish to make a formal complaint to Monitor.[160]

8.5. Acting transparently

Commissioners are required to act in a transparent way when procuring services (Regulation 3(2) of the Procurement, Patient Choice and Competition Regulations). Transparency is important in ensuring that commissioners are accountable for their decisions.

It appears from our review that some decisions about the future of walk in centres may not always be as transparent as they might be. For example, while we saw several examples of a public consultation exercise that explained the processes and reasons for a proposed closure, we also saw examples in which commissioners appeared to have decided to close walk-centres without setting out their reasons for doing so and explaining the process they followed to reach their decision. Some providers also told us that they were unsure about what their local commissioners' intentions were with respect to the walk-in centre services that they provide, even though the contract was due to expire in the near future.

Commissioners must consider what steps they should take to ensure that people understand the reasons for the decisions that they are taking and the process that they are following to take them. This may include, for example, announcing when they are proposing to review the future of a walk-in centre, what process they intend to follow, and the decision that they ultimately take and the reasons for it.

Is this description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful?

Would further advice or guidance be helpful?

[160] Please see footnote 158 for more details on how to make a complaint to Monitor.

9. Summary of questions for readers

The specific questions asked in this document are listed below, however we welcome comments on any aspect of this report.

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

2. Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients?

   What additional information or evidence should Monitor consider?

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients?

   What other information or evidence related to this topic should Monitor consider?

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care?

   If so, which body and why?

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients?

   What other information or evidence related to this topic should Monitor consider?

7. Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful?

   Would further advice or guidance be helpful?

Annex 1: Alternatives to walk-in centres

This Annex describes a number of alternatives to walk-in centres that may be available within a locality for people needing advice or treatment for minor illness or injury. The alternatives are:

- urgent care centres;
- minor injuries units;
- A&E departments;
- NHS Direct and NHS 111 services;
- GP services (in hours);
- out-of-hours GP services;
- community pharmacy services; and
- self-care and self-management.

Urgent care centres

Urgent care centres (UCCs) often provide services that are very similar to those offered at walk-in centre, though there can be "wide variation" in the nature of services labelled as urgent care centres.[161] As services are GP-led, many UCCs allow patients to walk in and will treat routine primary cases which could ordinarily be dealt with by out-of-hours GP services or walk-in centres.[162] However, some UCCs will receive only patients who have been streamed from an A&E department, or will direct non-urgent cases back to their own GPs.

Many UCCs are co-located with a hospital with access to a full range of staff and services or are located away from a hospital but act as mini-A&Es with a full range of diagnostics and clinical staff. Others that are remote from a hospital may have more limited services (eg, a limited capability for dealing with fractures).[163]

UCCs are generally open seven days a week; some open for 24 hours a day, others for extended hours.[164] They are required to provide care for patients within the four hour standard, as is required for A&E departments.[165]

[161] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.3. Available at: www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf
[162] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012.
[163] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.8.
[164] Primary Care Foundation, Urgent Care Centres, What works best, Oct. 2012, p.14.
[165] Healthcare for London, A service delivery model for urgent care centres: Commissioning advice for PCTs, p.12, available at: www.londonhp.nhs.uk/wp-content/uploads/2011/03/Urgent-care-centres-

UCCs evolved as a way to reduce A&E attendances, as well as to reduce waiting times for patients with minor conditions who could otherwise face long waiting times at an A&E.[166,167]

Minor injuries units

A minor injuries unit (MIU) is an assessment and treatment centre led by specially trained nurses, such as emergency nurse practitioners.[168,169] It is designed to handle less serious injuries than would ordinarily be treated at an A&E department, including broken bones, sprains, wound infections, minor eye problems, minor burns, bites and cuts.[170] As MIUs do not have the full range of facilities and support services that A&E departments have, the units cannot treat major injuries, chest and stomach pains, breathing difficulties, allergic reactions, overdoses and other more serious health problems.[171,172] If a patient requires further diagnosis and treatment, (s)he will most likely be sent to the A&E department (which may be on another site) or referred to another, more appropriate service. Some MIUs, like some nurse-led WICs, do not treat young children, setting a minimum age for patients that they can treat.[173]

Services at MIUs are available on a walk-in basis.[174] Opening hours vary by location. They are generally open seven days a week; some operating 24 hours a day, others with set opening times (eg, 7am-10pm, 9am-8pm). The main difference between an MIU and a walk-in centre is that MIUs do not typically deal with patients' routine primary care needs.[175] The service is nurse-led, and onsite staff are not typically trained in primary care. Like UCCs and major A&E departments, MIUs are required to provide care within a four hour standard.[176]

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delivery-model.pdf; Department of Health, Urgent and emergency care services http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/healthcare/urgentandemergencycare/urgentandemergencycareservices/index.htm

[166] Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.3.

[167] For example, Urgent care centre pilot launched at UCH, 19 September 2011, www.uclh.nhs.uk/news/Pages/UrgentcarecentrepilotlaunchedatUCH.aspx

[168] See NHS Choices: Emergency and urgent care services, www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

[169] For example, http://www.bartshealth.nhs.uk/your-visit/in-an-emergency/

[170] http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

[171] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx, www.collemergencymed.ac.uk/asp/document.asp?ID=2980

[172] www.herefordshire.nhs.uk/docs/Policies/MIU_Operational_Policy.pdf

[173] www.herefordshire.nhs.uk/docs/Policies/MIU_Operational_Policy.pdf

[174] For example, www.bartshealth.nhs.uk/your-visit/in-an-emergency/

[175] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

[176] See, eg, www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=3&fldMenu=1&fldSubMenu=0&fldKey=965

MIUs began to appear in the UK in the mid 1990s, typically replacing small A&E departments. This was motivated by policies to move health care into the community and to rationalise and centralise the provision of emergency care.[177]

A&E departments

A&E departments are intended to deal with serious injuries and illnesses. An A&E department can provide care for emergency conditions of all types and for patients of all ages.[178,179] This includes illness and injury, mental health problems and life-threatening emergencies including:

- loss of consciousness;
- acute confused state and fits that are not stopping;
- persistent, severe chest pain;
- breathing difficulties; and
- severe bleeding that cannot be stopped.[180]

Major A&E departments –Type 1 A&Es – are consultant-led and have access to full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.[181]

Most A&E departments offer guaranteed access to care 24 hours a day, seven days a week.[182] Patients can self-present or be brought to A&E by an ambulance.

NHS Direct and NHS 111 services

Rolled out nationally in October 2000, NHS Direct was established as a national provider of a 24-hour nurse-led telephone health advice line. The NHS Direct service was first introduced as part of the government's plans to modernise NHS services, and its main aim was to "provide people at home with easier and faster advice and

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[177] See, for example, Brian Dolan, Jeremy Dale, *Characteristics of self referred patients attending minor injury units*, Journal of Accident and Emergency Medicine, 1997; 14:212-214

[178] A&E may not be suitable for patients with multiple, serious injuries. Such patients may need to be transferred to a major trauma centre. This is a hospital where there is a full range of trauma specialists, including orthopaedics, neurosurgery and radiology teams. Care at major trauma centres is led by a trauma consultant, who is available 24 hours a day.

[179] NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.49.

[180] www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx

[181] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206267/15_01final3_v3.pdf

[182] NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.49.

information about health, illness, and the NHS."[183] The service was also meant "to point people in the right direction for the most appropriate form of treatment."[184] The service was replaced from 2013 by the NHS 111 service.

NHS 111 was launched as the new telehealth and patient triage service to help people access NHS health care services for urgent medical problems. It was introduced in response to public concern and frustration about accessing NHS care, especially at weekends and out-of-hours.[185] It is intended to simplify access to non-emergency health care by providing a memorable number (111) that was free to the caller,[186] to provide consistent clinical assessment at the first point of contact, and to route customers to the right NHS service first time. A key difference to the NHS Direct service is that the NHS 111 service is commissioned locally, and is intended to be linked electronically to a skills-based directory of local services. It is hoped that this will make the service more integrated with the local health economy and therefore make it easier for users to access the most appropriate health care service, quickly.[187]

The service is available 24 hours each day of the year. Calls are free of charge from landlines and mobile phones. The service is designed for situations that are not life threatening[188] and where callers are unsure about what service they need or they need access to care out-of-hours. Key features of the service are:

- calls are assessed by a trained, non-clinical call adviser using clinical assessment software to determine both the type of service needed and the timescale within which help is required;
- where possible, appointments are made with the correct service at the time of the call;
- calls that require further clinical assessment can be transferred to a clinical nurse advisor or GP within the same call; and
- if a call requires an emergency ambulance response, a vehicle can be dispatched without the need for further triage.[189]

[183] Pilot NHS Direct programmes began in 1998 and a complimentary website was launched in 1999. www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/History
[184] www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/History
[185] www.england.nhs.uk/2013/06/07/nhs-111-improving/
[186] NHS Direct operated a national phone line, 0845 4647; while the service was free to use, callers would incur calling charges.
[187] University of Sheffield, Evaluation of NHS 111 pilot sites, Final Report, August 2012. www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf
[188] The NHS 111 service is not intended to replace the 999 number for life threatening emergencies. www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx
[189] University of Sheffield, Evaluation of NHS 111 pilot sites, Final Report, August 2012. www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf

The service was first introduced as a pilot scheme in 2010. Initially due for rollout to the whole of England by April 2013, the deadline was extended in some areas by up to six months. [190,191] There are a few areas in England that at the time of writing had not yet launched the service.[192]

A range of providers have been contracted to provide the service, including Ambulance Service Trusts and out-of-hours GP service providers.[193] NHS Direct was originally contracted to provide the service to about a third of England's population. However, it withdrew from the 111 service on financial grounds[194] and has since announced that it will cease operations at the end of March 2014.[195]

The launch of the 111 service has not run smoothly and may take some time to win public confidence. For example, when NHS Direct launched its two largest services in March 2013, it found that it did not have sufficient capacity to handle the calls it received. Calls had to be diverted back to GP out-of-hours organisations and to its original service.[196] Some have expressed concerns regarding inadequately trained staff, a lack of personnel, long waits and out-of-hours GPs having to take on extra work.[197]

[190] Department of Health, Subject: NHS 111 rollout deadline extension, 14 June 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214977/dh_134585.pdf
[191] Eight CCGs apply for NHS 111 delay, *Pulse*, 1 August 2012, www.pulsetoday.co.uk/eight-ccgs-apply-for-nhs-111-delay/14370420.article#.UmK9C7wYLVo
[192] For example, the 111 service was expected to go live in early November 2013 in three boroughs of East London (City and Hackney, Newham and Tower Hamlets). www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Board%20Papers/Friday%2027%20September%202013%20CCG%20Board%20agenda%20and%20papers.pdf
[193] By way of example, NHS 111 in Devon is run by the South Western Ambulance Service Foundation Trust; the service in Nottinghamshire is operated by Derbyshire Health United, a GP-led social enterprise company operating the Out-of-Hours GP service. www.bbc.co.uk/news/uk-england-devon-23935801 http://www.nottinghamnortheastccg.nhs.uk/community/reassurance-over-nhs-111/
[194] NHS Direct, The Future of NHS Direct's 111 Services: press release, 29 July 2013, www.nhsdirect.nhs.uk/About/~/media/Files/2013PressReleases/NHS%20Direct_111future20130729.ashx
[195] NHS Direct, NHS Direct To Close At The End Of The Financial Year: press release, 24 October 2013, http://www.nhsdirect.nhs.uk/News/LatestNews/NHSDirectToClose
[196] NHS Direct, The Future of NHS Direct's 111 Services: press release, 29 July 2013, www.nhsdirect.nhs.uk/About/~/media/Files/2013PressReleases/NHS%20Direct_111future20130729.ashx
[197] CCG places NHS 111 rollout on hold indefinitely, *Pulse*, 13 May 2013, www.pulsetoday.co.uk/commissioning/commissioning-topics/urgent-care/nhs-111-implodes-as-gpc-withdraws-support-for-urgent-care-hotline/20002392.article#.Ul2Sz7wYLVo

Out-of-hours GP services

The out-of-hours (OOH) GP service is an urgent primary care service provided outside of standard GP practice working hours.[198] The service is available from 6.30pm – 8am during weekdays, and 24 hours at weekends and on bank holidays.

If a patient urgently needs to see a GP when a GP practice is closed, and the patient cannot wait until the practice is open, the patient can call the OOH service using a given phone number.[199] A nurse or GP will assess the caller's symptoms over the phone and the caller will then be:

- given advice over the phone on how to best manage their symptoms;
- asked to come into the nearest OOH centre for an appointment with a GP or nurse; or
- offered a home visit from a GP or nurse.[200]

OOH GP services are not designed to deal with routine primary care needs; therefore the provider will not, for example, make routine appointments on the caller's behalf or issue routine prescriptions. Instead, the caller will be advised to contact their GP practice during opening hours.[201]

Changes to the GP contract in 2004 gave practices that had previously been required to provide OOH services to their patients the ability to opt-out of OOH services. Where GPs have opted out, OOH services are commissioned from a separate provider.[202] It has been estimated that around 90% of GPs have opted out.[203]

Out-of-hours cover may include some or all of the services below:

- GPs working in A&E departments, MIUs or walk-in centres;
- teams of health care professionals working in A&E departments, MIUs or walk-in centres;

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[198] This service is distinct from extended opening hours schemes that many GP practices provide which allow patients to receive their normal in-hours GP services beyond the core times of 8am – 6.30pm.
[199] The intention is that once the 111 service is operational in an area all calls to the out-of-hours GP service will be transferred automatically to 111. During transition, depending on the arrangements for the GP practice, a patient calling her/his GP practice when it is closed will either be given the OOH GP service phone number or asked to call NHS 111 or will be automatically directed through to one of these numbers.
[200] OFT, Completed Acquisition by Care UK Group of HWH Group Limited, ME/5840/12, 8 March 2013, paragraph 11.
[201] www.pelc.nhs.uk/services/out-of-hours-gp-services.html
[202] www.england.nhs.uk/wp-content/uploads/2013/04/pri-med-care-ccg.pdf
[203] OFT, Completed Acquisition by Care UK Group of HWH Group Limited, ME/5840/12, 8 March 2013, paragraph 13. www.oft.gov.uk/shared_oft/mergers_ea02/2013/care-uk.pdf

- GPs or other health care professionals operating from mobile facilities making home visits; and/or
- ambulance services moving patients to places where they can be seen by a GP or nurse, to reduce the need for home visits.[204]

GP practices (in hours)

GP practices provide a broad range of health services to patients, including but not limited to, health advice, assessment of symptoms, prescription of drugs, care or advice for minor illness, urgent primary care, and management of long-term conditions.[205] GP practices are usually staffed by GPs and nurses, but may also include other health care professionals such as health assistants and health visitors.[206] Practices may have other health professionals co-located in the same building, eg, pharmacist, physiotherapists, midwives, and district nurses.

If a GP cannot treat a patient, the GP is able to refer the patient to a specialist health practitioner or to a hospital for further investigation and treatment.[207]

Core opening hours for GPs under the GMS contract are from 8:00am to 6:30pm, Monday to Friday, except Good Friday, Christmas day or bank holidays.[208] Core hours under PMS and APMS contracts are those negotiated and specified in the contracts. In addition, NHS England, and previously PCTs, must offer directed enhanced services (DES) contracts to GPs for extended hours, based on a formula of 30 minutes per week for every 1,000 registered patients.[209] But GPs need not offer extended hours. Some GP practices – particularly single-GP practices – close for one or more afternoons a week or during holidays or other breaks.

Services are available for patients registered at the GP practice, although practices may also see out-of-area patients as temporary residents.[210]

For the most part, patients must book an appointment to see a GP, although the process for managing appointments often differs across practices. Some practices may provide appointments following a telephone consultation or via a web-based online booking system. In addition, to meet a perceived increase in demand, GP practices have adopted various approaches, such as: informal open lines for

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[204] www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/out-of-hours-services.aspx
[205] www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx
[206] A health visitor is a nurse with a specialist training particularly related to children and pregnancy. Health visitors can be employed by the GP practice, but more often are salaried NHS staff.
[207] www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx
[208] NHS Employers, BMA, NHS England, 2013/14 extended hours directed enhanced service guidance, May 2013. www.nhsemployers.org/Aboutus/Publications/Pages/2013_14_extended_hours_DES_guidance.aspx
[209] Id.
[210] People may register as a temporary resident with a GP practice in England if they are in an area for longer than 24 hours but less than three months. NHS Choices, www.nhs.uk/chq/Pages/how-do-i-register-as-a-temporary-resident-with-a-gp.aspx?CategoryID=68&SubCategoryID=158

telephone calls (often interrupting face to face consultations), offering a telephone call if no face to face appointments are available, or an initial GP phone call in response to all or most patient demand.

For urgent appointments, some practices triage requests with a GP telephone consultation to assess the patient, provide advice or make a same-day appointment, or provide a queuing service by making a certain number of urgent same-day appointment slots available on a first come first served basis; these are allocated either by patients arriving during set times of the day on a first come first served basis (ie, on a walk-in basis), or by patients telephoning the practice and being allocated an appointment time. [211]

Community pharmacy services

The traditional role of community pharmacies has been to prepare and dispense prescription and non-prescription medicines to the general public, and offer advice on the safe use of medicines. However, this role has expanded recently to include:

- advice and treatment of minor ailments (eg, coughs, colds, aches and pains, minor injuries, skin conditions and allergies);
- the provision of advice to promote healthy lifestyles (eg, advice on healthy eating and stopping smoking);
- testing and screening for particular conditions (eg, pregnancy testing, chlamydia screening and treatment); and
- supporting people with particular long-term conditions using new medicines. [212]

Some pharmacies may also do flu jabs, medicines reviews, emergency contraception and weight management.

Pharmacists can also help patients decide whether they need to see a GP.[213]

Pharmacies are often located within the community, and they may be co-located within a primary care setting (such as a GP practice or walk-in centre). Sometimes they are located near or within a hospital setting.[214]

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[211] www.hsj.co.uk/home/innovation-and-efficiency/better-gp-access-better-ae-outcomes/5061857.article

[212] www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx; and NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.33.

[213] www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx

[214] www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx

Services are accessible without patients needing to make an appointment. Consultation can also be private; around 85% of pharmacies now have a private consultation area where patients can discuss issues with pharmacy staff without being overheard by other members of the public.[215]

Community pharmacy services are currently seen as playing an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions. However, reports suggest that there is little public awareness of the range of services provided by pharmacies.[216]

Self-care and self-management

Self-care for minor ailments and self-management of long-term conditions are increasingly being promoted within the NHS. Around 80% of all health problems are currently treated or managed at home without the use of NHS services, and it is thought that, by improving access and encouraging the use of support for self-care and self-management, this can help free capacity in routine primary care and prevent unnecessary use of urgent and emergency care services.[217]

There are a range of services available to support self-care and self-management. This includes:

- web-based health tools (eg, online symptom checker applications provided by NHS Choices);
- self-management education programmes and courses for patients;
- establishment of peer support groups;
- embedding self-care and self-management support into primary care environments.[218]

[215] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.33.
[216] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.33.
[217] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.29.
[218] NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.29.

Annex 2: List of current walk-in centres

Name	Address
1. 8am to 8pm Health Centre	79a Upper Parliament Street, Nottingham, NG1 6LD
2. Accrington Victoria Health Access Centre	Accrington Victoria Community Hospital, Haywood Road, Accrington, BB5 6AS
3. All Day Health Centre	Arrowe Park Hospital, Arrowe Park Road,Upton, Wirral, CH49 5PE
4. Angel Medical Practice	34 Ritchie Street, London, N1 0DG
5. Ashford Health Centre	Ashford Hospital, London Road, Ashford, Middlesex, TW15 3FE
6. Ashton GP Led Health Centre	Old street, Ashton under Lyne, OL6 7SR
7. Banbury Health Centre	58 Bridge Street, Banbury, Oxfordshire, OX16 5QD
8. Barbara Castle Way Health Centre	Simmons' St, Blackburn, BB2 1AX
9. Barkantine Practice	121 Westferry Road, London, E14 8JH
10. Bath NHS Healthcare Centre	Riverside Health Centre, James Street West, Bath , BA1 2BT
11. Battle Hill Health Centre	Battle Hill Health Centre, Belmont Close, Wallsend, Tyne and Wear, NE28 9DX
12. Birmingham NHS Walk-in Centre	66 High Street, Birmingham, West Midlands, B4 7TA
13. Bitterne Walk-in Centre	Commercial Street, Southampton, Hampshire, SO18 6BT
14. Blackpool GP Led Walk-in Centre	Whitegate Health Centre, 150-158 Whitegate Drive, Blackpool, FY3 9ES
15. Blaydon GP Practice and Minor Injury and Illness Unit	Shibdon Road, Blaydon, NE21 5NW
16. Boscombe & Springbourne Health Centre	66-68 Palmerston Road, Bournemouth , BH1 4JT
17. Brent GP Access Centre	Wembley Centre for Health & Care, 116 Chaplin Road, Wembley, HA0 4UZ
18. Brighton Station Health Centre	Aspect House, 84-87 Queens Road, Brighton, BN1 3XE
19. Broad Street Medical Centre	Morland Road, Dagenham, RM10 9HU
20. Broadmead Medical Centre	59 Broadmead, Bristol , BS1 3EA

21. Broughton Gate Health Centre	Glyn Valley Place, Broughton, Milton Keynes, Buckinghamshire, MK10 7EF
22. Bunny Hill Minor Injury and Illness Unit	Bunny Hill Primary Care Centre, Hylton Lane, Downhill, Sunderland, SR5 4BW
23. Burntwood Health and Wellbeing Centre	High Street, Chasetown, Burntwood, Staffordshire, WS7 3XH
24. Bury Walk-in Centre	Moorgate Primary Care Centre, 22 Derby Way, Bury, BL9 0NJ
25. Calder Community Practice	82 Halifax Road, Lower George Street, Todmorden, OL14 5RN
26. Camphill GP Led Health Centre	Ramsden Avenue, Camphill, Nuneaton, CV10 9EB
27. Cardrew Health Centre	60 Cardrew Industrial Estate, Cardrew Industrial Estate, Redruth, TR15 1SS
28. Carfax NHS Medical Centre	Swindon Health Centre, Carfax Street, Swindon, SN1 1ED
29. Castle Health Centre	3-4 York Place, Scarborough, North Yorkshire, YO11 2NP
30. Cator Medical Centre	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3FD
31. Chester Walk-in Centre	Countess of Cheshire Hospital, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL
32. City Health Centre	32 Market Street, Manchester, Lancashire, M1 1PL
33. City of Coventry NHS Walk-in and Healthcare Centre	Stoney Stanton Road, Coventry, CV1 4FS
34. Clifton Nurse Access Point	Clifton Cornerstone, Southchurch Drive, Nottingham, NG11 8EW
35. Clover Health Centre	Equitable House, 10 Woolwich New Road, London, SE18 6AB
36. Crawley Health Centre	Cross Keys House, 14 Haslett Avenue West, Crawley, West Sussex, RH10 1HS
37. Cricklewood GP Health Centre	Barnet Hospital A&E, Britannia Business Village, Cricklewood, Barnet, NW2 1DZ
38. Darwen Health Centre	James St West, Darwen, BB3 1PY
39. Derby NHS Walk-in Centre	Entrance C, London Road Community Hospital, Osmaston Road, Derby, Derbyshire, DE1 2GD
40. Derby Open Access Centre	Lister House, 207 St Thomas Road, Derby, DE23 8RJ

41. Doncaster 8-8 Health Centre	The Flying Scotsman Centre, St Sepulchre Gate West, Doncaster, DN1 3AP
42. Dudley Borough Walk-in Centre	Holly Hall Clinic, Stourbridge Road, dudley, DY1 2ER
43. Earls Court Health & Wellbeing Centre	2B Hogarth Road, Earls Court, London, SW5 0PT
44. Easington Healthworks Medical Centre	Paradise Lane, Easington Colliery, Peterlee, County Durham, SR8 3EX
45. Eastbourne Station Health Centre	Eastbourne Station, Terminus Road, Eastbourne, BN21 3QJ
46. Eastham Walk-in Centre	Eastham Clinic, Eastham Rake, Wirral, Merseyside, CH62 9AN
47. Edgware NHS Walk-in Centre	Edgware Community Hospital, Burnt Oak Broadway, Edgware, Middlesex , HA8 0AD
48. Edmonton GP-led Walk-in Service	1 Smythe Close, Edmonton, Middlesex, N9 0TW
49. Edridge Road Health Centre	Impact House, 2 Edridge Road, Croydon, Surrey, CR9 1PJ
50. Encompass Health Centre	The Galleries Health Centre, Washington, Tyne and Wear, NE38 7NQ
51. Erdington GP Health and Wellbeing Walk In Centre	196 High Street Erdington, Erdington, B23 6SJ
52. Eston Grange NHS Health Care Centre	Low Grange Health Village, Normanby Road, Middlesbrough, TS6 6TD
53. Featherstone Road Health Centre	Hartington Road, Southall, Middlesex, UB2 5BQ
54. Fellview Medical Practice	Cleator Moor Health Centre, Birks Road, Cleator Moor, Cumbria, CA25 5HP
55. Finchley NHS Walk-in Centre	Finchley Memorial Hospital, Granville Road, London, N12 0JE
56. Folkestone Walk-in Centre	Royal Victoria Hospital, Radnor Park Avenue, Folkestone, Kent, CT19 5BN
57. Fulham Centre for Health	Charing Cross Hospital, Fulham Palace Road, London, W6 8RF
58. Fylde and Wyre Same Day Health Centre	Same Day Health Centre, Fleetwood Health & Wellbeing Centre, Dock Street, Fleetwood, Lancashire, FY7 6HP
59. Gateshead Walk-in Service	Queen Elizabeth Hospital, Gateshead, NE9 6SX
60. Gloucester Health Access Centre	Eastgate House, 121-131 Eastgate Street, Gloucester, Gloucestershire, GL1 1PX

61. Gosbury Hill GP Clinic	Orchard Gardens, Chessington, Surrey, KT9 1AG
62. Gracefield Gardens GP Centre	2-8 Gracefield Gardens, Streatham, London, SW16 2ST
63. Greyfriars Health Centre	Phoenix House, Howard Street South, Great Yarmouth, Norfolk, NR30 2PT
64. Grindon Lane Minor Injury and Illness Unit	Grondon Lane Primary Care Centre, Grindon Lane, Sunderland, SR3 4DE
65. Guildhall Walk Healthcare Centre	27 Guildhall Walk, Portsmouth, PO1 2DD
66. Halewood Walk in Centre	The Halewood Centre, Roseheath Drive, Halewood, Liverpool, L26 9UH
67. Half Penny Steps Health Centre	427-429 Harrow Road, London, W10 4RE
68. Hammersmith Centre for Health	Hammersmith Hospital, Du Cane Road, W12 0HS
69. Hanley Health and Wellbeing Centre	Potteries Shopping Centre, 69/71 Stafford Street, Hanley, Stoke-on-Trent, ST1 1LW
70. Harold Wood GP Walk in Centre	St Clements Avenue, Off Gubbins Lane, Harold Wood, RM3 0FE
71. Hartlepool NHS Healthcare Centre	One Life Hartlepool, Park Road, Hartleepool, TS24 7PW
72. Hastings Medical Practice & Walk-in Centre	Station Plaza Health Centre, Station Approach, Hastings, TN34 1BA
73. Hawthorn Medical Centre	Unit K, Fallowfield Retail Park, Birchfields Road, Levenshulme, M14 6FS
74. Hayes Town Medical Centre	52 Station Road, Hayes, Middlesex, UB3 4DD
75. Haywood Community Hospital Walk-in Centre	Haywood Hospital, High Lane, Burslem, ST6 7AG
76. Herefordshire GP Access Centre	ASDA Building, Belmont Road, Hereford, HR2 7JE
77. Hillside Bridge Health Centre	Hillside Bridge Health Centre, 4 Butler Street, Bradford, BD3 0BS
78. Huyton Walk in Centre	Nutgrove Villa, Westmoreland Road, Huyton, L36 6GA
79. Jarrow Health Centre	Palmer Community Hospital, Wear Street, Jarrow, NE32 3UX
80. John Radcliffe Hospital GP-led walk-in centre	John Radcliffe Hospital, Headley Way, Headington, Oxford, OX3 9DU
81. King Street Health Centre	47 King Street, Wakefield, WF1 2SN
82. Kirkby Walk in Centre	St Chads Clinic, St Chads Drive, Kirkby, L32 8RE

83. Langbaurgh Medical Centre	Coatham Health Village, Coatham Road, Redcar, TS10 1SR
84. Leigh Walk-in Centre	Leigh Health Centre, The Avenue, Leigh, Lancashire, WN7 1HR
85. Lincoln Walk-in centre	63 Monks Road, Lincoln, LN2 5HP
86. Lindley Medical Practice	Integrated Care Centre, New Radcliffe Street, Oldham, Lancashire, OL1 1NL
87. Litherland Town Hall Health Centre	Hatton Hill Road, Litherland, Liverpool, L21 9JN
88. Liverpool City Centre NHS Walk-in Centre	52 Great Charlotte Street, Liverpool, L1 1HU
89. Locala Walk in Centre	Dewsbury & District Hospital, Halifax Road, Dewsbury, West Yorkshire , WF13 4HS
90. Malling Health Telford	39-41 Sherwood Row, Town Centre, Telford, Shropshire, TF3 4DZ
91. Malling Health Wrekin	Princess Royal Hospital, Apley Castle, Apley, Telford, Shropshire, TF1 6WL
92. Market Hill 8 to 8 Health Centre	The Ironstone Centre, West Street, Scunthorpe, North Lincolnshire, DN15 6HX
93. Medway NHS Healthcare Centre	547 - 553 Canterbury Street Gillingham, Kent, ME7 5LF
94. Middleton Health Centre	Middleton Shopping Centre, Middleton, Greater Manchester, M24 4EL
95. Midway Medical and Walk-in Centre	Morton House, The Midway,Newcastle-under-Lyme, ST5 1QG
96. Molineux Street Walk-in Centre	Molineaux NHS Centre, Off Shields Road, Byker, NE6 1SG
97. New Cross GP Walk-in Centre	Suite 3 Waldron Health Centre, Amersham Vale, London, SE14 6LD
98. NHS Parsonage Street Health Centre	Parsonage Street, West Bromwich, West Midlands, B71 4DL
99. NHS Sheffield Walk-in Centre	Rockingham House, 75 Broad Lane, Sheffield, S1 3PB
100. NHS Walk-in Centre Widnes	Health Care Resource Centre, Oaks Place, Caldwell Road, Widnes, Cheshire, WA8 7GD
101. North Chelmsford NHS Healthcare Centre	Sainsbury's, 2 White Hart LANE, Chelsmford, Essex, CM2 5EF

102. North Colchester Healthcare Centre	Colchester Primary Care Centre, Turner Road, Colchester, Essex, CO4 5JR
103. North West London Medical Centre	56 Maida Vale, London, W9 1PP
104. Northumberland Health Medical Centre	Hind Crescent, Erith, Kent, DA8 3DB
105. Oadby and Wigston Walk-in Centre	18 The Parade, Oadby, Leicestershire, LE2 5BJ
106. Old Swan Walk-in Centre	Crystal Close, St Oswald St, Liverpool, L13 2GA
107. Oliver Road Polyclinic	Oliver Road Polyclinic Walk-in Service, 75 Oliver Road, Leyton, E10 5LG
108. Orchard Village Walk in Centre	2 Roman House, Roman Close, Rainham, RM13 8QA
109. Park Community Practice	Horne Street Medical Centre, Hanson Lane, Halifax, HX1 5UA
110. Parsons Green NHS Walk-in Centre	5-7 Parsons Green, London, SW6 4UL
111. Peckham GP Walk in Centre	Lister Health Centre, 101 Peckham Road, London, SE15 5LJ
112. Peterborough Walk-in Centre	City Care Centre, Thorpe Road, Peterborough, PE3 6DB
113. Phoenix Centre	Phoenix Centre, Parkfield Road, Wolverhampton, WV4 6ED
114. Ponteland Road Health Centre	169 Ponteland Road, Newcastle upon Tyne, NE5 3AE
115. Prestwich Walk-in Centre	Fairfax Road, Prestwich, Manchester, Lancashire, M25 1BT
116. Primary Care Emergency Centre	Manchester Royal Infirmary, Oxford Road/Upper Brook Street, Manchester, M13 9WL
117. Putnoe Medical Centre	93 Queen's Drive, Bedford, MK41 9JE
118. Quayside Medical Centre	76b Cleethorpe Road, Grimsby, Linconshire, DN31 3EF
119. Reading Walk-in Health Centre	1st Floor 103-105 Broad St Mall, Reading, RG1 7QA
120. Resolution Health Centre	11 Trinity Mews, North Ormesby, Middlesbrough, Cleveland, TS3 6AL
121. Rotherham NHS Walk-in Centre	Rotherham Community Health Centre, Greasbrough Road, Rotherham , S60 1RY
122. Royal Devon & Exeter Walk-in Centre	Royal Devon and Exeter Hospital, Barrack Road, Exeter, EX2 5DW
123. Rugby Walk-in Centre	Rugby Urgent Care Centre, Hospital of St Cross, Barby Road, Rugby, CV22 5PX

124. Salisbury Walk-in Health Centre	Avon Approach, Salisbury, Wiltshire, SP1 3SL
125. School House Practice	Dewsbury Health Centre, Wellington Rd, WF13 1HN
126. Shakespear Medical Practice	Burmantofts medical centre, Cromwell Mount, Leeds , LS9 7TA
127. Sheppey NHS Healthcare Centre	Sheppey Community Hospital, Plover Road, Minster-on-Sea, Sheerness, ME12 3LT
128. Shiremoor Health Resource Centre	Earsdon Road, Shiremoor, Newcastle Upon Tyne, Tyne And Wear, NE27 0HJ
129. Showell Park Health and Walk In Centre	Fifth Avenue, Showell Park, Wolverhampton, West Midlands, WV10 9ST
130. Shrewsbury Walk-in Health Centre	Whitehall, Monkmoor Road, Shrewsbury, Shropshire, SY2 5AP
131. Sidwell Street Walk-in Centre	31 Sidwell Street, Exeter, Devon, EX4 6NN
132. Skelmersdale NHS Walk-in Centre	116-118 The Concourse, Skelmersdale, WN8 6LJ
133. Slough Walk-in Health Centre	Upton Hospital, Albert Street, Slough, SL1 2BJ
134. Soho Walk-in Centre	1 Frith Street, London, W1D 3HZ
135. Solihull Healthcare and Walk in centre	Solihull hospital, Lode Lane, B91 2AE
136. South Birmingham GP Walk-in Centre	15 Katie Rd, Birmingham, B29 6JG
137. South Liverpool NHS Walk-in Centre	Church Road, Garston, L19 2LW
138. Spring House Medical Centre	Ascots Lane, Welwyn Garden City, Hertfordshire, AL7 4HL
139. SSAFA Care CIC Health and Walk In Centre	1 Spinney Hill Road, Leicester, Leicestershire, LE5 3GH
140. St Andrews Health Centre	2 Hannaford Walk, Bow, London, E3 3FF
141. St Helens Minor Injuries Unit and Walk in Centre	The Millennium Centre, Corporation Street, St Helens , WA10 1HJ
142. St Luke's Health Centre	Pantile Avenue, Southend on Sea, Essex, SS2 4BD
143. St Neot's Health Centre	24 Moores Walk, St Neots, Cambridgeshire, PE19 1AG
144. St Oswald's Hospital Walk-in Centre	St Oswald's Hospital, Clifton Road, Ashbourne, Derbyshire , DE6 1DR
145. Stockton NHS Healthcare Centre	Tithebarn House, High Newham Road, Hardwick Estate, Stockton-on-Tees, TS19 8RH

146. Story Street Medical Practice and Walk-in Centre	Wilberforce Centre, 6-10 Story Street, Hull, HU1 3SA
147. Summerfield GP and Urgent Care Centre	Summerfield Primary Care Centre, 134 Heath Street, Winson Green, Birmingham, B18 7AL
148. Teddington Walk-in Centre	Teddington Memorial Hospital, Hampton Road, Teddington, Middlesex, TW11 0JL
149. Thamesmead NHS Health Centre	4 - 5 Thames Reach, London, SE28 0NY
150. The Beacon Health Centre	St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, P030 5TG
151. The Connaught Square Practice	41 Connaught Square, London, W2 2HL
152. The Hill General Practice and Urgent Care Centre	Sparkhill Primary Care Centre, 856 Stratford Road, Sparkhill, Birmingham, B11 4BW
153. The Junction Health Centre	Arches 5-8 , Clapham Junction Station, SW11 2NU
154. The Nottingham NHS Walk-In Centre	Seaton House, London Road, Nottingham, Nottinghamshire, NG2 4LA
155. The Orchard Medical Centre	Macdonald Walk, Kingswood, Bristol, BS15 8NJ
156. The Pinn Medical Centre	37 Love Lane, Pinner, Middlesex, HA5 3EE
157. The Practice Loxford, Loxford Polyclinic	Loxford Polyclinic, 417 Ilford Lane, Ilford, Essex, IG1 2SN
158. The Ridgeway Surgery	Alexandra Avenue Health and Social Care Centre, 275 Alexandra Avenue, Rayners Lane, Harrow, HA2 9DX
159. The Skelton Medical Centre	Byland Road, Skelton-in-Cleveland, North Yorkshire, TS12 2NN
160. The Wilson Health Centre	Cranmer Road, Mitcham, Surrey, CR4 4TP
161. Thurrock Health Centre	57 High Street, Grays, Essex, RM17 6NJ
162. Timber Hill Health Centre	Level 4, 115-117 The Castle Mall, Norwich, NR1 3DD
163. Tollgate Lodge Healthcare Centre	57 Stamford Hill, Stoke Newington, N16 5SR
164. Town Centre GP Surgery	14-16 Chapel Street, Luton, LU1 2SE
165. Trafford Health Centre	Trafford general hospital, Moorside Road, Davyhulme, Manchester, M41 5SL
166. Upney Lane Walk-in Centre	Barking Community Hospital, 132 Upney Lane, Barking, IG11 9LX
167. Urgent Care Centre, Guy's Hospital	Guy's Hospital, Great Maze Pond , SE1 9RT
168. Vicarage Lane Health Centre	10 Vicarage Lane, Stratford, E15 4ES

169. Victoria Central Walk-in Centre	Mill Lane, Wallasey, Wirral, CH44 5UF
170. Walsall Walk-in-Health Centre	19-21 Digbeth, Market Square, Walsall, West Midlands, WS1 1QZ
171. Wansbeck Primary Care Access Centre	Wansbeck General Hospital, Woodhorn Lane, Ashington, Northumberland, NE63 9JJ
172. Warren Farm Urgent Care Centre	Warren Farm Rd, Kingstanding, B44 0PU
173. Washwood Heath Urgent Care Centre	Washwood Heath Health and Wellbeing Centre, Clodeshall Rd, Saltley, B8 3SN
174. West Herts Medical Centre	Hemel Hempsted Hospital, Hillfield Rd, Hemel Hempstead, Hertfordshire, HP2 4AD
175. West Lancashire Health Centre	Ormskirk & District Hopsital, Wigan Road, Ormskirk, Lancashire, L39 2AZ
176. Westgate Walk in Centre	Westgate Road, Newcastle-upon-Tyne, NE4 6BE
177. Westminster & Pimlico Health Centre	15 Denbigh Street, London, SW1V 2HF
178. Westwood 8 to 8 Primary Care Centre	Pelham Street, Worksop, S80 2TR
179. Weybridge Walk-in Centre	Weybridge Community Hospital, 22 Church Street, Weybridge, KT13 8DY
180. Weymouth GP-led Walk In Centre	Weymouth Community Hospital, 3 Melcombe Avenue, Weymouth, Dorset, DT4 7TB
181. White Horse Surgery & Walk-in Centre	Vale Rd, Northfleet, Gravesend, Kent, DA11 8BZ
182. Woking Walk-in Centre	Woking Hospital, Heathside Road, Woking, GU22 7HS
183. Wolds View Primary Care Centre	Bridlington and District Hospital, Bessingby Road, Bridlington , YO16 4QP
184. Worcester Walk-In Health Centre	Farrier House, Farrier Street, Worcester, WR1 3BH
185. Yeovil Health Centre	37 Middle Street, Yeovil, BA20 1SB

Annex 3: List of closed walk-in centres

Name	Address
1. Alma Road Primary Care Centre	Central Peterborough, PE1 3FG
2. Ancoats Walk-in Centre	Old Mill Street, Ancoats, M4 6HH
3. Ashfield Walk-in Centre	Kirkby-in-Ashfield, NG17 7AE
4. Bexley North Health Centre	Crayford Road, Bexley, DA1 4ER
5. Blackpool NHS Walk-in Centre	26, Talbot Road, Blackpool, Lancashire, FY1 1LF
6. Bolton Walk-in Centre	Lever Chambers, Bolton, BL1 1SQ
7. Bristol City Gate Walk-in Centre	Broad Street, Bristol, BS1 2EZ
8. Canalside Medical Centre	Monton, Greater Manchester, M30 8AR
9. Canary Wharf NHS Walk-in Centre	30 Marsh Wall, Isle of Dogs, London , E14 9TP
10. Colchester NHS Walk-in Centre	Suite B, Ground Floor, The Octagon, Middleborough, Colchester , CO1 1TG
11. Crown Health Centre	Withersfield Road, Haverhill, CB9 9LA
12. Croydon Walk-in Centre	45 High Street, Croydon, Surrey, CR0 1QD
13. Darlington Urgent Care Centre (Dr Piper House)	King Street, Darlington, DL3 6JL
14. Forum Health Walk-in Service	Forum Square, Wythenshawe, M22 5RX
15. Hampshire Healthcare Centre	Basingstoke and North Hampshire Hospital, Basingstoke, RG24 9NA
16. Harlow Walk-in Centre	1a Wych Elm, Harlow, Essex, CM20 1QP
17. Harness Harrow Walk in Centre	46 South Parade, Mollison Way, Edgware, HA8 5QL
18. Headrow NHS Walk-in Centre	Balcony Level 7, The Light, The Headrow, Leeds, LS1 8TL
19. Hornsey Central Walk-in Clinic	Park Road, London, N8 8JD
20. Ilford Walk-in Centre	201-205 Cranbrook Road, Ilford, Essex, IG1 4TD
21. Ilkeston Family Practice and Walk-in Centre	Ilkeston Community Hospital, Derbyshire, DE7 8LN
22. Lakeside Plus/Corby Urgent Care Centre	Corby, NN17 2UR
23. Laurels Neighbourhood Practice	Haringey, North London, N15 5AZ

24. Leighton Hospital Walk-in Centre	Leighton Hospital, Crewe, CW1 4QJ
25. Little Hulton Walk-in-Centre	Haysbrook Avenue, Worsley, Manchester, M28 0AY
26. Liverpool Street NHS Walk-in Centre	Exchange Arcade, 175 Bishopsgate, London, EC2M 3WA
27. Loughborough Walk-in Centre	Pinfold Gate, Loughborough, Leicestershire, LE11 1BE
28. Manchester Picadilly Walk-in Centre	1st Floor Gateway House, Station Approach, Piccadilly South, M1 2GH
29. Mersey View GP Access Centre	Everton Road, Liverpool, L6 2EH
30. Milton Keynes Walk-in Centre	Hospital Campus, Standing Way, Eaglestone, Milton Keynes, MK6 5NG
31. Monkgate Walk-in Centre	Monkgate Health Centre, 31-33 Monkgate, York, YO31 7WA
32. Mount Gould Local Care Centre	Plymouth, PL4 7QD
33. Newcastle Central Walk-In Centre	Unit 5,The Bar (Jury's Inn) Newcastle, NE1 4BH
34. NHS Barnsley Health Centre	Unit 1, Gateway Plaza , Sackville Street, Barnsley, South Yorkshire , S70 2RD
35. Norwich Walk-in Centre	Dussindale Centre, Pound Lane, Norwich, NR7 0SR
36. Pendleton Walk-in-Centre	Rear of Pendleton House, Broughton Road, Salford , M6 6LS
37. Rochdale Walk-in Centre	Rochdale Infirmary, 90 Whitehall Street, Rochdale , OL12 0ND
38. Royal Surrey County Hospital Walk-in Centre	Royal Surrey County Hospital, Egerton Road, Guildford, GU2 7XX
39. Shirley NHS Walk-in Centre	1a Howards Grove, Southampton, Hampshire, SO15 5PR
40. South Bristol Walk-in Centre	Knowle West, Bristol, BS4 1WH
41. Stapleford Walk-in Centre	Church Street, Stapleford, NG9 8DA
42. Stockport Health Centre (Walk-In Centre)	Wellington Road, Stockport, SK2 6NW
43. The Bay Health Centre	Torbay Hospital, Newton Road, Torquay, Devon, TQ2 7AA
44. The Practice Heart Of Hounslow NHS Walk In Centre	92 Bath Road, Hounslow, Middlesex, TW3 3LN

45. Tooting Walk-in Centre	A&E department, St George's Hospital, Blackshaw Road, Tooting, London, SW17 0QT
46. Victoria NHS Walk-in Centre	63 Buckingham Gate, SW1E 6AT
47. Wakefield NHS Walk-in Centre	Thornhill Street, Wakefield, West Yorkshire, WF1 1PG
48. Walk in Centre	Royal Hallamshire Hospital, S10 2TB
49. Warrington GP Health Centre	Sankey Street, Warrington, WA1 1TD
50. Weston Urgent Care Service	Weston General Hospital, Somerset, BS23 4TQ
51. Whitechapel Walk-in Centre	174 Whitechapel Road, London, E1 1BZ
52. Withington Walk-in Centre	Withington Community Hospital, Manchester, M20 2LR
53. Wycombe GP Health Centre	Queen Alexandra Road, High Wycombe, Buckinghamsire, HP11 2TT

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

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Review by Monitor of the provision of walk-in centre services in England

Issued on: 31 May 2013

Deadline for submissions: 28 June 2013

Review by Monitor of the provision of walk-in centre services in England

Scope of review

Background

1. Following the NHS Next Stage Review (Next Stage Review), the launch of the Equitable Access Programme ('the Programme') in 2008/9 led to the opening of new primary care services across England. As part of the Programme, all primary care trusts (PCTs) were required to commission at least one GP-led health centre to provide primary care services to both registered and unregistered patients requiring routine or urgent primary care without an appointment (walk-in patients). These health centres had to be open between 8am and 8pm, 7 days a week. For the purposes of this document we refer to these GP-led health centres as walk-in centres.

2. PCTs generally commissioned walk-in centres through competitive procurements, and awarded time-limited Alternative Provider of Medical Services (APMS) contracts.[1] Although PCTs had flexibility to determine the contract duration, the typical contract length was five years. PCTs identified as having the greatest health needs were provided with funding aid from the Department of Health (DH) to implement the Programme.

3. We understand that the launch of walk-in centres following the Next Stage Review was met with high patient usage of the facilities. As early as 2009, a number of PCTs across England began to renegotiate or, in a few cases, terminate walk-in centre contracts. We understand that the rationale for renegotiation or termination was often that there had been an unexpectedly high number of walk-in consultations (leading to higher payments than anticipated) and fewer than expected registered patients.

4. In February 2011, a letter from DH to PCTs and Strategic Health Authorities[2] explained that NHS England would take over responsibility for existing contracts for walk-in centres from April 2013. In the run up to contract expiry, it was envisaged that NHS England would evaluate the case for recommissioning services for patients registered at walk-in centres (or would make arrangements for those patients to be transferred to a GP practice). It would be a matter for clinical commissioning groups (CCGs) to decide whether to recommission services for non-registered patients, such as urgent care and out-of-hours services.

5. We have seen reports that a number of walk-in centres were closed in 2012.[3]

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[1] For more information on Alternative Provider of Medical Services (APMS) contracts see: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Primarycare/Primarycare contracting/APMS/index.htm

[2] Letter from the National Managing Director of Commissioning Development to PCTs and Strategic Health Authorities. http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_123925

[3] See for example: http://www.bbc.co.uk/news/uk-politics-18503034

6. Monitor considers that it is in the interests of patients to undertake a review into changes to arrangements relating to services provided by walk-in centres in order to understand the impact of these changes on choice and competition.

7. This review is a separate exercise from the recommendation contained in the Fair Playing Field Review[4] that Monitor should issue a call for evidence to help determine the extent to which the commissioning and provision of general practice and associated services is operating in the best interests of patients. That call for evidence will take place in due course.

8. This review is also separate from, but potentially related to the review of urgent and emergency care services[5] and the programme to improve A&E performance being led by NHS England.[6] Although those projects may touch on the role of walk-in centres, their focus is on the provision of urgent and emergency care services.

Purpose of review

9. The purpose of the review is to:
    a. Examine changes to arrangements regarding the services provided by walk-in centres that have taken place over the past two to three years;
    b. Assess the impact of these changes insofar as they may affect patient choice and competition; and
    c. Understand current commissioning practices in relation to walk-in centres and possible future developments.

10. This review is not an investigation by Monitor into possible infringements of the applicable choice and competition rules under our formal enforcement powers.

11. The review will gather evidence from interested and relevant stakeholders.

12. We are now calling for initial submissions to help us consider the issues set out above. A list of suggested areas that we invite initial submissions on is set out in the Annex. Our aim is to gather evidence from a wide range of stakeholders, but we are particularly interested in hearing from patient groups, commissioners and providers of walk-in centres.

13. As part of the review process, Monitor will also be seeking information directly from a range of stakeholders and we will be contacting them in the next few weeks to seek information about the commissioning of walk-in centres, the services that they offer and the funding arrangements. However, we also welcome submissions from any other stakeholders that are not contacted by us directly.

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[4] See Recommendation 15 of "A fair playing field for the benefit of NHS patients. Monitor's independent review for the Secretary of State for Health" (March 2013).
[5] Review led by Sir Bruce Keogh to review the model of urgent and emergency care services in England (January 2013). http://www.england.nhs.uk/2013/01/18/service-review/
[6] NHS England announced that plans to strengthen the performance in urgent and emergency care were being put in place across the country to help hospital A&E departments meet demand and tackle waiting time pressures (May 2013). http://www.england.nhs.uk/2013/05/09/sup-plan/

14. Please provide initial submissions to walkincentresreview@monitor.gov.uk **by 5pm on 28 June 2013**.

15. We will produce a report setting out our findings once we have finished our review.

16. Our review may lead to a range of outcomes. These include:

- No further action;
- Action focused on raising patient awareness of the options available to them;
- Recommendations to commissioners and providers;
- Recommendations to Government;
- Investigation and enforcement action;[7] and
- A market investigation reference to the Competition Commission.[8]

Timing

17. The timetable for the review is set out below:

Monitor publicly announces review and calls for submissions	31 May 2013
Deadline for initial submissions	28 June 2013
Preliminary views published for comments	October 2013
Deadline for comments on preliminary views	November 2013
Findings published	December 2013

Contact

To contact us about this review:

Aneeka Ghela, Inquiries Assistant
Telephone: 020 7972 3929
Email: aneeka.ghela@monitor.gov.uk

[7] Monitor has the power to enforce a number of different rules relating to choice and competition including the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and the competition and choice conditions in the provider licence. Monitor also has concurrent powers with the OFT to enforce the Competition Act 1998 and the equivalent rules of the Treaty on the Functioning of the European Union in so far as they concern the provision of health care. Further information on the rules that Monitor enforces and our approach to enforcing them is available here.

[8] Monitor has concurrent powers with the OFT to make a market investigation to the Competition Commission where we have reasonable grounds for suspecting that any feature, or combination of features of a market is preventing, restricting or distorting competition. Guidance on the approach that Monitor takes when using these powers is available here.

Annex

Monitor welcomes submissions regarding any aspect relating to services provided by walk-in centres. Suggestions of areas on which views and evidence would be most helpful are set out below.

Questions primarily for commissioners and providers of walk-in centres

1. We understand that GP-led walk-in centres were required to provide core GP services to registered and unregistered patients, with or without an appointment, for a minimum of 12 hours a day, 7 days a week. We would like information on:
    - Any services that were commissioned and provided above and beyond those requirements, for example locally-enhanced services;
    - Any ratios of pre-bookable appointments to walk-in appointments specified in contracts with walk-in centres; and
    - Any other service characteristics which are unique to walk-in centres, particularly compared to other providers of primary care services.

2. We would like to receive evidence on the extent to which walk-in centres were used, the types of services offered, and the types of medical needs that they catered for. Information might include:
    - Numbers of appointments;
    - The case-mix of patients who used the service;
    - The hours of the day when walk-in centres were most popular;
    - The frequency with which particular medical needs were treated (eg, urgent versus non-urgent needs);
    - The proportion of patients who were registered at another GP practice; and
    - The extent to which patients switched GP in order to register at walk-in centres.

3. We would like to understand the financial implications that walk-in centres had, or continue to have on commissioners. For example, we are interested in information regarding:
    - How walk-in centre providers are (or were) paid;
    - How forecasts of patient volumes and costs compare with actual volumes and costs;
    - Whether attempts have been made to manage local demand for walk-in centres;
    - The impact of walk-in centres on attendance at other primary care and/or acute care providers; and
    - The impact of walk-in centres on payments to GPs and/or other health care providers.

4. We would like information on the number of walk-in centres that continue to be commissioned after April 2013 and whether any changes have been made to the original contract specifications.

5. Where possible we would like to understand how walk-in centres fit in with primary care commissioning intentions more generally.

6. Where walk-in centres have been decommissioned, we would like to understand the motivation for this and current arrangements for unscheduled or urgent primary care.

Questions primarily for patients, including patient groups

7. We would like to hear from patients in order to understand the rationale for using walk-in centres. For example, we would be interested to hear the extent to which services were used because of:
    - Any difficulty in registering with a GP;
    - GP opening hours and waiting lists;
    - The locations of walk-in centres compared with GP practices;
    - Expected waiting times at other health care facilities such as urgent care centres or A&Es; and/or
    - Particular medical needs or other patient preferences.

8. We would also like to hear more generally about patients' views on the implications of the closure of walk-in centres.

Question(s) primarily for GPs

9. We would like to gain an understanding of how GP practices were affected by the introduction of walk-in centres. For example,
    - Whether walk-in centres had any effect on the number of people attending GP practices or registered with them; and
    - Whether the introduction of walk-in centres led to any changes to the services that GPs provide, for example, the range or quality of services offered.

Monitor, 4 Matthew Parker Street, London SW1H 9NP

Telephone: 020 7340 2400
Email: enquiries@monitor.gov.uk
Website: www.monitor.gov.uk

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How is the health and social care system performing? June 2013

Quarterly monitoring report

Download .pdf

4th June 2013 | Comments: 6

John Appleby, Richard Humphries, James Thompson, Amy Galea

This quarter's report aims to take stock of what has happened over the past year and assess the state of the health and care system halfway through the £20 billion Nicholson Challenge.

The report finds that for the final quarter of 2012/13, nearly 6 per cent of patients waited four hours or longer in A&E, the highest level since 2004.

The growing pressure on hospitals is also reflected in a survey of NHS finance directors carried out for the report. This suggests that, although the NHS will end 2012/13 in a healthy financial position, the outlook for the next two years is bleak, with the majority expecting the NHS to fail to meet its target to deliver £20 billion in productivity improvements by 2015.

Despite the pressures in emergency care, other NHS performance measures are continuing to hold up well. Waiting times for referral to treatment in hospital, the number of health care-acquired infections and delays in transferring patients out of hospital all remain stable.

Related pages:

- New analysis confirms government target missed as A&E waiting times hit nine-year high
- Urgent and emergency care
- Evidence submission: Health Select Committee's inquiry into emergency services and emergency care
- Quarterly monitoring report

Related slideshow::

Pressures on A&E services »

John Appleby looks at the facts behind A&E attendances.

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
1	CPRD	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Section 251 (ECC: 5-05 (a)/2012) approval is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	CPRD seeks to enhance the research capability and value of its primary care database by adding details of relevant (matched) secondary care events from the HSCICs HES database. The new enhanced data will be made available to CPRD customers for use in academic research, pharmacovigilance, drug monitoring, and health outcomes analysis. CPRD operates within the MRHA, a UK Trading Fund organisation.
2		Data Linkage and Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Section 251 (ECC: 5-05 (a)/2012) approval is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	
3		Data Linkage and Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Section 251 (ECC: 5-05 (a)/2012) approval is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	
4		Data Linkage and Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Section 251 (ECC: 5-05 (a)/2012) approval is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	
5		Data Linkage and Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
6	University College London	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Informed Patient Consent Health and Social Care Act 2012	Study: CATCH trial (Cathater Infections in Children) ICH Depts from University College London and Liverpool University will use the data to follow up on patient studies for 6 months post randomisation and University of Wales Bangor will be using the data for a health economic analysis. At Bangor, we will be analysing the costs per blood stream infection averted and assessing theimpact of death on intervention effect and costs (and hence cost-effectiveness), we will undertake a sensitivity analysis by excluding those subjects who have died. At London, they will be looking at the 30 day mortality rates. The aggregated data publications will also avoid small cell sizes so as to prevent any deductive disclosure. ICH Depts from University College London and Liverpool University will use the data to follow up on patient studies for 6 months post randomisation and University of Wales Bangor will be using the data for a health economic analysis. There will be no selling or sharing of information beyond the publication of the aggregated results in international scientific journals.
7		Data Linkage and Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Informed Patient Consent Health and Social Care Act 2012	
8		Data Linkage and Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Informed Patient Consent Health and Social Care Act 2012	
9		Data Linkage and Bespoke Extract; ONS Mortality	Pseudonymised	Sensitive	ONS Data Controller approval under Section 42(4) Informed Patient Consent	
10	IMS	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	IMS Health has been granted s251 approval for identifiable data extracted from hospital pharmacy systems to be sent from hospitals to the HSCIC for linkage to HES. The HSCIC return a pseudonymised output to IMS Health (who therefore receive no identifiable data). IMS have confirmed that national ethics approval has been granted by the NRES Committee South West-Bristol, and approval has been given by the Caldicott Guardian and R&D offices of all NHS Hospital Trusts from which data are received.	Purpose: This database will for the first time allow researchers an insight into the interaction between disease, treatment and prescribing across primary and secondary care, enabling more informed analysis of the impact of services and pharmaceuticals. [Note added 28/3: The data are onwardly released only in aggregate form] Products: Products will be both syndicated and customised depending on the needs of the different customers Commercial activity: The main customer for these products will be the pharmaceutical industry. Services will also be offered to the NHS Trusts that provide information, regulatory bodies and other organisations involved in pharmaceutical research and policy formulation.

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
					Health and Social Care Act 2012	Further to the above purpose, the right to use or re-use includes the following non-exclusive rights: - Use only within the Field and the Territory; - Publishing the material in any medium, including featuring the data on websites which can be accessed via the Internet or via an internal electronic network or on an Intranet; - Authorising users and subscribers who use the licensee's electronic or digital products to access the material; - Translating the data into another language or converting to Braille or other formats for people who are visually impaired; - Copying material from the information asset for research or study; - Copying by libraries; In each case, only to the extent permitted by GPRD's Department of Health Patient Information Advisory Group approval
11		Data Linkage and Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	IMS Health has been granted s251 approval for identifiable data extracted from hospital pharmacy systems to be sent from hospitals to the HSCIC for linkage to HES. The HSCIC return a pseudonymised output to IMS Health (who therefore receive no identifiable data). IMS have confirmed that national ethics approval has been granted by the NRES Committee South West-Bristol, and approval has been given by the Caldicott Guardian and R&D offices of all NHS Hospital Trusts from which data are received. Health and Social Care Act 2012	
12		Data Linkage and Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	IMS Health has been granted s251 approval for identifiable data extracted from hospital pharmacy systems to be sent from hospitals to the HSCIC for linkage to HES. The HSCIC return a pseudonymised output to IMS Health (who therefore receive no identifiable data). IMS have confirmed that national ethics approval has been granted by the NRES Committee South West-Bristol, and approval has been given by the Caldicott Guardian and R&D offices of all NHS Hospital Trusts from which data are received. Health and Social Care Act 2012	
13	Public Health England	Bespoke Extract; HES Inpatient	Identifiable	Non-Sensitive	ECC: 5-04(L)/2011	Using evidence to reduce risk of healthcare acquired infection following primary hip replacement.
14		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
15		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
16		Bespoke Extract; PROMS	Pseudonymised	Sensitive	ECC: 5-04(L)/2011 Health and Social Care Act 2012	
17	Ardentia	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Ardentia Limited intend to use the data to provide analysis and insight using information derived from the data and aggregate linkage to other data sources within potential services, including Benchmarking, Activity Flow, Data Quality, Consultancy and Comparative analysis, tabulations etc.
18		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
19		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
20	BUPA Health Dialog	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Sensitive	DAAG: 310112-a Health and Social Care Act 2012	To assist the NHS and Bupa Group companies in the UK to improve the quality of healthcare management and service delivery in England by benchmarking performance against national trends. This request is for the sensitive field Consultant code to be supplied in a HES monthly managed extract. The data is used to enable BUPA Health Dialog to analyse patterns of variation among consultants within a treatment specialty. Productivity measurements and benchmarking reports will then be produced and used to inform healthcare organisations that are working with BUPA to try to improve the quality of healthcare delivered to patients.
21		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Sensitive	DAAG: 310112-a Health and Social Care Act 2012	
22		Standard Monthly Extract Service; HES A&E	Pseudonymised	Sensitive	DAAG: 310112-a Health and Social Care Act 2012	
23		Standard Monthly Extract Service; PbR APC Episodes, PbR APC Spells, PbR OP, PbR A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
24	CHKS Ltd	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	CHKS Limited uses HES data to supplement data that are received directly from NHS Trusts. The data are aggregated to provide benchmarks and comparative performance across a wide range of indicators. The whole HES dataset is also used to analyse market share of individual trusts and PCTs. CHKS also uses the data to provide analysis and commentary on trends in healthcare. CHKS will also use some of these data to provide services to hospitals and commissioners in Wales, Scotland and Northern Ireland and in the provision of epidemiological studies to the pharmaceutical industry. No individuals, doctors, hospitals or patients are identified.
25		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
26		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
27		Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
28		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
29		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
30		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
31	Care Quality Commission	Standard Monthly Extract Service; HES Inpatient	Identifiable	Sensitive	DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifiable data	With respect to HES and MHMDS, CQC's principal aims are to provide: patients and users of services with clear assessments of the safety, quality, efficiency and effectiveness of the services they receive; patients, the public and health & social care professionals with the sound and fair information about health and social care, both at a national and local level.
32		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
33		Standard Monthly Extract Service; HES Outpatient	Identifiable	Sensitive	DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifiable data	
34		Standard Monthly Extract Service; HES A&E	Identifiable	Sensitive	DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifiable data	
35		Standard Monthly Extract Service; ONS Mortality	Identifiable	Sensitive	DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifiable data	
36	Harvey Walsh	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used with the NHS and Pharma for service delivery. We will use it for business intelligence tools.
37		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
38		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
39		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
40	Lightfoot Solutions UK Ltd	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used by Lightfoot's own consultants and/or our associate organisations to produce standard reports as well as bespoke analysis of emerging trends in the data using Lightfoots sfn (signalsfromnoise) SPC based performance management software. The reports and this analysis will be offered as a commercial service to NHS Trusts and other NHS and public sector organisations. In addition, we will offer these organisations the ability to access the system for a fee in order to undertake analysis using the sfn system. These services will be provided solely to NHS and related public sector organisations in the UK. The data will be used to undertake analysis of trends utilising Lightfoot's sfn (signalsfromnoise) SPC based performance management software. The data will be loaded into the sfn system using Lightfoot's proprietary ETL (Extract, Transform and Load) routines. The sfn system will then be configured with appropriate measures and dimensions (data views) that will enable analysts to undertake root cause analysis of the trends that are identified by the SPC based trend analysis that is produced by the sfn system. The output of the analysis will be provided to NHS Trusts and other NHS and related public sector organisations with the objective of assisting them to better understand the factors underlying activity and performance. NHS Trusts and other related public sector organisations will also be able to undertake their own analysis of the data using sfn for a fee. The data will be used as the underlying source data for the SPC based analysis that is undertaken by the sfn system. The output from the system consists of SPC charts, Pareto charts, Benchmark charts and Dashboards. These charts can be tailored to the needs of particular organisations and organisational sub groups. A full description of the sfn system can be provided if required.
41		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
42		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
43	MedeAnalytics	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	MedeAnalytics international and/or parent company MedeAanalytics Inc. provides a service to a number of NHS trusts. These customers supply their own 'lead data' and we are required to provide modules that allow them to access (benchmark) their data against comparable national datasets. The HES data requested will allow us to meet the majority of their requirements. The benchmarking data will be provided at aggregate level for key performance indicators - for example, the average length of stay per peer group average mortality rates for specific conditions) Onos preventing the ability to access individual patient level records. The data will be used to feed the competitive analysis we provide to NHS clients. There are no plans for any re-use beyond that over the next 12 months Raw HES data is not shared. Aggregated statistical comparisons from the data will be shared with this NHS trusts in context to their organisations performance
44		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
45		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
46	Northgate	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used for incorporation into Northgate's information solutions to provider information on the management of healthcare delivery and utilisations of resources to organisations NOT limited to just those delivery healthcare in England. The market may also include commercial organisations.
47		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
48	Nuffield Trust	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used for the purposes of health services research, for the benefit of the NHS in England. Specific projects include: 1) Evaluations of the impact of innovations in health and social care on hospital utilisation. Such
49		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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50		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	projects include the Whole System Demonstrator of telecare and telehealth, the Integrated Care Pilots, and the Partnership for Older People Projects (POPPs), all of which are funded by the Department of Health in England. 2) Research studies involving the surveillance of patterns in hospital admission at primary care trust level in England, aimed at identifying areas where innovation in service delivery is taking place. 3) Research studies relating to hospital utilisation at the end of life. 4) Research studies relating to the level of competition in the English NHS. The results of the analyses will be made available in reports to the Department of Health, in peer-reviewed academic journals, and to the wider public through Nuffield Trust publications. We will comply with the NHS IC's Small Numbers Special Terms and Conditions and publish only aggregated data with the minimum counts. We will perform statistical analysis using statistical software including SAS. For example, the evaluation strand outlined in section (1) above will involve analysis on several outcome measures, risk adjustment and the construction of control groups. We will not sell or trade the data we have requested.
51	University Hospital Birmingham NHS Foundation Trust	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Sensitive	DAAG: 240412-a Health and Social Care Act 2012	Quality and benchmarking analysis. We wish to publish analysis/research that we have done using HES data in an international journal. DAAG approval granted for sensitive fields Consultant Code, Local Patient ID, Code of Patient's Registered or Referring General Medical Practitioner and Person Referring Patient. The ability to link ONS records to HES episode level data sets is required in order to form analytical overviews relating to post discharge mortality. Specifically such overviews would relate to standardised post discharge mortality monitoring within distinct clinical cohorts and bespoke long term survival monitoring. The output of such analytics will allow the identification of trends pertinent to the conduct of clinical reviews of pathways within distinct patient groups. The output of these analytics will be used to increase the understanding of patient outcomes within University Hospitals Birmingham and other NHS organisations.
52		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
53		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Sensitive	DAAG: 240412-a Health and Social Care Act 2012	
54		Standard Monthly Extract Service; HES A&E	Pseudonymised	Sensitive	DAAG: 240412-a Health and Social Care Act 2012	
55		Standard Monthly Extract Service; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
56	General Health Care Group (BMI)	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	GHG/BMI is a provider of NHS care to both the primary and secondary care area. At present we work with over 110 PCTs and have 56 BMI sites offering Choose and Book services. GHG/BMI are working closely with the NHS to both improve and look at new pathways to support the ever increasing need for efficiency and deliver value for money services. By GHG/BMI having access to this data, it will allow us to complete analysis when looking at services closure to relevant community settings. It will also let us look at the other ways of working, and partnering with other services to make sure patients experience and care is at the front of the decision making process.
57		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
58	AQuA (NHS Organisation)	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	AQuA intend to use the data internally for research and development purposes. Additionally it will be used by AQuA in the development, delivery and support of programmes and products across the public sector health and social care economy. AQuA will not profit from the provision of HES data to it's clients. To understand variations in mortality rates between our member organisations when compared to their peers, to +I benchmarks, To use quantitative analysis as a stimulation for discussion and deeper review of working practices within hospitals (and the wider health economy), in order to identify opportunities for improvement.
59		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
60		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
61		Standard Monthly Extract Service; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
62	McKinsey and Co.	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be extracted/used by a group of analysts employed by the company who have signed this agreement. We intend to use this data as part of our consulting services for clients. The majority of these clients will be NHS clients in England, and the data is used to research performance and outcomes, and identify improvement opportunities. The data is used to populate PowerPoint charts and Excel models provided to clients as part of these services.
63		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
64		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
65		Standard Monthly Extract Service;	Pseudonymised	Non-	Health and Social Care Act 2012	

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		HES A&E		Sensitive		The clients with whom we work will only have access to summarised non patient identifiable data that results from the work that we do with them. The data will be used to aid decision making on the part of our clients, but we will not share data with them in the complete format that we receive it. We will only share summary data and subset data with clients, to aid decision making
66		Standard Monthly Extract Service; PbR APC Episodes, PbR APC Spells, PbR OP, PbR A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
67	BMJ Publishing Group Ltd	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We will be taking on individual projects from NHS providers, commissioners, central NHS bodies, medical royal colleges, medical organisations , private sector providers and charities who will be seeking insight from the APC, OP and A&E data. a) We will analyse and interpret the data on their behalf and provide them with a summary of our findings. This could take the form of a written report, Excel spread sheet(s) of data tabulations or a data visualisation of the findings. Potential project areas include healthcare planning, clinical audit, benchmarking, performance improvement, medical research, policy development, public health and health surveillance and monitoring. The organisation commissioning individual projects would usually use the findings to improve the service they provide to patients. The projects are often required urgently and it is both impractical and uneconomical to make a separate application for each project. Our focus will be predominantly on helping clinicians to understand the activity data, identified as an issue by the Information Centre and the Academy Of Medical Royal Colleges in 'Hospital Episode Statistics (HES): Improving the quality and value of hospital data'. b) We will be creating a series of products to NHS providers, commissioners, central NHS bodies and private sector providers who wish to have an innovative and user friendly interface to the APC, OP and A&E data. These products will include the ability to do status reporting, benchmarking, comparisons and data analysis on a variety of data sources including the APC, OP and A&E data. These products will be predominantly be designed by clinicians for direct use by clinicians although inevitably some management use of the products is also expected. The clinicians using these products would use them to help improve patient care. Our focus will be on ensuring the information needs of clinicians are met and to develop innovative ways of exploiting data for the benefit of health services, both identified as issues in the Information Revolution consultation
68		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
69		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
70	AstraZeneca	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Insights into national and local secondary resource usage. Epidemiological, patient pathway and resource use studies Sharing with the NHS to look at local outcomes and service provision Inclusion in health economic and environmental models and analyses, which may take the form of (but not exclusive to) Excel-based tools, PowerPoint presentations, Word report or web-based applications.
71		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
72		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
73		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
74	Clatterbridge Hospital	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	1: England - this is NON-IDENTIFIABLE extract containing all episodes. It is used for the same purposes list below when no linkage or geographical mapping is needed. It also facilitates analysis of procedures or diagnoses which are excluded from the extracts below. 2: Cancer - this extract is used to build a range of identifiable and non-identifiable data sources which are used to provide data to support the National Cancer Program. Requests using HES data are alone use only the non-identifiable sources, the identifiable data is used for linkage purposes (to update dates of death from the batch tracing service, to link to other databases e.g.: National Radiotherapy Dataset, in line with ECC approvals), and for geographical mapping purposes using the full postcode to correctly allocate the patient within a range of geographical boundaries. Outputs are in the form of tabulations, containing no identifiers. Some tabulations including small numbers are shared using a non-disclosure agreement previously approved by DAAG. NatCanSAT is in discussion with the IC regarding sharing individual identifiable records with the National Cancer Intelligence Network which will become part of Public Health England. 3: Cardiovascular Disease - this extract is used to support the National Cardiovascular Disease Program. This year the extract has been used to assemble episode and spell records into pathways for stroke and for procedures following myocardial infarction and for analysis of heart
75		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
76		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
77		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
78		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
79		Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	
80		Bespoke Extract; SUS PBR	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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						failure to support NHS Improvement's work in streamlining pathways or these patients, to support the National Specialised Commissioning Team's work on congenital heart disease in adults and children, and to produce tabulations of non-identifiable data to support the development of a National CVD strategy. Tabulations including small numbers are shared using a non-disclosure agreement previously approved by DAAG.
81	Clatterbridge Hospital	Bespoke Extract; HES Inpatient	Identifiable	Sensitive	Section 251 approval CAG 1-06(FT2) 2013 DAAG approval ref 310112-a	This extract is used to build a range of identifiable and non-identifiable data sources which are used to provide data to support the National Cancer Program. Requests using HES data are alone use only the non-identifiable sources, the identifiable data is used for linkage purposes (to update dates of death from the batch tracing service, to link to other databases e.g.: National Radiotherapy Dataset, in line with ECC approvals), and for geographical mapping purposes using the full postcode to correctly allocate the patient within a range of geographical boundaries. Outputs are in the form of tabulations, containing no identifiers. Some tabulations including small numbers are shared using a non-disclosure agreement previously approved by DAAG. NatCanSAT is in discussion with the IC regarding sharing individual identifiable records with the National Cancer Intelligence Network which will become part of Public Health England.
82		Bespoke Extract; HES Outpatient	Identifiable	Sensitive	Section 251 approval CAG 1-06(FT2) 2013 DAAG approval ref 310112-a	
83	Clatterbridge Hospital	Bespoke Extract; HES Inpatient	Identifiable	Sensitive	Section 251 approval CAG PIAG 4-09(g)2003 DAAG: 310112-b	This extract is used to support the National Cardiovascular Disease Program. This year the extract has been used to assemble episode and spell records into pathways for stroke and for procedures following myocardial infarction and for analysis of heart failure to support NHS Improvement's work in streamlining pathways or these patients, to support the National Specialised Commissioning Team's work on congenital heart disease in adults and children, and to produce tabulations of non-identifiable data to support the development of a National CVD strategy. Tabulations including small numbers are shared using a non-disclosure agreement previously approved by DAAG.
84		Bespoke Extract; HES Outpatient	Identifiable	Sensitive	Section 251 approval CAG PIAG 4-09(g)2003 DAAG: 310112-b	
85		Bespoke Extract; HES A&E	Identifiable	Sensitive	Section 251 approval CAG PIAG 4-09(g)2003 DAAG: 310112-b	
86		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
87	Public Health England (National Cancer Intelligence Network)	Data Linkage and Bespoke Extract; HES Inpatient	Identifiable	Sensitive	Section 251 approval PIAG 03-(a)/2001) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	This HES extract will be used by all cancer registries to both support the registries' cancer registration processes and for analyses through the National Cancer Data Repository (NCDR). Analysis leads to production of information and publications such as peer-reviewed research papers, grey literature reports, reports for NHS organisations and information for service commissioners. Registries will use these data to compare cases, diagnoses and treatments between HES and the cancer registration datasets, filling gaps in existing cancer registration records and prompting new registrations. The registries will continue to use HES provider and local patient identifier data to identify further sources of registration information for cancer registrations made only on the basis of death certificates and will continue to investigate the characteristics of episodes in the HES extract that do not link to cancer registration records. These episodes will be used to improve the cancer registration process. For analytical purposes, these data will be used within the NCDR - a national dataset comprising of cancer registrations linked to other data sources related to the treatment or care of these patients. More information is available from http://www.ncin.org.uk/collecting_and_using_data/national_cancer_data_repository/default.aspx. The latest version of this repository is a combined national database comprising linked data from cancer registries' regional records, IP HES, the Office for National Statistics national registry and National Clinical Audit data and will be made available to others under our data sharing sublicensing agreement with the HSC IC. The repository provides the basis for cancer intelligence, combining the strengths of the component datasets. The NCDR has enabled new and innovative analysis to improve our understanding of cancer and patient pathways, and helped to identify areas for improvement. Analytical outputs have included cancer incidence by ethnic group (derived from HES) for twenty-one different cancer sites; which patients receive major resections (using treatment information from HES) and novel research into variations in clinical practice, including analysis of 30 day post-operative mortality. Many cancer patient outcomes such as survival are affected by co-morbid conditions and the registries will continue to use diagnostic information from HES to produce and develop analyses incorporating co-morbidity, which may help explain continuing inequalities in outcomes. The extract being applied for will enhance the NCDR and allow new analysis of cancer from referral through diagnosis, co-morbidities, treatment and recurrence. More accurate and more detailed information about the different stages of the cancer pathway is required to identify gaps
88		Data Linkage and Bespoke Extract; HES Outpatient	Pseudonymised	Sensitive	Section 251 approval PIAG 03-(a)/2001) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	
89		Data Linkage and Bespoke Extract; HES A&E	Pseudonymised	Sensitive	Section 251 approval PIAG 03-(a)/2001) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	

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						and variations in cancer services provision and to support NHS cancer commissioning. Data from HES are vital to continue our greater understanding of cancer.
90	Public Health England	Bespoke Extract; HES Inpatient	Identifiable	Non-Sensitive	Informed Patient Consent	The PHE Respiratory Diseases Department is responsible for the surveillance, control and prevention of respiratory diseases, including national surveillance for influenza, Respiratory Syncytial Virus (RSV) and other respiratory diseases. As such the department collects a range of epidemiological data on a number of respiratory diseases. However, a number of these surveillance systems lack the key items of information of public health importance critical to understand the burden of disease due to these infections and thus inform the development of vaccination and other intervention programmes. However some of the datasets hold personal identifiable information such as date of birth, patient name, NHS number. As such we wish to link these data sets with HES data. The patient identifiable HES data will only be used for linkage, once this has been completed, this data will be removed from the dataset. Particular data which the HES data will be linked with are laboratory data from Labbase (a voluntary reporting system that covers all the NHS laboratories in England which collects information (amongst others) on positive results of respiratory virus testing of respiratory swabs together with available personal identifiers) and Datamart (collects information on results (positive and negative) of laboratory respiratory virus testing of all respiratory swabs submitted to a network of 14 HPA and NHS laboratories in England.) The data will also be used to evaluate the UK Severe Influenza Surveillance System (USISS) which is a new hospital based reporting system for severe influenza. The HES data will also be linked to ONS mortality data, held by HPA, to enhance the quality of outcome data. Some of the key public health objectives include: - To describe the viral aetiology amongst persons admitted to hospital with acute respiratory infection and describe the burden of disease (length of stay, admission to ICU and death) in children, adults and the elderly; - To identify and quantify the underlying clinical and demographic risk factors for severe RSV (hospitalisation, death and ICU admission) compared to community, non-hospitalised cases of RSV; - To identify and quantify the underlying clinical and demographic risk factors for severe influenza (both seasonal and pandemic) (hospitalisation, death and ICU admission) compared to community, non-hospitalised cases of influenza; - To evaluate the completeness and reliability of the severe disease surveillance systems operating for influenza (pandemic web system, USISS mandatory and sentinel surveillance systems) since their creation in 2009.
91		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
92	St Marks Academic Institute	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To ascertain mortality statistics and survival trends in patients treated in the NHS in England for a variety of cancers and benign conditions. The study aims to analyse the impact of patient characteristics and demographics on incidence, morbidity and survival in benign and malignant disease. This will allow the clinicians to identify patient groups which are at an increased risk of postoperative complications amongst several patient outcome. This in turn will allow better management of patients and enable the clinician to improve patients' clinical journey, improve the clinicians' practice and skill sets and improve hospital and regional healthcare standards. These data is requested to undertake medical research, analyse and improve patient outcome/clinical practice.
93		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
94		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	

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						Use of anonymised data to determine high risk groups, morbidity, mortality and other outcome amongst specific disease cohorts in the English population. Outputs from the analyses will be scientific articles, medical presentations and in the long term, these will translate into improved patient outcome.
95	Compufiles Systems Limited	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We intend to use the data to understand the patient journeys into and through the hospital system. To do this we need to work with individual patient records, hence the need for detailed HES data sets. These patient records will be aggregated to provide statistically robust information on similarities (and differences). The aim of the analysis will ultimately be to provide data to support cost benefit arguments to improve patient outcomes and or reduce treatment costs. Our primary customers are service providers to the NHS, principally pharmaceutical companies but also medical supplies/devices companies. We may also directly or indirectly be providing data analyses to the NHS itself.
96		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
97		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
98		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
99	Keele University	Data Linkage and Bespoke Extract; HES Inaptient	Pseudonymised	Non-Sensitive	Section 251 approval ECC: 8-02(FT1)/2012) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	Multisite pain (MSP) is common in older people and often prompts people to consult their GP. Previous US-based research found that people with MSP were more likely to fall than those without MSP. This is important as falls have serious physical, social, psychological and economic consequences. GPs aim to prevent their patients from falling, but there are currently few treatments available to GPs that have proved successful. This research aims to identify potential interventions for GPs to prevent their older patients from falling by seeking to establish the relationship between MSP and falls in a UK population, identify modifiable risk factors that mediate that relationship, and identify the factors that increase the risk of a poor outcome i.e. that increase the risk of death. Specific objectives of the PhD are to test in a cohort of community dwelling older people the hypotheses that: 1. MSP is associated with a higher rate of falling 2. The relationship between MSP and falls is mediated by factors that are amenable to intervention and are known to be associated with chronic pain 3. The relationship between falls and poor outcome (including fracture or death) will be moderated by the presence of MSP The requested HES and ONS data will be linked with existing cohort study (NorStOP) survey responses about pain and respondents' primary health care records. HES and ONS data will be used to investigate falls rate (non-injurous and injurious), fall severity and cause of death. The self-reported falls measure in NorStOP is subject to recall bias and falls are often underrecorded in primary care records. Therefore, secondary care data is required to ensure maximum capture of falls and fall-related events. The vital status for each NorStOP participant and, for decedents, the cause of death, is required from ONS Mortality data to determine the effect of MSP on the risk of falls, fall-related injuries and death. Access to sensitive data (as defined by HES) is not required. The linked database will be interrogated using statistical techniques including generalised estimating equations, structural equation modelling and cox proportional hazard ratios. Intended outputs are publication of anonymous study results in a PhD thesis, peer-reviewed journals, national and international primary care-related conferences and dissemination in workshops for clinicians.
100		Data Linkage and Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Section 251 approval ECC: 8-02(FT1)/2012) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	
101		Data Linkage and Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4) Section 251 approval ECC: 8-02(FT1)/2012) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	
102	Office of Health Economics	Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	The linked HES data and PROMs data is the best dataset to achieve the research aim of this project. The primary aim of this project is to investigate whether and how the degree of competition between hospitals for the provision of the four elective surgical interventions has an observable relationship with the average quality of the hospital, as measured by their average performance on case-mix adjusted PROMs scores. We request a linked dataset of HES and PROMs from the HSCIC to achieve this aim. 1) PROMs data will provide information about patients self-reported health outcomes (i.e. EQ-VAS, EQ-5D profile and condition specific scores). 2) HES data will provide variables that could be used to calculate the market concentration index (e.g. postcode of hospitals and patients' residence). 3) The regression analysis also needs to control for the patients characteristics (e.g. social economic factors, geographical variables). HES data will provide those information.
103		Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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						2. How will you use the data? We will use the patients' self-reported health outcomes directly from the PROMs dataset. The PROMs dataset provides key variables which will be used to proxy patients' health outcomes, i.e. EQ-VAS, EQ-5D profile and four condition specific scores. The code to calculate market concentration indices for 2009, as used in Professor Carol Propper's previous work, are available for this empirical analysis. They will be used to measure the intensity of hospital competition. The variables that we need to calculate the indices are the postcode of hospitals and patients' residence areas. They are both recorded in the HES dataset. We will re-work the indices to represent not only the overall level of competition facing each hospital, but also the level of competition specific to the clinical area i.e. hip replacement, knee replacement, varicose vein and hernia repair. The PROMs dataset and the market concentration indices will be linked together by the Middle Super Output Area variable. 3. What will the outputs of your analysis be? This study will represent one of the first attempts in the health economics literature to evaluate the impact of hospital competition on health outcomes by linking the PROMs data with indices of the extent of competition in local health economies. The results will provide empirical evidence to our research questions: 1) What is the relationship between market structure, patient outcomes and patient severity for four common elective procedures? 2) What is the relationship between patients' choice, market structure and patient severity for four common elective procedures?
104	University of York	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used to support research into economic matters relating to health and health care provision. The HES data is essential to support a range of academic research projects funded by the Department of Health and other research councils such as the NIHR, MRC, ESRC etc. The HES data will be used to run internal and external training courses to facilitate the understanding and use of HES. How will the data be used: The data will be used to undertake statistical and econometric analysis to explain variations and test hypotheses relating to health care utilisation, patient outcomes and clinical practice. The data will be used to analyse the efficiency, effectiveness and equality of the health care system. We will quantify differences in health care utilisation, expenditure, morbidity and mortality over time, across geographic regions, health providers, and among different patient groups in order to evaluate the impacts of health care policy, organisation, finance and delivery of NHS services. The research will measure productivity in the delivery of health care nationally, sub-nationally and among hospitals. We will evaluate differences in the performance of hospitals in terms of the cost of provision and in patient outcomes including mortality and self-reported morbidity. We also investigate socio-economic inequality in the use healthcare and patient outcomes. The data will be used to analyse access to care, the market for health care, including choice of provider and competition and concentration of health care services across England. The research will encompass the different sectors of the health care system, looking at the effects of quality and access of primary care on patient use and outcomes in secondary care; and the relationship between long term care, social care and secondary care utilisation. What will be the outputs of your analysis: The research outputs will consist of peer reviewed papers in academic journals, research reports for funders and conference presentations. We will report aggregate results that show trends over time, differences across providers, commissioners, geographical areas and by patient subgroups and patients characteristics. Statistical results will be presented in tables of aggregate statistics summarising patient characteristics and will comply with ONS guidelines on disclosure of potentially patient identifiable data i.e. no small numbered cells and figures will be reported. The results will contain estimated correlations showing associations between patient outcomes and patient characteristics, hospital, institutional, geographic and environmental factors. The reports will contain maps at small area level but will not show point level data for individuals at low levels of granularity.
105		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
106		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
107		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
108	Central Midlands CSU	Bespoke Extract; HES Inpatient	Pseudonymised	Non-	Health and Social Care Act 2012	We provide high level analysis to support strategic change and reconfiguration projects. We will

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				Sensitive		use the data for the purposes of providing senior NHS management within CCGs and other NHS organisations with analytical products that largely fall within four core areas: Descriptive analysis – developing a holistic picture of a service area drawing on data from multiple sources Retrospective analysis – identifying the cause (s) of historical successes of failures with the local health system Service monitoring – monitoring the impact of an intervention one implemented Prospective modelling – modelling the likely impact of planned change to healthcare services.
109		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
110		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
111		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
112		Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	
113		Bespoke Extract; SUS PBR Episodes,Spells	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
114	Imperial College of Science, Technology and Medicine (Imperial College London)	Standard Monthly Extract Service; HES Inpatient	Identifiable	Sensitive	PIAG 2-05(d)/2007	1. To use hospital administrative data in the form of HES, PEDW, NWCS and data supplied through SUS to provide measures of quality of delivery of healthcare by providers, or in some instances, by area. 2. To support a management information function for the NHS 3. The information generated from the analysis of the data is provided via Dr Foster Intelligence [Note: Imperial college have stated that DAAG ref: 181011-c relates to the sharing of data to Dr. Foster Intelligence] through a range of tools and services to help primary care and secondary care clinicians and managers with their common agenda of improving the quality and efficiency of health and social care. 4. Provide aggregate information to help the public make better choices via the Good Hospital Guide and other such publications. 5. In addition to this the Licensee are granted permission to use these data to: 6. Provide tools/bespoke reports to Non NHS organisations (including but not limited to independent sector and other organisations whose inclusion would benefit healthcare delivery). Note disclosure of data to Non NHS organisations is aggregated with small number suppression applied. 7. Allow the use of data in the development of Hospital Standardise Mortality ratios (HMSR's) including a continuation of the joint working with the DoH in the development of the Summary Hospital-level Mortality Indicator (SHMI). 8. To support the development of indicators in line with the recently published NHS Outcomes Framework. 9. To provide NHS number directly to GPs and commissioners of care to allow GPs to identify their own patients most at risk of repeat emergency admissions.
115		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
116		Standard Monthly Extract Service; HES Outpatient	Identifiable	Sensitive	PIAG 2-05(d)/2007	
117		Standard Monthly Extract Service; HES A&E	Identifiable	Sensitive	PIAG 2-05(d)/2007	
118	East London & the City Alliance	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We are requesting data to support contractual and strategic benchmarking.
119		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
120		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
121		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
122	Department of Health	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Quantitative analysis - comparing size of service, rates of referral, equity in referral to IAPT and their clinical outcomes, contrasting people with and without MUS and LTCs. Including change in PHQ9 and other scales. Economic analysis - to ascertain the cost-effectiveness of the service in improving outcome of the different patient sub-groups (i.e. with and without MUS and/or LTCs). The economic analysis will convert change in Work and Social Adjustment Scale (WASAS) or other repeated outcomes scores into QALYs. The analysis and audit of all pathfinder date along with a review of service models and care pathways, patient centred assessment, clinical and economic outcome measures, Pathfinder workforce competency and LTC/MUS training will inform a final report which is a key deliverable of this project. It is envisaged that this report will provide evidence to inform service transformation and achieve improvement in access to psychological therapies which in term will reduce the long-term costs for the NHS.
123		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
124		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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125	London School of Economics and Political Science	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We will principally use HES data for three streams of research at LSE Health. The first steam will use the data to analyse the impact that various aspects of policy-development in the NHS have had on patient outcomes, waiting times, and provider behaviour. The second stream of work will use the data to compare hospital performance in several countries with the aim of spreading best practice across different countries. The third stream of our work will use HES data to develop and test a range of multi-dimensional health care quality indicators. All analysis will be published at an aggregate level where no hospitals, GPs or patients are identifiable.
126		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
127		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
128		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
129	Nuffield Trust	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The Nuffield Trust vision is to help provide the objective research and analysis works to promote improvements in the quality of care and care policy. In doing so it seeks to improve services user care, health and wellbeing for all members of the public. Examples of the research areas are: Evaluating the impact of service innovations, such as the implications of telehealth and telecare, integrated care services and virtual wards. Developing predictive risk modelling to forecast the future uses of health and social care Studying end of life care Studying the interplay between primary, secondary, mental health and social care. Investigating the cost of care such as looking at costs for chronic diseases. In accessing the data we intend to use the information in publicly funded research projects or in either commercially funded research project or in as service given freely to our customer that's benefits the public.
130		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
131		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
132	Imperial College London	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Section 251 approval ECC: 4-03(f)/2012) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	We would like to obtain data for all patients not recruited into the IMPROVE trial, at English IMPROVE trial centres during the time period of the trial, in order to assess the outcomes and outline costs for these patients. The IMPROVE trial is an emergency surgery trial for patients admitted with a ruptured abdominal aortic aneurysm, looking at Open repair versus Endovascular repair. Returns from IMPROVE trial centres have indicated that only about half of the patients with ruptured aneurysms presenting at these sites are recruited into IMPROVE. To enhance the generalisability of the IMPROVE trial findings, with respect to mortality and costs, it would be helpful to outline outcomes in non-recruited patients, using anonymised Hospital Episode Statistics data for English sites, linked to mortality data. This will provide data for age, gender, procedures, survival (30-day and beyond), length of hospital stay, as well as allowing monitoring of re-interventions for aneurysm-related procedures and more detailed use of hospital resources. National Information Governance Board and Ethical Approvals are in place to support the collection of these data. All trial centres in England, who started randomising patients before 2013, will be included in the analysis with account taken of hospital mergers, re-organisation of vascular services and ethical issues since randomisation started at each site. Data on all patients admitted before 31st January 2013 will be requested. This will cover complementation for the majority of patients randomised (approximately 500). Patients randomised in Scotland, Wales and Canada will not be considered as reporting of routine data differs in these countries and England has provided the large majority of patients.
133		Data Linkage and Bespoke Extract; ONS Mortality	Identifiable	Sensitive	Section 251 approval ECC: 4-03(f)/2012) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012 ONS data: ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	
134	Optum UK (formerly United Health UK)	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Re-Use Application Statement Data is used in calculating relative risk for profiling populations and also for various benchmarking measures to compare to local data feeds. Application statement(above), The HSCIC grants to Licensee a non-exclusive licence to use or re-use the data specified in section 3 above for the following purposes:
135		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
136		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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						• Use only within the Field and Territory as specified in this Agreement. • Publishing the material in any medium, including featuring the information asset on websites which can be accessed via the Internet or via an internal electronic network or on an Intranet. • Authorising users and subscribers who use the Licensee's electronic or digital products to access the material. • Translating the information asset into another language or converting to Braille or other formats for people who are visually impaired.
137	Methods Insight Analytics	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The linked HES/ONS data will be used to create SHMI and HSMR indicators to support existing work with NHS partners such as National Rightcare for the Commissioning Board and the continuation of the Acute Trust Quality Dashboard which will be made freely available to the NTDA. The data will be analysed and aggregated to an appropriate level so we can provide statistically robust measures which will provide national benchmarking to show variation and difference in services.
138		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
139		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
140		Standard Monthly Extract Service; ONS Mortality	Identifiable	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	
141	University of Manchester	Bespoke Extract; HES Inpatient	Identifiable	Sensitive	PIAG 3-04(e)/2006 ECC: 7-05(g)/2011	We require data to compare against our own dataset in order to check its completeness and identify which trusts are and are not submitting full data. We will feed these results back to the trusts in privately circulated reports and also display completeness information on our website, as we have since first receiving HES data in 2008. In addition to summary figures, we will also provide processed patient level HES data to the trusts in order that they may link it to their own SUS activity data. This will take the form of lists of cases in the HES dataset which meet the TARN inclusion criteria for severity of injury. We will not make any patient level information public, only summary analyses.
142		Bespoke Extract; HES A&E	Identifiable	Sensitive	PIAG 3-04(e)/2006 ECC: 7-05(g)/2011	
143	Public Health England	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	As part of our national surveillance remit our uses of the HES data set are used for the following: a) To monitor trends in the incidence of admission by age, sex, underlying co-morbidities, ethnicity, season and geographical area for vaccine-preventable diseases and other conditions with an infectious aetiology b) To obtain incidence data by these variables for conditions that could represent adverse effects of vaccines in order to inform assessments of vaccines safety by the Medicine and Healthcare products Regulatory Agency. c) To estimate the burden of disease, including financial costs of admissions attributable to specific infections or putative adverse events in order to inform economic analyses conducted on behalf of the Department of Health Any final reports will be submitted for publication in a peer-reviewed journal and in national reports on specific infectious diseases which will be available on online.
144		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
145	Imperial College London	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Informed Patient Consent Health and Social Care Act 2012	In this specific context, HES data will be used to determine prevalent cases at baseline and subsequent incident cases for each outcome under study (for example, irritable bowel syndrome or coronary heart disease). Participants with prevalent disease or with any other disease that might enter in our exclusion criteria will be excluded from the analyses. Survival analyses will be performed to investigate the association between stress at work and the risk of incident cases for each disease using multivariable Cox models. More generally, HES data will be used to extend information at participant-level and provide a better understanding of the medical history of Airwave participants throughout the follow up. HES data will be used for various other analyses in the Airwave Health Monitoring study to better understand the health risk specific to police forces.
146		Data Linkage and Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Informed Patient Consent Health and Social Care Act 2012	
147	PricewaterhouseCoopers LLP	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	PwC has been engaged by a number of the newly appointed Clinical Commissioning Groups (CCGs) within the NHS to undertake a series of projects involving review and analysis of available secondary care information. Our analysis is being used to provide a high level summary of where there may be potential efficiency savings in secondary care.
148		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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149		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
150		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
151	Royal National Orthopaedic Hospital	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will enable the RNOH and the Specialised Orthopaedic Alliance to examine the national casemix and incidence of specialised Orthopaedic activity for its own business practices and to provide advice, expertise and information for the Specialised Commissioning process.
152		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
153	Central Manchester University Hospitals NHS Foundation Trust	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The application is for the collation and analysis of attendances at hospitals in England, with particular reference to patient co morbidities. As a large specialist organisation providing complex care to patients from a broad range of demographic backgrounds we strive to provide the best care possible for our patients. This entails understanding the complex co morbidities of our patient population, through which we aim to establish a patient co morbidity index for the greater Manchester area. Multiple co morbidities are increasingly recognised as a major public health issue in England and have a significant impact on a range of health outcomes such as mortality, health-related quality of life and quality of health care. Access to HES data will provide a better understanding of the current healthcare needs of the population we serve, and identify opportunities for improving patient care. This will be achieved by improving health outcomes and the patient experience through more efficient, appropriate clinical management, reducing health costs through a reduction in length of stay, and a reduction in mortality rates. The provision of HES data will also enable the Trust to identify specific cohorts of patients who are at a high risk of emergency admission. Through comparative analysis and benchmarking with peer groups, access to HES data will improve the effective delivery of healthcare and the patient experience, and provide the opportunity for any issues relating to patient care to be addressed through clinical governance and performance management reporting measures. Outputs of analysis will be in the form of reports and dashboards, which will highlight any pertinent issues relating to the quality of patient care, and will provide recommendations regarding the implementation of specific measures to improve the efficiency and effectiveness of care. An additional output will be the creation of a co morbidity Index which will highlight patients at particular risk of specific medical complications/diseases due to their co morbidities identified.
154		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
155		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
156		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
157	Imperial College London	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We wish to determine population trends in hospital admissions, procedures and mortality from thoracic aortic aneurysm (TAA) in England, to contrast these data with trends in other cardiovascular disorders and to investigate specifically the impact of endovascular repair in thoracic aortic diseases (TEVAR) on early and late outcomes. As you know, freely available data (or non-linked data) do not permit us to directly assess the early or long term outcomes of procedures, because the procedures are not linked to mortality and this is what we require here. These linked data are a vital piece of information. We know that there has been a steep increase in overall aneurysm repairs (a 6 fold increase since 2000 in patients aged >75years), mainly driven by TEVAR procedures; however we do not know from non-linked HES data, whether this increase of TEVAR is beneficial for the patients at all with respect to survival. A recently published paper of the US Medicare data (Goodney et al, Circulation 2011) suggests that patients selected for TEVAR have worse long-term survival than patients selected for open repair. We believe that this topic deserves further consideration, especially in the view of the tremendous increase of TEVAR within the last few years. Emergency procedures, especially in aortic repair and even more in thoracic aortic repair have very distinct outcomes, worse than the outcomes of elective procedures. Therefore, it is essential that there is knowledge of the urgency of patients' presentation. However, as you know, ICD 10 codes do not specify the urgency of the TEVAR procedures and so the only way to get this information is by linking the data to admissions and urgency of admissions. There is another very essential purpose for getting these linked HES data. As described above, we do not know yet whether TEVAR is effective with regard to survival compared to no intervention. Approximately 12 years ago, the same question was raised for abdominal aortic
158		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	

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						aneurysm repair and was investigated in a randomised controlled trial, the EVAR 2 trial. It is legitimate and probably of even more importance nowadays, to assess such an uncertainty via a randomised controlled trial. Survival in the long term is relevant and cost effectiveness of such costly treatments is becoming more and more significant. Our study, based on these linked data, may provide vital information required for any power calculation of such a randomised trial comparing TEVAR to no intervention in patients with thoracic aortic aneurysm. Consequently, the purposes of this study are manifold; the study itself is very relevant and timely and relies on the availability of linked data.
159	OmegaSolver	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	OmegaSolver are requesting the data to develop a new service offering to both the NHS and commercial organisations. The main purpose will be to understand patient pathways and identifying resource use between commissioners and providers within NHS and non-NHS (i.e. private provider) settings. The data will be used to support a service offering aimed at improving commissioning patient care pathways. The analysis would not require any 'sensitive HES data fields'. We will request a regular subscription of the dataset and data from previous years (2 years). As part of our service offering we will also require a commercial re-use licence.
160		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
161		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
162		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
163	Leading Light Software Services Limited (L2S2)	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The ONS data is required in order to support the urgent review of outcomes at a number of Trusts as part of the Mortality Outlier Review into the 14 trusts that have been outliers on either SHMI or HSMR for the last two consecutive years. The data will be used to populate a system called CRAB that produces risk-adjusted reports to be used as part of the analysis. Mortality results are a key part of the required analysis. The data will be used to produce risk-adjusted analysis of organisational, departmental and individual consultant performance within the target Trusts identified by NHS England. Drill-down to individual patient coding will be required in order to track any issues to a common denominator (e.g. patterns in certain types of complication, such as infection, within a speciality or for a particular consultant), but we are not directly comparing individual patient outcomes, nor are we validating other data sources.
164		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
165		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
166	University of Leicester	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Nationwide outcomes after cardiovascular surgery: Anonymised linkage of HES and ONS datasets. 1. To analyse the trends in incidence over time of surgically treatable cardiovascular disease in England. 2. To analyse regional variations in the surgical treatment of cardiovascular disease and how these have changed over time. 3. To examine outcomes following diagnosis of, or presentation with, cardiovascular disease. 4. To identify and quantify risk factors associated with outcomes for surgically treatable cardiovascular disease. This study will be a retrospective (non-concurrent) cohort study. We will obtain anonymised linked HES and ONS data for all patients admitted to NHS institutions between 1/1/2003 and 31/12/2012 and extract records with primary ICD-10 diagnostic or OPCS-4 procedural codes relating to surgically treatable cardiovascular disease. We will determine the outcomes of index admissions for surgically treatable cardiovascular disease using the same datasets. We will specifically search for specific and general complications and causes of death. We will use this data to quantify outcomes on a national basis and determine the magnitude of variation in outcomes. We do not aim to compare outcomes between individual practitioners or hospitals. We will use these datasets to determine mortality and morbidity outcomes after cardiac surgery, carotid endarterectomy, aortic aneurysm/dissection repair/treatment, lower limb bypass/angioplasty, major lower limb amputations, varicose vein surgery and arteriovenous fistula construction.
167		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
168		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
169		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
170		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	
171	University of Leeds	Data Linkage and Bespoke Extract; HES Inpatient	Identifiable	Non-Sensitive	Informed Patient Consent	The primary outcome of the SHIFT Trial requires collection of data for all participants relating to any hospital attendances following a self-harm episode. In addition hospital attendance (for all reasons) data informs safety monitoring and analysis. The results of the SHIFT Trial will inform clinical practice for young people attending Child and Adolescent Mental Health Services following self-harm.
172		Data Linkage and Bespoke Extract; HES A&E	Identifiable	Non-Sensitive	Informed Patient Consent	
173	University of Hertfordshire	Bespoke Extract; HES Inpatient	Pseudonymised	Non-	Health and Social Care Act 2012	Our project aims to build on the extraordinary potential of the enhanced healthcare datasets and

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				Sensitive		deliver two key advances for value based healthcare: 1) models focusing on the appropriate definition and measurement of value, effectiveness and cost-effectiveness (of care pathways), opening the way to patient centred outcomes data based quality improvement; 2) preliminary models to indicate the value of service provision, where costs are attached to various services against outcomes over time.
174		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
175		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
176		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
177		Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	
178		Bespoke Extract; SUS PBR	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
179	University of Oxford	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Evaluate variation in the delivery of secondary fracture prevention services after hip fracture across 11 hospitals in the South Central region.
180		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
181		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
182		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
183		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	
184		Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	
185	Finnamore Management Consulting	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We are requesting the data so that we can providing comparative information to support improvement projects (typically performance improvement) in the NHS organisations with which we work.Our analyses include: - Reconciliation with Trust data in demand and capacity modelling - LoS and occupancy analysis, analysis of follow up and conversion ratios - Market share assessment of provider/PCT/CCG combinations Outputs will comprise aggregate and summary results in tables and graphs from the modelling, analysis and comparisons outlined above.
186		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
187		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
188	NHIS Limited	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity.
189		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
190		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
191	Bayer PLC	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	To identify the size of the uterine fibroids market in the UK to feed into the marketing strategy process. It wil aid decisions regarding the level of investment that should be put into this area of the business.
192		Bespoke Tabulation; HES Outpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	
193	The Kings Fund	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data set will only be used by the authorised team within the King's Fund policy directorate for research purposes. All our research is targeted to advance knowledge within the NHS and the recipients of the products we supply are NHS or NHS-related organisations. The King's Fund does not intend to trade using the data.
194		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
195		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
196	Monitor	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Under the Health & Social Care Act, Monitor is taking on new responsibilities: - Licensing providers: Monitor will license providers of NHS services in England. - Regulating prices for NHS-funded care: Monitor will take on responsibility for pricing, working together with the NHS Commissioning Board. - Integrated care: Monitor will have a duty to consider how it can enable or facilitate the delivery

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197		Standard Monthly Extract Service; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	of integrated care for patients where this would improve quality of care or improve efficiency. - Preventing anti-competitive behaviour: Under the Act Monitor's role will focus on making sure that any competition in the health sector is fair and that it operates in the best interests of patients. - Supporting the continuity of services: Monitor will support commissioners to ensure that patients could continue to access the care that they need if a healthcare provider fails. Access to detailed hospital activity information describing all aspects of healthcare over a number of years is essential for these functions to operate effectively, for example, assessing activity in a health economy to identify anti-competitive behaviours, by comparing referral rates or activity volumes, or considering how a failing Provider's activity may be re-directed to other hospitals or services, or modelling new Tariffs according to life-years-of-care to investigate the effects of potential Tariff changes on the health economy. Data at its most granular level (without identifiers and sensitive items) is needed because the data will need to be queried, aggregated and combined in many different ways to support the variety of business queries that each of the above functions will generate; requesting ad-hoc extracts / tabulations from the HSCIC for each specific case will be ineffective and hugely inefficient. Following the Francis Report into Mid Staffordshire Foundation Trust, Monitor is acutely aware of the need to use data much more effectively to fulfil its regulatory responsibilities, and will therefore use detailed record-level data in different combinations of indicators and metrics to form a better contextual view of Provider performance and delivery to ensure that organisations are meeting the terms of the license.
198		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
199		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
200		Standard Monthly Extract Service; PbR APC Episodes, PbR APC Spells, PbR OP, PbR A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
201	Civil Eyes Research Limited	Bespoke Extract; HES Inpatient	Pseudonymised	Sensitive	DAAG: 270613-a Health and Social Care Act 2012	The key themes in the Civil Eyes Research Valuing Medical Resources network are consultant productivity and appraisal. Their analysis of productivity involves the collection of manpower data from our client NHS hospitals, and then matching it up with consultant level admitted patient care and outpatient activity volumes. Consultants often operate across more than one NHS provider, so Civil Eyes regularly need to search for additional activity outside of the host organisation. Civil Eyes need consultant identifiers in their HES data extracts to facilitate a positive match between the activity and the collected manpower data which is often recorded local under a variety of different codes.
202		Bespoke Extract; HES Outpatient	Pseudonymised	Sensitive	DAAG: 270613-a Health and Social Care Act 2012	
203		Bespoke Extract; HES A&E	Pseudonymised	Sensitive	DAAG: 270613-a Health and Social Care Act 2012	
204		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
205	Guy's and St Thomas' NHS Foundation Trust	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Study Title: Pilot Evaluation of a Whole Genome Sequencing Service to Track Transmission of Methicillin Resistant Staphylococcus aureus (MRSA) and Target Infection Control Interventions across South London. Synopsis: We are investigating how MRSA transmits within hospitals, across hospitals and between hospitals and the community to improve the rationalisation and cost-effectiveness of prevention and control resources. To achieve this, we are using whole genome sequencing to characterise the genetic profile of MRSA isolates obtained at five hospitals which provide microbiology diagnostic services for inpatients, outpatient clinics and community patients in Lambeth, Southwark, Lewisham, Wandworth, Merton, Sutton and Bromley London boroughs. We are also mapping the distribution of MRSA cases in relation to social and economic inequalities in the South London. Purpose of Data Request: Preliminary disease mapping of MRSA at the lower super output area level, suggests that the risk of MRSA is greater in the most deprived areas. However, because MRSA is typically associated with hospital contact, it is possible that the increased risk of MRSA in most deprived areas results from an increased number of hospital contacts in these locations. To account for this possible confounding, we require the total number of persons in each LSOA, which have had at least one hospital contact over the study period. We will then adjust the analysis by accounting for the percentage of residents in each LSOA that may have been at greater risk of MRSA through hospital contact. Preliminary analysis also suggests that the spatial
206		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
207		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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						distribution of MRSA is associated with the distribution of particular ethnic groups. The requested data will also allow adjusting by the number of hospital contacts recorded from each ethnic group. Analysis output: MRSA risk mapping in relation to social and economic inequalities in the South London community.
208	New Medica	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	The purpose of this data request is primarily for its own internal business research within the organisation. The data will act as a valuable resource to gain an understanding of the demand for ophthalmology services in England, by researching attendance levels and activity volumes over a period of three years; this is with the intent of improving service delivery within our organisation. Therefore, only aggregate level data is requested for analysis and no external outputs (e.g. publications in peer review journals) should be expected.
209		Bespoke Tabulation; HES Outpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	
210	Moorfields Eye Hospital NHS Foundation Trust	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data requested will be used to perform detailed assessments of Moorfields' share of Ophthalmic episodes across London as well as the rest of the UK.
211		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
212	NHS Greater Manchester	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	NHS Greater Manchester CCG, Healthier Together Programme is undertaking a detailed hospital activity analysis and capacity planning exercise to support development of a revised hospital model of care, and to drive the development of options and required options appraisal. The data will be presented on a summarized level in tables and graphs in internal reports only. Any numbers lower than 6 will be anonymised. The plan is to hold the data for 3 years, as it will be needed to monitor the changes being implemented by the programme, and illustrate the impact these changes have on the activity base. This will be reviewed every year to ensure it is still required.
213		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
214		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
215	National Audit Office	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	NAO are requesting the data to use for National Audit Office value for money reports on the NHS. We plan to use the data in our analysis in future studies including studies on demand management of emergency admissions and waiting times. NAO will be looking at the data to consider the value for money to the public purse achieved by specific areas of the NHS. This holds the Department accountable for services delivered and funds spent, and leads to potential cost savings or service improvements.
216		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
217		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
218		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
219		Bespoke Extract; SUS PBR	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
220	The Checklist Partnership Limited	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used to produce benchmark data, for example average lengths of stay, for use with the company's software products. These are all for use by NHS organisations in the UK and healthcare organisations in Canada and Australia who are clients of the company. The software is intended for healthcare capacity management, waiting list management and bed management. The data could also be used for other ad hoc projects which would all involve benchmark values for the NHS and other healthcare organisations.
221		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
222		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
223	Clatterbridge	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	These extracts are intended to be used to replace those previously taken from the HES Business Objects interface to build a range of non-identifiable data sources which are used to provide data to support the National Cancer Program, the National Cardiac program and other parts of the NHS, Public Health England and Department of Health. Examples of the work carried include: Work with NHS Improvement (now part of NHS IQ) to assess progress on the implementation of 'Enhanced Recovery' programs across Acute Trusts in England by monitoring the length of stay for a range of specific procedures, supporting the DH Cancer team when responding to parliamentary questions with information on numbers or locations of specific procedures or diagnoses, supporting the development of a National Cardiac Strategy by the provision of data linking diagnosis and treatment spells. Outputs are in the form of tabulations, containing no identifiers.
224		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
225		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
226	NHS Litigation Authority	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	The NHS LA intends to use the data to assist in the calculations of the 2014-15 member contributions. We use the activity data alongside the WTE data we receive to arrive at a risk for each of our members.
227		Bespoke Tabulation; HES Outpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	

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228	St George's University of London	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To analyse outcomes following admission to hospital in relation to demographics, co-morbidity, specific treatments and surgical procedures, and the processes and structure of delivery of healthcare at individual Trusts.
229		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	
230	Beacon Consulting	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Data will be used to update a database of HES APC and OP data, which has been developed over a period of years. The database is used to provide NHS suppliers with insights into current and potential demand for products and services to optimise business planning. The outputs are typically: bespoke reports and presentations; spread sheet based analytical tools and online reporting services such as Meditrends.co.uk
231		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
232	NHS England	Bespoke Extract; SUS PBR Episodes,Spells,Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used to analyse the impact of proposed changes to specialised services definitions.
233		Standard Monthly Extract; SUS PBR Episodes,Spells,Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
234	Health IQ Ltd	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The aggregated, pseudonymised extract, will be used to analyse disease burden and hospitalisation outcomes for a range of conditions for projects in healthcare and life sciences. This analysis will be used to support organisations in a range of projects, including service redesign, QIPP delivery and market access. The outputs will be in the form of aggregated excel tables and web applications.
235		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
236		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
237		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
238	CARE UK	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Care UK wishes to retain the data in order to review historical referral patterns in the local health economies and sectors in which we work. The Care UK Information Team will use the data in conjunction with other information (such as published NHS tariffs) to inform the organisation of health and social care trends in the areas we provide services.
239		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
240		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
241		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
242	Olivery Wyman	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data set will be used to inform analysis of the NHS healthcare market. We intend to load the data onto a secure SQL database and query it to inform our analysis of the market. For example, analysis will cover areas such as the number of episodes (in-patient and out-patient) by geography, hospital and the distance travelled for consultations. Analysis will also cover the patient path taken through the healthcare system and the outcomes of episodes. Additionally the data will be used as the basis of market size and growth assessments. Outputs of analysis will include articles and booklets for publication, presentations and varied other tools to communicate insight derived from the analysis. Analyses will be conducted to investigate a number of areas such as quality of care, patient experience, care pathways and patient needs. Ultimately, there should be a large patient benefit, especially in terms of patient experience, outcomes and wider care provision.
243		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
244		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
245		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
246		Bespoke Extract; MHMDS and MHMDS-HES Bridging File	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
247	PricewaterhouseCoopers LLP	Standard Monthly Extract Service; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	PwC has been (and is expecting to continue to be) engaged by a number of the newly appointed Clinical Commissioning Groups (CCGs), providers and other health organisations to undertake a series of projects involving review and analysis of available secondary care information. The analysis is being used, for example, to provide a high level summary of where there may be potential efficiency savings in secondary care. We anticipate using the monthly data sets to provide on-going support to CCGs, providers and other health organisations in the form of regular updates of the analysis.
248		Standard Monthly Extract Service; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
249		Standard Monthly Extract Service; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
250		Standard Monthly Extract Service; PbR APC Spells, PbR OP	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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251	Care Quality Commission	Bespoke Extract; HES Inpatient	Identifiable	Sensitive	DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifialbe data	With respect to HES and MHMDS, CQC's principal aims are to provide: patients and users of services with clear assessments of the safety, quality, efficiency and effectiveness of the services they receive; patients, the public and health & social care professionals with the sound and fair information about health and social care, both at a national and local level.
252		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
253		Bespoke Extract; HES Outpatient	Identifiable	Sensitive	DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifialbe data	
254		Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4) DAAG: OC/HES/019 NIGB Approval 070510-5-e notes the additional powers under s64 of the Health and Social Care Act of 2008 for CQC to receive specific identifialbe data	
255	Imperial College	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Research. We will provide new evidence on the main factors responsible for the variation in the quality of care across health providers, small areas and over time. Our research will be useful to health care providers, commissioners and to the public in promoting higher quality and more efficient services, choice and accountability. How the data will be used: Data will be stored in a secured network drive password protected with access restricted to only those nominated in this agreement. Patient level information will be used for statistical analysis only and will not be published in any output of the study. Outputs of the analysis: Peer reviewed publications in academic journals. A number of Tables containing the results of the statistical analysis and aggregated descriptive statistics. A large longitudinal database of patients' utilisation of health care services, provider characteristics, environmental and policy factors that could be useful for future research.
256		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
257		Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
258		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
259	Nottingham Uni-Qresearch	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The QResearch database consists of pseudonymised electronic health records from primary care patients registered with approximately 670 general practices spread throughout the UK. The database was established in 2002/3 and is widely used for medical research into the causes of disease, its natural history, treatment and outcomes. In addition to coded data from the GP electronic record, the QResearch database also contains the linked cause of death derived from the death certificate data supplied by the Office of National Statistics following approval by Trent MREC and Secretary of State for Health in 2007. We would now like to extend the content of the data held within the QResearch database to include additional health information from secondary care. Similar data linkages have been successfully undertaken by other similar GP databases, such as the General Practice Research Database and researchers report that the additional information is valuable for research projects. Approval is now sought to link the database at patient level with the following data sources: a) Hospital Episode Statistics (HES) The licencee will be linking the HES data to GP data already held in the QResearch database. The licencee will also be providing aggregated linked data back to GPs.
260		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
261		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
262	Swansea University	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Sensitive	ECC: 3-03(a)/2012 - SAFER 2 Care of older people who fall: Evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care. Health and Social Care Act 2012	Emergency calls to ambulance services are frequently made for older people who have fallen, but ambulance crews often leave patients at the scene without ongoing care. Evidence shows that when left at home with no further support older people often experience subsequent falls which result in injury and emergency department attendances. Aim: To assess the benefits and costs to patients and the National Health Service (NHS) of a complex intervention comprising education, clinical protocols and pathways enabling paramedics to assess older people who have fallen and refer them to community-based falls services when

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263		Data Linkage and Bespoke Extract; HES A&E	Pseudonymised	Sensitive	ECC: 3-03(a)/2012 - SAFER 2 Care of older people who fall: Evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care. Health and Social Care Act 2012	appropriate. Design: Pragmatic randomised controlled trial. We are following up patients for six months after the index incident. Outcomes required are: Principal outcomes: The rate of further contacts with emergency healthcare providers (999 calls, ED attendances, emergency admissions or death) – both for any cause and specifically for falls. Secondary outcomes include: Duration of inpatient episodes; Fractures arising from further falls; Self-reported further falls; Pathway of care as measured by routine ambulance service data on proportions conveyed to ED, referred to falls service, referred to other providers, or left at scene without further care; Durations of: ambulance service job cycle; episode of care; time to falls service response. The data we are requesting comprises the outcomes for the study, and will allow us to detect clinically important differences in outcomes at six months, whilst monitoring the safety of the intervention at one month. The study results will inform policy and service development on a national scale. A successful trial will provide robust evidence about the value of this new model of care and enable ambulance services to use resources efficiently. Data will only be used for the purposes stated above (research outcomes) and in the context of the SAFER 2 trial. Results will be disseminated through peer reviewed journals, conference presentations and our service user representatives.
264		Data Linkage and Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	ECC: 3-03(a)/2012 - SAFER 2 Care of older people who fall: Evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care. Health and Social Care Act 2012	
265		Data Linkage and Bespoke Extract; ONS Mortality	Identifiable	Sensitive	The ONS data are supplied under the Statistics and Registration Service Act 2007 section 42(4) as amended by s287 of the Health and Social Care Act 2012, for the purpose of assisting the Secretary of State for Health, or the Welsh Ministers, in the performance of his, or their functions in relation to the health service.	
266	NHIS	Bespoke Extract; MHMDS and MHMDS-HES Bridging File	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Data outputs will be used for internal research and external-facing client systems. For example, an interactive system to use with the NHS to investigate trends in hospital activity, including any subsequent or preliminary usage of secondary mental health services and whether a patient has accessed diagnostic imaging services. Data suppression will be applied where appropriate and in accordance with guidelines.
267	Keele University	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data is used in a number of reports produced by the department for PCTs / CCGs / Trusts in England as commissioned by the PCTs / CCGs / Trusts throughout the year. The data is standardised using denominators such as PU, QOF disease registers and total number of admissions and practice level analysis only undertaken where there are sufficient admissions to ensure patient confidentiality can be maintained.
268		Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
269	NHIS	Diagnostic Imaging Dataset	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Data outputs will be used for internal research and external-facing client systems. For example, an interactive system to use with the NHS to investigate trends in hospital activity, including any subsequent or preliminary usage of secondary mental health services and whether a patient has accessed diagnostic imaging services. Data suppression will be applied where appropriate and in accordance with guidelines.
270	University of York	Bespoke Extract; HES Inpatient	Pseudonymised	Sensitive	DAAG: 310713-d for HES Health and Social Care Act 2012	Why are we requesting the data: The data will be used to carry out research into economic matters relating to mental health and mental health care provision. The MHMDS data with linkage to HES data is essential to support a range of academic research projects funded by the Department of Health and the NIHR. There has been a long-standing gap in the evidence base related to mental health care system performance, not least due to the lack of good quality data. This research aims to contribute to filling this information gap by exploiting the rich individual-level data that is now available. The various strands of our research will focus on patient groups that have been particularly under-researched and are of high government policy priority. How will the data be used: The data will be used to undertake statistical and econometric analysis to explain variations and test hypotheses relating to mental health care utilisation, patient outcomes and clinical practice. The data will be used to analyse the efficiency, effectiveness and quality of the mental health care system such as variations in costs, outcomes, length of stay, resource use, morbidity and mortality, across geographic regions, mental health care providers, and amongst different patient groups (e.g. those with psychosis or dementia). This will enable us to evaluate the impacts of mental health policy, organisation, finance and delivery of NHS services. The research will also form part of analyses to measure the productivity in the delivery of mental health care nationally,
271		Bespoke Extract; MHMDS and MHMDS-HES Bridging File	Pseudonymised	Sensitive	DAAG: 310713-d for HES Health and Social Care Act 2012	

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						sub-nationally and among mental health hospitals. We will model variations in patient costs and outcomes for the full patient care pathway and examine the characteristics of patients associated with different levels of resource use and outcomes. Our analyses will take account of 1) patient demographic and socio-economic information such as age, gender, ethnicity, marital status, carer support, deprivation measures; 2) patient diagnostic information such as primary and secondary diagnoses (co-morbidities), psychiatric history, PbR care cluster; 3) treatment information such as specialty of provider, use of the Mental Health Act, community and inpatient services received by patients, 4) quality and outcomes such as HoNOS and PHQ-9 scores, waiting times, readmissions, use of restraint, assaults on patients, and social outcomes such as employment and accommodation status; 5) service level factors such as number of contacts with staff, periods of seclusion, and delayed discharge. There is a notable body of work utilising HES data to examine variations in costs and outcomes for the acute care sector and we have considerable expertise and a proven track-record of analysing this data in CHE. However similar research is sorely lacking for mental health care. The availability of linked HES and MHMDS data will allow novel research questions to be explored around variations in utilisation, costs and outcomes for the full patient care pathway in mental health. Such work is particularly relevant in the current policy climate with the introduction of PbR in mental health. Why we are requesting sensitive data (DAAG permission): We are requesting sensitive MHMDS and sensitive HES psychiatric fields. These relate to the legal category / legal status of the patient and if our analyses are to be robust, are crucial for our models as an important indicator of patient severity. We will need all sensitive data items to accurately control for the impact of detention on resource use and utilisation. We need to check data consistency between HES and the MHMDS and therefore require sensitive data on legal status in both datasets. Furthermore there will be a group of patients detained under the Mental Health Act who do not access inpatient care (HES) and are just treated in the community (MHMDS) for whom we would need to know their legal status to control for the impact of detention on their treatment care pathway. What will be the outputs of the analysis: The research outputs will consist of peer reviewed papers in academic journals, research reports for funders and conference presentations. We will report aggregate results that show differences across providers, geographical areas and by patient subgroups. Statistical results will be presented in tables of aggregate statistics summarising patient characteristics and will comply with guidelines on disclosure of potentially patient identifiable data i.e. no small numbered cells and figures will be reported. The results will contain estimated correlations showing associations between patient outcomes and patient characteristics, hospital, geographic and environmental factors.
272	University of Oxford	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	ECC: 1-02 (FT3)/2013 Understanding failure in Unicompartmental Knee Replacement - Linkage of HES/PROMs data to National Joint Registry data by the HSCIC trusted data linkage service.	We are requesting linkage of HES/PROMS data to an existing extract of NJR data which will be provided in an identifiable form to the HSCIC by HQIP. The applicant is conducting a study comparing total and unicompartmental knee replacement which will form part of his PhD and will be published in peer-reviewed journals. Outcomes of each procedure will be compared for matched patients; outcomes will include revision rate, mortality, functional outcome (PROMS), reoperation (aside from revision) and postoperative morbidity. HES/PROMS data is needed for three reasons: 1. To cross-check the data from the NJR extract. 2. To provide additional data for patient matching and stratification (eg Charlston index, IMD) 3. To provide additional outcome data (such as length of stay, readmission, reoperation details, and PROMS). The data will be linked using NHS number, date of birth and postcode. The Patient Identifiable data will be removed from the dataset prior to disclosure to the applicant and the identifiable data will be destroyed as soon as linkage is complete in accordance with the approval granted by the Ethics and Confidentiality Committee under the Health Service (Control of Patient Information) Regulations 2002.
273		Data Linkage and Bespoke Extract; PROMS	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

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274	NHiS Ltd	Bespoke Extract, HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity.
275		Bespoke Extract, HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
276		Bespoke Extract, HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
277		Bespoke Extract, HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
278	NHiS Ltd	Bespoke Extract, HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity.
279		Bespoke Extract, HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
280		Bespoke Extract, HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
281	Swansea University	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To be used as part of a publicly funded research project Joint Action on Monitoring Injuries in Europe (JAMIE) funded by EU and Department of Health. JAMIE is a European public health joint action project partially funded (50%) by the EU with co-funding from Member States. JAMIE involves utilising emergency department, inpatient and mortality data to measure the incidence of home and leisure injuries for calculation of the European Community Health Indicator 29b and the measurement of injury related Disability Adjusted Life Years (DALYs). The Department of Health has signed up to the EU JAMIE project on behalf of the UK. The project “Prognostic Factors and Outcomes for Medical Emergency Admissions” which is funded by the Wellcome Trust, is investigating factors – such as week day of admission, hospital size and major services provided, and month and year of admission – that may affect outcomes following admission for various common emergency conditions in hospitals across England & Wales. The project involves utilising inpatient, mortality and GP data, the main outcome measures are mortality and readmissions, and the conditions being studied include acute MI, stroke, hip fracture, asthma and COPD.
282		Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
283		Bespoke Extract, HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
284		Bespoke Extract, HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
285		Bespoke Extract; ONS Mortality	Pseudonymised	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study.	
286	Monitor Group	Bespoke Extract, HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Our organisation will use this data to determine the secondary care clinical pathways for different cohorts of patients. These pathways will be developed by analysing relevant episode-level HES information such as diagnosis codes, procedure codes, and bed days to see how patients move through the system. Once we have identified the various pathways, we will perform statistical anlayses that will study topic areas such as similarities and differences between pathways or frequency of various pathways for different patient cohorts. We work with organisations (both NHS and suppliers to the NHS) that have the capabilities to improve the delivery of care to patients in terms of outcomes and cost effectiveness. Using our pathway analytics, organisations can determine where and how their assets, pathways, products and services can be most useful and also what additional innovations may be valuable in improving patient care. All of analysis will be conducted in England and the majority of the client organisations to whom we will present our insights will be based in England. However, we cannot guarantee that these organisations will not share final summary presentations based on HES data with other parts of their Global Organisations. Thus have selected 'worldwide' as our Territory of Use
287		Bespoke Extract, HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
288		Bespoke Extract, HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
289		Bespoke Extract, HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
290	Ernst & Young LLP	Bespoke Extract, HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used to help organisations understand their performance and to be used as a basis for scenario analysis for decision making purposes. The data will be analysed at aggregate level and will not be used for isolation or identification of individual patients
291		Bespoke Extract, HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
292		Bespoke Extract, HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
293		Bespoke Extract, HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
294	National Audit Office	Bespoke Extract, HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Study: National Audit Office value for money programme We are requesting the data to use for National Audit Office value for money reports on the NHS. We plan to use the data in our analysis in future studies including studies on demand management of emergency admissions and waiting times. We will be looking at the data to consider the value for money to the public purse achieved by specific areas of the NHS. This holds the Department accountable for services delivered and funds spent, and leads to potential cost savings or service improvements.
295		Bespoke Extract, HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
296		Bespoke Extract, HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
297		Bespoke Extract, HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
298		Bespoke Extract, SUS PBR APC Episodes	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
299		Bespoke Extract, SUS PBR APC Spells	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	
300	HMRC	GP Census data at individual level for all 4 Countries (England, Wales, Scotland and NI) supplied to HMRC to link to their Tax Return data to supply an annonymised aggregated Earnings data set back to HSCIC Workforce.	Identifiable	Non-Sensitive	The Health and Social Care Act 2012 places a duty, on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. In addition Information Governance is being reviewed as part of the wider Workforce Information Architecture programme of work in 2014 and improved where necessary with Fair Collection Notices in future.	GP Census data at individual level for all 4 Countries (England, Wales, Scotland and NI) supplied to HMRC to link to their Tax Return data to supply an annonymised aggregated Earnings data set back to HSCIC Workforce.
301		Dentist data at individual level for all 4 Countries (England, Wales, Scotland and NI) supplied to HMRC to link to their Tax Return data to supply an annonymised aggregated Earnings data set back to HSCIC Workforce.	Identifiable	Non-Sensitive	The Health and Social Care Act 2012 places a duty, on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. In addition Information Governance is being reviewed as part of the wider Workforce Information Architecture programme of work in 2014 and improved where necessary with Fair Collection Notices in future.	
302	NHIS Limited	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	NHiS is a provider of market intelligence and insight to the NHS and healthcare sector. NHiS has used the HSCIC's HES inpatient and outpatient data for over 5 years for internal research and external-facing client systems. The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity. Example outputs include an interactive system to use with the NHS to investigate trends in hospital activity, whether a patient has accessed diagnostic imaging services and any subsequent or preliminary usage of secondary mental health services. Data suppression is applied where appropriate in accordance with guidelines released by the HSCIC.

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
303	NHIS Limited	Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	NHiS is a provider of market intelligence and insight to the NHS and healthcare sector. NHiS has used the HSCIC's HES inpatient and outpatient data for over 5 years for internal research and external-facing client systems. The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity. Example outputs include an interactive system to use with the NHS to investigate trends in hospital activity, whether a patient has accessed diagnostic imaging services and any subsequent or preliminary usage of secondary mental health services. Data suppression is applied where appropriate in accordance with guidelines released by the HSCIC.
304	NHIS Limited	Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	NHiS is a provider of market intelligence and insight to the NHS and healthcare sector. NHiS has used the HSCIC's HES inpatient and outpatient data for over 5 years for internal research and external-facing client systems. The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity. Example outputs include an interactive system to use with the NHS to investigate trends in hospital activity, whether a patient has accessed diagnostic imaging services and any subsequent or preliminary usage of secondary mental health services. Data suppression is applied where appropriate in accordance with guidelines released by the HSCIC.
305	NHIS Limited	Bespoke Extract; HES Critical Care	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	NHiS is a provider of market intelligence and insight to the NHS and healthcare sector. NHiS has used the HSCIC's HES inpatient and outpatient data for over 5 years for internal research and external-facing client systems. The data will be incorporated, in conjunction with other healthcare-related data, in a range of tools and analyses to give online and tailored reports to allow our customers to understand and quantify NHS activity. Example outputs include an interactive system to use with the NHS to investigate trends in hospital activity, whether a patient has accessed diagnostic imaging services and any subsequent or preliminary usage of secondary mental health services. Data suppression is applied where appropriate in accordance with guidelines released by the HSCIC.
306	BUPA	Bespoke Extract; SUS PBR Episodes,Spells,Outpatient,A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To assist the NHS and Bupa Group companies in the UK to improve the quality of healthcare management and service delivery in England by benchmarking performance against national trends." This request is for the sensitive field Consultant code to be supplied in a HES monthly managed extract. The data is used to enable BUPA Health Dialog to analyse patterns of variation among consultants within a treatment specialty. Productivity measurements and benchmarking reports will then be produced and used to inform healthcare organisations that are working with BUPA to try to improve the quality of healthcare delivered to patients.
307	AQuA (NHS Organisation)	Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	AQuA intend to use the data internally for research and development purposes. Additionally it will be used by AQuA in the development, delivery and support of programmes and products across the public sector health and social care economy. AQuA will not profit from the provision of HES data to it's clients. To understand variations in mortality rates between our member organisations when compared to their peers, to +I benchmarks, To use quantitative analysis as a stimulation for discussion and deeper review of working practices within hospitals (and the wider health economy), in order to identify opportunities for improvement.

Row ID	Organisation Name	Type of Data Provided	Data provided to customer: Identifiable, Pseudonymised, Anonymised, aggregated-anonymised	Sensitive or Non-Sensitive	Legal Basis for Provision of Data	Purpose
308	University of Bristol	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We have built up a research database of all HES inpatient episodes since 1991/2, which contains some patient identifiers held under Section 251 approval. In discussion with the NIGB-ECC and HSCIC, we have taken the decision to work solely with non-identifiable non-sensitive data fields, using the pseudoanonymised HES ID to differentiate between patients. We have expunged our existing datasets with identifiers. Our request is to rebuild the database with a new encryption key and with non-identifiable, non-sensitive data only. We use this research database for a portfolio of academic research projects on the topic of 'patterns of hospital admissions in England.' Since 2005, we have used our existing HES database in approximately 40 peer-reviewed publications in high impact medical journals. Analyses vary from highlighting long waiting lists for elective care in English hospitals (www.bmj.com/content/326/7382/188.1) to studying the impact of SSRI prescribing on self-harm related admissions (www.bmj.com/content/336/7643/542). The research database is used exclusively by the staff of the School of Social & Community Medicine (SSCM) at the University of Bristol. We do not release it to other researchers or research organisations. All staff working with HES data understand the HES publication restrictions (in particular prevention of identification through suppressing small cell numbers in publication). SSCM is a leading centre for health services research and epidemiology in the UK and internationally. Access to the HES database will enable us to continue to conduct research evaluating the equality of access to NHS care and its effectiveness, safety and cost-effectiveness. By publishing this research we aim to improve NHS services and benefit future patients.
309	University of Edinburgh	Bespoke Extract; HES Inpatient	Pseudonymised	Sensitive	DAAG: 301012-aHealth and Social Care Act 2012	Our study aims to produce a map of “hotspots” of falls in the UK, and we anticipate doing this by: i) mapping falls across country to identify hotspots of localities with particularly high and low rates with a view to producing a series of national maps; ii) examining geographical variations across places and over time, differentiated by age, gender, urban and rural indicators, and socioeconomic status; and iii) identifying sources of information to locate the types of places where people fall over. Data on falls in the HES dataset will provide us with information around the type of fall, the place of occurrence and the patient output area. Analysis of this dataset will enable us to verify the variables that can be used to find “hot spots”. To better understand inequalities in falls, we will examine whether the geographical variability in outdoor falls is linked to area-level social deprivation (using the index of multiple deprivation) and urban/rural status. We will stratify by age and sex; and also examine whether these “hotspots” change over time (from 1996 to present day). This study is an audit for service improvement. We hope to identify a list of useful variables from appropriate datasets to enable us to produce national maps of falls, and measures of inequality over time. The list of variables will be used to generate further hypothesis for future study, and identify data gaps with an aim to push for better recording of outside fall data. The overall aim of our study is to shape effective environmental interventions that may lead to improved health and quality of life in older age while respecting the diverse capabilities and ‘personal projects’ of individuals.

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310	The Nuffield Trust	Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	1. Investigating the long term costs of chronic diseases - The aim is to describe patterns of hospital use and estimated cost of care for patients with selected conditions (e.g. chronic renal disease, COPD, diabetes) over time in England using routinely collected data. 2. Investigating the variations in the use of hospital care and costs at the end of life - Assuring quality care for people at the end of their lives is increasingly recognised as a priority for health and social care services across the world. The quality of "end of life" care is clearly important to patients, their carers and relatives. A particular concern is to reduce avoidable hospital care which can be expensive and often does not reflect the patient's preferred locus of care. The project will look at the patterns of hospital use and costs for people in the last 12 months of their lives and to gain a better understanding of variation in patterns of care, with a goal of identifying opportunities to improve quality and efficiency. It addresses difference related to several factors including age, gender, ethnicity, predominant hospital used, area of residence, cancer /non cancer, long term conditions/no long term conditions, place of death, cause of death. 3. Investigating the impact of community based Red Cross Care in the home on NHS hospital use - The aims is to use data linkage techniques to look at healthcare utilisation and associated costs for patients receiving Red Cross services in England, and compare their patterns of NHS care to a matched control group to ascertain whether Red Cross services led to significant reductions in hospital use and costs at the end of life.
311	University of Manchester	Bespoke Extract; HES Inpatient	Pseudonymised	Sensitive	PIAG 4-08(d)/2003 Health and Social Care Act 2012	HES data is needed to identify cases of Sudden Unexplained Death (SUD) among in-patients under mental health services. The aims of the SUDs project are to: 1) determine the number and rate of SUD in psychiatric in-patients in England and Wales, 2) conduct a detailed examination of circumstances leading up to SUD, and 3) carry out a national case-control study identifying independent risk factors for SUD.
312	University of Liverpool	Bespoke Tabulation; HES Outpatient	Aggregated - Small numbers suppressed	Non-Sensitive	Health and Social Care Act 2012	We have conducted a survey of recruitment experience of clinical teams involved in recruitment to a randomised controlled multicentre trial in children: the MAGNETIC trial. The MAGNETIC trial recruited from 30 sites across the UK and we have investigated the recruitment experience of clinical teams at all these sites. We are requesting data on the number of AE attendances of children <18 years at these sites (NHS Hospitals) to be able to calibrate the sites and look for correlation between recruitment performance and site specific responses.

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313	University of York	Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	The data will be used to support research into economic matters relating to health and health care provision. The HES data is essential to support a range of academic research projects funded by the Department of Health and other research councils such as the NIHR, MRC, ESRC etc. The HES data will be used to run internal and external training courses to facilitate the understanding and use of HES. How will the data be used: The data will be used to undertake statistical and econometric analysis to explain variations and test hypotheses relating to health care utilisation, patient outcomes and clinical practice. The data will be used to analyse the efficiency, effectiveness and equality of the health care system. We will quantify differences in health care utilisation, expenditure, morbidity and mortality over time, across geographic regions, health providers, and among different patient groups in order to evaluate the impacts of health care policy, organisation, finance and delivery of NHS services. The research will measure productivity in the delivery of health care nationally, sub-nationally and among hospitals. We will evaluate differences in the performance of hospitals in terms of the cost of provision and in patient outcomes including mortality and self-reported morbidity. We also investigate socio-economic inequality in the use healthcare and patient outcomes. The data will be used to analyse access to care, the market for health care, including choice of provider and competition and concentration of health care services across England. The research will encompass the different sectors of the health care system, looking at the effects of quality and access of primary care on patient use and outcomes in secondary care; and the relationship between long term care, social care and secondary care utilisation. What will be the outputs of your analysis: The research outputs will consist of peer reviewed papers in academic journals, research reports for funders and conference presentations. We will report aggregate results that show trends over time, differences across providers, commissioners, geographical areas and by patient subgroups and patients characteristics. Statistical results will be presented in tables of aggregate statistics summarising patient characteristics and will comply with ONS guidelines on disclosure of potentially patient identifiable data i.e. no small numbered cells and figures will be reported. The results will contain estimated correlations showing associations between patient outcomes and patient characteristics, hospital, institutional, geographic and environmental factors. The reports will contain maps at small area level but will not show point level data for individuals at low levels of granularity.

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314	University of York	Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	The data will be used to support research into economic matters relating to health and health care provision. The HES data is essential to support a range of academic research projects funded by the Department of Health and other research councils such as the NIHR, MRC, ESRC etc. The HES data will be used to run internal and external training courses to facilitate the understanding and use of HES. How will the data be used: The data will be used to undertake statistical and econometric analysis to explain variations and test hypotheses relating to health care utilisation, patient outcomes and clinical practice. The data will be used to analyse the efficiency, effectiveness and equality of the health care system. We will quantify differences in health care utilisation, expenditure, morbidity and mortality over time, across geographic regions, health providers, and among different patient groups in order to evaluate the impacts of health care policy, organisation, finance and delivery of NHS services. The research will measure productivity in the delivery of health care nationally, sub-nationally and among hospitals. We will evaluate differences in the performance of hospitals in terms of the cost of provision and in patient outcomes including mortality and self-reported morbidity. We also investigate socio-economic inequality in the use healthcare and patient outcomes. The data will be used to analyse access to care, the market for health care, including choice of provider and competition and concentration of health care services across England. The research will encompass the different sectors of the health care system, looking at the effects of quality and access of primary care on patient use and outcomes in secondary care; and the relationship between long term care, social care and secondary care utilisation. What will be the outputs of your analysis: The research outputs will consist of peer reviewed papers in academic journals, research reports for funders and conference presentations. We will report aggregate results that show trends over time, differences across providers, commissioners, geographical areas and by patient subgroups and patients characteristics. Statistical results will be presented in tables of aggregate statistics summarising patient characteristics and will comply with ONS guidelines on disclosure of potentially patient identifiable data i.e. no small numbered cells and figures will be reported. The results will contain estimated correlations showing associations between patient outcomes and patient characteristics, hospital, institutional, geographic and environmental factors. The reports will contain maps at small area level but will not show point level data for individuals at low levels of granularity.
315	Royal College of Surgeons	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	Data will be requested to ascertain case numbers and outcomes following AAA and Carotid procedures based on OPCS codes and admission mode. This will be required on a quarterly basis for all practising hospitals and trusts in England. The data needs to be provided in an unmasked format. The trust level data will be sent to the vascular lead and the clinical governance lead at each of the trusts in England. This will be done to identify the rates of data contribution to clinical audit through the National Vascular Database (NVD). This data will be provided on a quarterly basis, unmasked to the relevant individuals only. The information provided will not contain any patient identifiable information and will only be used for data validation purposes. The data will also be used in annual reports to inform the public about local data entry rate and patient outcomes.
316	London Cancer Alliance	Bespoke Extract; SUS PBR	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The HSCIC grants to Licensee a non-exclusive licence to use or re-use the data specified in section 3 above for the following purposes:To be used internally by our organisations for its own internal business purposes.Based on your SUS PbR Extract Application statement(above), The HSCIC grants to Licensee a non-exclusive licence to use or re-use the data specified in section 3 above for the following purposes:Use only within the Field and Territory as specified in this Agreement.Publishing the material in any medium, including featuring the information asset on websites which can be accessed via the Internet or via an internal electronic network or on an Intranet.Authorising users and subscribers who use the Licensee's electronic or digital products to access the material.Translating the information asset into another language or converting to Braille or other formats for people who are visually impaired

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317	University of Ulster	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	The aim of this project is to examine the geographical variation in rates of compulsory psychiatric admissions to hospital under the Mental Health Act across England during 2010/11. The outputs of this project will be in the form of: (1) a final report to be submitted to the NIHR HS&DR (late 2013); (2) several research papers to be submitted for publication in peer-reviewed academic journals; (3) research presentations at national and international academic conferences; and (4) presentation and discussion of findings with patients and NHS managers.
318	University of Edinburgh	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	We are undertaking a comprehensive evaluation of the association between smoke-free legislation and a range of perinatal and paediatric health outcomes in England, Scotland, Wales and the Netherlands. As part of this, using HES data we aim to investigate if incidence changes in paediatric hospitalisations for respiratory infections occurred following the introduction of smoke-free legislation in England on July 1st, 2007. Interrupted time series analyses will be performed on each of the outcomes, adjusting for potential confounders. Results will be presented in a scientific paper to be submitted to a leading peer-reviewed medical journal. Results from this project will inform the development and implementation of global policy and strategies to further reduce SHS exposure in a particularly vulnerable population.
319	Christchurch Court Limited	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data is being requested to assist research commissioned by the Christchurch Group. This research is on the incidence of brain injury in the UK, and is being carried out by Rachel Goodwin. The data will be used to promote the need for specialised rehabilitation centres in particular pcts, and will be reported in an academic report, with the aim of publication. The (2010/2011) data set will be broken into simplified tables, such as finished admissions in each pct of e.g. traumatic injuries, stroke etc, and figures within each age and gender bracket. The number of patients receiving treatment out of their pct of residence will also be noted.
320	Imperial College London	Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS mortality data approved by ONS Data Custodian under the Statistics and Registration Service Act 2007 sections 23 and 39 (4) (i). Approved Researcher accreditation granted for specific individuals for the purpose of this study and Microdata release panel approval for the study.	Comparison of hospitals' mortality rates for in-hospital deaths with rates for all deaths (to evaluate the effect of differential discharge policies). Calculation of total post operative mortality rates e.g. when comparing operative techniques such as laparoscopy and open approaches. Assessing potential quality of care issues by comparing the cause of death with the reasons(s) for admission, e.g. for surgical patients who are discharged within 30 days of the procedure but who die at home (was the death related to their disease process or to complications of treatment)?
321	Roche Products Limited	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Map referrals between primary and secondary care organisations and produce aggregated analysis of patient numbers and episodes at Trust and Hospital level.
322	Centre for Health Service Economics and Organisations (CHSEO)	Business Objects: PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	To Implement an NIHR project – “managing planned care”, the aim of which is to provide CCGs with information to assist them in moderating the growth of elective care whilst minimising the sacrifice the health gain.
323	University of East London	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	I have used the National Cataract Register for Sweden to develop a mathematical model which describes the relationship between changes in the size of the waiting list and changes in the length of wait. I would like to test the model using Hospital Episode Statistics. I will use the extract of records to produce aggregate counts of elective admissions falling within specified calendar periods and cohorts, and I propose to use these to examine the relationship within the 'national waiting list' for each of the main specialties. But I'd also like to be able to examine the waiting list for individual providers or diagnostic groups or procedure codes in case I think of a sub-group of one of the national waiting lists which might provide a more hostile test of the model. I plan to report the results of my analysis as an article in a scientific journal.

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324	Asthma UK	Bespoke Tabulation; HES Inpatient	Aggregated - Anonymised	Non-Sensitive	Health and Social Care Act 2012	To be used internally by our organisations for its own business purposes. To be incorporated in to a publication which will be subsequently distributed free of charge" “for clarity: in the Data-Reuse Statement section, where we refer to use in publications, we mean we will occasionally quote regional or national numbers derived from the data, not that we'll make the data itself available to anyone. The data will mostly be used to inform our own work but we are sometimes asked questions by external stakeholders about how one part of the country compares with another or with England as a whole. Once again, we never share the complete data with anyone, only totals derived from the data.”
325	Birth Choice UK	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	BirthChoiceUK provides information to pregnant women to help them choose where to have their baby by way of our website www.birthchoiceuk.com. Our purpose is to increase health literacy amongst pregnant women, improving their capacity for shared decision-making and access to appropriate maternity services, thereby increasing the quality of maternity care that they receive. As BirthChoiceUK is an unincorporated organisation with no capacity to enter into a contract, we ask that the contract is made with Rod Gibson Associates Ltd, a limited company wholly owned by Rod Gibson, data analyst with BirthChoiceUK. Both Miranda Dodwell and Rod Gibson hold ADLS (Administrative Dataset Liaison Service) Safe Researcher certificates. Although we are not requesting sensitive or identifiable data, we use secure processes, practices and technology for storage and access to the data. Both applicants are experienced users of HES maternity data, having worked with academic institutions in projects using the data. As in previous years we would like to use HES records to provide information to women giving birth in England which is not currently available from the Information Centre, for example, we produce 'normal delivery' rates according to the consensus definition of the Maternity Care Working Party, not currently calculated by the HSCIC. Data we produce from HES records will be displayed on our website identifying HSCIC as the source of the data and giving information about our methodology. Care will be taken to ensure we only publish non-disclosive data, both internally and when compared to other published maternity statistics in accordance with the HES small numbers policy. In addition, we may provide intervention rates stratified/adjusted by other factors such as maternal age range, risk, parity or ethnicity to provide more tailored information to pregnant women, and profile hospitals according to these factors where data quality allows and numbers are sufficiently large. We also plan to use HES data to provide other organisations with aggregated information about maternity services.
326	Dr Alison Leary - Independent Analyst on behalf of Multiple Sclerosis Trust	Bespoke Extract; HES A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	This is a service evaluation on behalf of the Multiple Sclerosis Trust. Since 2005 the MS Trust have supported a community nursing post. The nurse has put in place protocols to avoid unscheduled care in A&E and we are trying to evaluate this. This data will be used an anonymised form in a service evaluation document and possible academic publication.
327	Greenstreet Berman Limited	Bespoke Tabulation; HES A&E	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	We are completing an evaluation of a Home Safety promotion scheme. The scheme entailed volunteers visiting people with infants in their home, providing home safety advice and free home safety equipment such as stair gates. The evaluation is being completed at the level of local authorities. The scheme ran in some areas but not others. Therefore, we can compare changes in incident rates between areas that had and areas that did not have home safety visits. So we are requesting the data to enable an evaluation of the Home Safety scheme. Data on the number of A&E first attendances will be aggregated per local authority for each of 2008/09, 2009/10, 2010/11 and 2011/12. We have data on the number of home visits per local authority and the population per local authority, to calculate rates of incidents per million infants in each local authority per year. We will then compare the incident rates before the scheme was launched (2008/09 and 2009/10) against the year after the scheme was run (2011/12) to test changes between the before and after periods. This will entail descriptive statistics and an Analysis of Variance (ANOVA) test of the statistical significance of changes in incident rates. We can also compare the extent of change in incident rates to the rate of home safety visits across the local authorities that ran home safety visits. this will include correlation and regression

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						analysis of change in incident rates per local authority against rate of home visits.
328	Public Health England	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	These data will support PHE to: highlight where inequalities or threats to the public's health exist;assess health needs;support national surveillance programmes on healthcare associated infections, antibiotic resistance, surgical site infections, vaccine-preventable disease, vaccine safety, non-vaccine preventable invasive bacterial infections and invasive fungal infections;review the wider determinants of health;engage with local and national organisations to determine what health intelligence is required to help improve health;work in partnership with local and national agencies to deliver products that increase health intelligence;provide targeted analyses to decision makers identifying areas where preventative interventions or investment in secondary care is required to address risks to public health. These overarching aims will be achieved by the provision of intelligence which monitors health and disease trends and highlights areas for action; draws together information from different sources in new ways to improve health, looks ahead to give early warning of future public health problems and identifies gaps in health information.
329	Fletcher Spaght Inc.	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We are working with a private-sector client to better understand the patient population and procedures done for aortic valve disease. Our client is developing new treatments for aortic valve disease. The focus of our analysis is aortic insufficiency, but it is important to us to analyse those patients in the context of all aortic valve disease, also when other valves are affected. The etiologies are shifting, as are the procedures being done, and the picture is not clear based on published medical literature, so we would like to analyse detailed data ourselves. We will analyse data on patients operated on for aortic valve disease to understand the proportion with aortic insufficiency vs. aortic stenosis (AI vs. AS) and how treatment varies. We want to understand the numbers of surgical and interventional procedures by type (OPCS 4.6 code) for AI vs. AS. We will analyse related factors such as patient age, emergent vs. elective nature of cases, etc. The outputs of our analyses will be tables and graphs detailing the current surgical and interventional treatment of aortic valve disease by sub-diagnosis. They will support internal decision making by our client and are not intended for publication.

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330	Department of Health	Data Linkage and Bespoke Extract; PDS data linked to HES index	Pseudonymised	Non-Sensitive	Section 251 approval ECC: 3-02(FT2)/2011) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Data is made available under the UK Government Licensing Framework and release is compliant with the Data Protection Act 1998, The Information Commissioners Data Sharing Code of Practice and The HSCIC's A Guide to Confidentiality in Health and Social Care.	The Person Based Resource Allocation (PBRA) project requires linkage of information on hospital activity to a population based view of all people within a given area to be linked to the HESID Index. The output will be a pseudonymised extract provided to the Department of Health.
331	Otsuka Pharmaceuticals Limited	Bespoke Tabulation; HES Inpatient	Aggregated - Anonymised	Non-Sensitive	Health and Social Care Act 2012	This HES data will be used to populate a budget impact model developed by Otsuka Pharmaceuticals ltd to help the NHS plan for the introduction of their drug Samsca. This interactive excel based model will be provided to the NHS and allow local NHS policy makers/decision makers and budget holders to input local data to understand and plan for the impact of using this drug. The model will however be populated with default data which this HES data request will be used for. Accession healthcare has been commissioned to develop this model on behalf of Otsuka.
332	Northumberland, Tyne & Wear NHS Foundation Trust	Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	To enable a deeper analysis of PROMs data, in particular to determine whether the outcomes relate to primary or revision surgery for the orthopaedic procedures
333	Nuffield Trust	Bespoke Extract; ONS Mortality	Identifiable	Sensitive	ONS Data Controller approval under Section 42(4)	Evaluation of the Met Office Healthy Outlook service From the winter of 2007/08, the Met Office has run an information and advice service for patients with COPD, referred to as Health Outlook. At its core is a system for issuing automatic, interactive telephone alerts delivered direct to patients' homes during periods when the risk of exacerbation of COPD is assessed to be high on the basis of weather forecasts and infectious disease data. The aims of the study are to evaluate the Met Office COPD service, Health Outlook, in terms of its impact on health service use and costs.
334	Ernst and Young LLP	Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	We intend to use PROMS data to inform statistical research on the links between quality and cost so we can help NHS trusts deliver high quality safe services efficiently. The data will not be resold to any organisation. We will be using the data for work with our NHS clients only and will not be charging them a fee for access to the data. The basis of the fees will be on delivering actions indicated by the data only.
335	NHS England	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Flag HES data with specialised services identify using HSCIC prescribed services grouper and then aggregate data to CCG for presentation to others with NHS England.
336	Baxter Healthcare	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	Baxter BioSurgery sells biosurgical products used in surgical procedures in theatres. Our products are suitable for particular procedures only and in order for the sales team to assess where they should concentrate their efforts they are advised by marketing of hospitals where these particular procedures take place and the frequency/amount so that they can plan their time according to the greatest potential. Only 2 people in the marketing team will see the data requested. It will not be sold to anyone else or used by any other part of the organisation inside or outside the UK

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337	University of Oxford	Data Linkage and Bespoke Extract; HES Inpatient	Identifiable	Non-Sensitive	Section 251 approval PIAG 3-09(e)/2003 and PIAG 1-05(d)/2008) is in place for the flow of identifiable data to the HSCIC which is then linked before a pseudonymised output is returned to the customer. Health and Social Care Act 2012	The dataset will be used by a team of epidemiologists and statisticians in the Cancer Epidemiology Unit at the University of Oxford. The dataset received from HES will not be traded or distributed to other countries. EPIC-Oxford is a national prospective cohort study of health with a focus on vegetarians. The study is funded by Cancer Research UK and the Health and Safety Executive. The study involves 65,000 men and women who have given consent for follow-up through their medical records to examine how dietary and other lifestyle and biological factors affect their future health. We have published 3 papers using data from our previous HES extract (ET2682), see attachment 1. We wish to examine a wide range of disease groups including cancer diagnosis, cardiovascular disease, joint replacements and fractures. Our study has approval from Scotland A Research Ethics Committee (MREC 02/0/90), and conforms to ethical and legal guidelines regarding consent and confidentiality. Further information can be found on our website www.epic-oxford.org. The HES data will be used to examine the relationships between dietary, lifestyle and other potential risk factors and the incidence of a range of outcomes including cardiovascular disease, gastro-intestinal disorders, cancer, joint replacements and fractures. The results will be published in peer-reviewed scientific journals and thus contribute to knowledge of the epidemiology and aetiology of common diseases and other causes of hospital admissions.
338	University OF Southampton	Bespoke Tabulation; SUS PBR Inpatient Spells and Outpatient	Aggregated - Small numbers suppressed	Non-Sensitive	Health and Social Care Act 2012	The project aims to (i) update the cost of malnutrition in England by amalgamating data from the Information Centre with the prevalence of malnutrition established through national surveys by the British Association for Parenteral and Enteral Nutrition (ii) Economic evaluation of interventions to treat malnutrition based on the NICE costing document, involving a comparison of the current pathway of care with a proposed pathway of care.
339	Asthma UK	Bespoke Tabulation; HES Inpatient	Aggregated - Anonymised	Non-Sensitive	Health and Social Care Act 2012	To be used internally by our organisations for its own business purposes. To be incorporated in to a publication which will be subsequently distributed free of charge" “for clarity: in the Data-Reuse Statement section, where we refer to use in publications, we mean we will occasionally quote regional or national numbers derived from the data, not that we'll make the data itself available to anyone. The data will mostly be used to inform our own work but we are sometimes asked questions by external stakeholders about how one part of the country compares with another or with England as a whole. Once again, we never share the complete data with anyone, only totals derived from the data.”
340	EC Harris LLP	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	This data will be used by the healthcare planning team within EC Harris. We will not directly sell or trade the requested data. This data will be used as comparative data to benchmark client hospitals to inform healthcare related reports and for healthcare research. Data will be anonymised before sharing with clients. This data will not be used outside the UK, but data derived analysis may be referenced in international reports.

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341	University of Liverpool	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We are requesting these data in order to compute standardised illness (hospitalisation) rates for the 39 New Deal for Communities areas - and 39 comparator areas. The project, funded by the Policy Research Division in the Department of Health, will provide statistical analyses of the impact on health inequalities of the various NDC initiatives and should lead to recommendations for methods for improving health in areas of social deprivation. In order to aggregate these data to NDCs we will need an NDC area code on each record and will supply an ONS generated postcode to NDC look-up for this purpose. As we do not think this represents data linkage in the sense used in this form, we have not completed section 5. As NDC areas have average populations of 9000 and are larger than LSOAs (which are not a sensitive field), we do not think that adding this code will make cause the data to be classed as identifiable or sensitive. Since the only other geographical ID we are requesting is the local authority district code, there is no question of identifying smaller areas by difference. We are requesting these data because previous evaluations of the impact of the New Deal for Communities Policy on Health Inequalities have mainly relied on the four MORI surveys of 2002, 2004, 2006 and 2008 - which provide a small panel data set and four cross sectional data sets. For the purpose of analysing health inequalities, the survey data are limited in two ways: (1) they are based on a relatively small sample, which limits the ability to explore the health of sub-groups and, (2) the questions do not have a strong focus on health. The previous evaluation partly compensated for these limitations, by constructing several health indicators from administrative data, including four HES based standardised morbidity ratios for alcohol, drug, cancer and heart disease related admissions. These indicators, based on HES data, were only computed for years up to 2003. We want to extend this set of indicators by computing values for the years up to the of the NDC initiative (2011). We would also like to use the HES data to compute new broader standardised indicators of health if the above more specific indicators prove insufficiently robust. Outputs from the project will be: reports on the health impacts of NDCs; and tables of the indicator values (standardised rates) that can be used by the Department of Health and other researchers.
342	SSentif Intelligence	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We will analyse the data and produce indicators to be used for benchmarking purposes. The aggregated data we have created will then be available in our benchmarking system to subscribers to our online system.
343	Hspot Ltd	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Sensitive	DAAG: 310713-b Health and Social Care Act 2012	We provide an independent online health information service that pulls in validated health information from NHS and private health sources to help inform prospective patients and their carers. The website is called 'Findmehealth.com' and serves as a comparison website reporting on the quality, location and price of procedures by hospital and clinician. Data will be published on a patient use website to help inform clinician experience for a range of specific surgical procedures. Data will be published alongside hospital quality information from the Care Quality Commission and patient and clinician feedback Average number of procedures for specific OPCS groups undertaken by each GMC registered Consultant in the NHS on an annual basis averaged over the past 3 years. Consultants can be sorted by clinical experience by procedure by patients using the webservice. Consultant identifying codes (General Medical Council or GMC code) is used within our database to ensure accuracy of the data received from HSIC and other independent sources of information, including private hospitals where consultants may practice. In so doing we can provide patients with a comprehensive impression of the expertise by procedure and by consultant across NHS and Private sectors. This is particularly important for patients looking for cosmetic procedures which are seldom done in the NHS. No HSIC data will be published without the relevant consultant clinicians consent.

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344	Gore Medical	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	Data will be used by K Iqbal within WL Gore for health economics & reimbursement team activities. It may be shared with other health economic and reimbursement colleagues within WL Gore. It will be shared with Sales Leadership for the UK It will be used within the UK only and will not be sold or traded. The data will be used to understand which hospitals are carrying out aortic & thoracic procedures in NHS England, as currently we do not have a clear understanding of this issue. It will also be used for sales planning activities i.e. to assess whether we are making contact with the high volume NHS hospitals.
345	University of Leeds	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The HSCIC has a strategic partnership with the University of Leeds. One area of collaborative activity is MSc students undertaking dissertations with the HSCIC. This data application relates to an MSc Statistics project on HES Maternity data. The student will undertake a more in-depth analysis of this rich data source. The findings of the analysis will principally form part of the student's dissertation, however findings will also be of significant interest to the HSCIC and will help the organisation gain a greater insight into the data that it holds and publishes
346	Device Access UK Limited	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	This data will be used to identify and understand the activities in NHS hospitals for internal economic and market access activities.
347	Royal Surrey County Hospital NHS Foundation Trust	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We intend to use the data for internal NHS analysis to support better decision-making, service redesign and planning within our Trust.
348	Queen Mary University of London	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	We would like to know the proportion of singleton preterm births in England, in each of the Strategic health Authorities and in the NHS Trusts which were involved in our study. Particularly we would like the proportion of singleton preterm births (gestational age 20-36) in each financial year from 2009-2012. This data will allow us to compare preterm rates for women in the study with those in each study site, regionally and nationally. Additionally in order to know the birth coverage in our study we would like to know in which NHS trusts the births included in our the study were born. For this a number of births by NHS Trust will be sufficient.
349	SSentif Intelligence	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	We will analyse the data and produce indicators to be used for benchmarking purposes. The aggregated data we have created will then be available in our benchmarking system to subscribers to our online system.
350	University of York	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	This is an annual request for cardiac conditions which will be used to provide the denominator for the number of patients who should have received Cardiac Rehabilitation. This data will be reported by SHA in the 2013 National Audit of Cardiac Rehabilitation Annual report.
351	University College London	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	The National Heart Failure Audit collects data on the treatment and management of acute heart failure patients in England. The audit measures case ascertainment by comparing the number of records submitted to the audit, to the number of patients meeting the same criteria recorded by HES. This request is for aggregate data, which records the number of heart failure episodes at each NHS Trust in England over the course of the year. The data will be published in the 2012/13 audit annual report.
352	Prescribing Services Limited	Standard Monthly Extract Service; PbR APC Episodes, PbR APC Spells, PbR OP, PbR A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The aim of the project is to provide an online analytical system to medicines management personnel within CCGs which will combine the HES data extract with existing prescribing data to provide aggregated summarised reporting. The output will be delivered to CCGs through secure online access allowing full analysis of their prescribing costs and trends combined with the referral and admission costs.
353	Scottish Government	Bespoke Tabulation; HES Inpatient	Aggregated - Anonymised	Non-Sensitive	Health and Social Care Act 2012	This data will be used to help answer ministerial briefings.

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354	Asthma UK	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	We will use the data to confirm the existence of a seasonal peak in emergency admissions for asthma. We have acquired similar data for the other parts of the UK and previous published studies have confirmed it in England but those studies are now quite old. We have no plans to publish the data but we may quote numbers derived from them eg admissions in September are usually three times higher than in August.
355	Maxwell Stanley Consulting	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	For a number of projects, when analysing client organisation activity data, it is useful to compare certain indicators with a national benchmark to ascertain whether the client organisation is above or below average. The purpose for requesting the Inpatient data tailored summary table is to be able to include more up-to-date national benchmarking information than what is available on HES Online (currently 2011/12 summary data is available) The Inpatient data tailored summary table will be used to calculate a national benchmark for the proportion of activity coded 'with complications' compared to 'without complications' for each HRG pair where a split between 'with complications and 'without complications' exists. Client organisation activity data can then be compared with this to understand levels of complexity compared to the national benchmark The output that can be derived from the summary data table requested will be a national benchmark '% with complications' figure for each HRG pair. These figures can then be used where required as a comparison when analysing individual organisations activity data.
356	Northumberland, Tyne and Wear NHS Trust	Bespoke Extract; MHMDS	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be used to support the work of the National Mental Health Payment by Results Quality and Outcomes Workstream. Specifically, Mental Health Cluster data will be analysed to support the development of reports, quality indicators and CROMs supporting the objectives of this workstream. The output of the work will form the basis of a report that will be considered by the Department of Health Product Review Group and is then likely to be published on the Department of Health website and be used to determine national policy.
357	St Jude Medical UK Limited	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	The aim of this project (as with previous HES request (see prt.4)) is to try and identify trends in procedures within the English healthcare market. We are attempting to gain more insight into the volumes of different procedures in different parts of the country over time. The data will be used for comparative analysis to establish procedure trends for internal use within the company. It will also be used as an internal comparison with internal estimates for the procedural volume in England. The outputs of this project will be greater understanding of procedures in admitted patients in England over time with a view to better identifying & meeting hospitals' needs in terms of aiding patient care and supplying new supportive technologies. Physically the outputs will likely be mainly informative graphics showing geographic or specific procedural trends. These will be used internally to establish better understanding of the transitional healthcare market.
358	GPrX Data Ltd.	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To identify the number of patients hospitalised for Cushing Syndrome and the proportion of those that receive surgery by individual hospital provider in England.The data are to be used for internal purposes only to assess the number of patients treated and hospitalised for Cushing's syndrome and will not be published.

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359	London School of Economics and Political Science	Bespoke Extract; PROMS	Pseudonymised	Sensitive	Health and Social Care Act 2012	Research project 1 The impact of Independent Sector Treatment Centres (ISTCs) Authors: Zack Cooper, Stephen Gibbons and Matthew Skellern During the 2000s, the British government facilitated the establishment of dozens of Independent Sector Treatment Centres (ISTCs), privately owned and managed centres for the provision of common elective surgical and diagnostic procedures to NHS patients. This research project will seek to measure the effect that the entry of these centres into NHS markets had on quality, waiting times and patient reported outcomes at neighbouring trusts. Research project 2 Patient choice of hospital for elective surgery: effects on hospital quality, as measured by PROMs Author: Matthew Skellern In 2006, English NHS patients were allowed to choose which hospital they attended. The intention was that patients would take into account hospital quality when choosing where to have surgery, and that hospitals would be forced to compete for patients by increasing their quality of care. Two important econometric papers (Cooper et al. 2011; Gaynor et al. 2012), using AMI and total mortality as their outcome variables, found that introducing patient choice of hospital for elective surgery led to a substantial improvement in health care quality. This research project seeks to add to this literature by estimating the effect of introducing patient choice, using patient-reported outcome measures. This will be the first time that elective-surgery-specific outcome measures have been used to measure the effect on quality of introducing patient choice of hospital for elective surgery. Research project 3 Patient quality of outcomes across and within hospitals Authors: Alistair McGuire and Irene Papanicolas Hospital performance is increasingly being gauged in terms of hospital risk-adjusted mortality rates. These risk-adjustments, although based on individual patient records, tend to be crude. This project will seek to enhance and smooth such risk-adjusted rates by augmenting the risk-adjustment with information from within individual hospitals over time and across hospitals, as well as drawing on patient-reported outcome measures. A natural question to explore is whether within hospital quality is correlated across different treatments, and whether the variance in quality outcomes within hospitals is greater/smaller than the variance in quality outcomes across hospitals. This research will use HES and PROMS data to explore these questions.
360	Capita Business Services Ltd	Bespoke Extract; SUS PBR Episodes,Spells,Outpatients,A&E	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Data will be used by Capita to support the DH's PbR Data Assurance Framework. The framework targets the quality of the data used to underpin payments to acute trusts under PbR through clinical coding audits along with providing benchmarking indicators which are used to target these auditing activities as well as providing a source of information for wider use by PCT's and trusts. Capita will use the data supplied to them to create a number of indicators covering a wide range of quality factors relating to PbR. The indicators are used to produce two main products, a set of audit reports for each acute trust due to be audited, which are supplied to the trust ahead of their audit, and an online benchmarking tool which currently provides NHS organisations with online access to the data quality indicators for benchmarking and other analytical purposes. The data will support the selection of patient records to be used for conducting clinical coding audited of NHS organisations throughout England on an annual basis.
361	Synergus	Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To understand how different diagnosis are being treated with different interventions/ procedure. The intended use of the data is to understand current treatment patterns to help understand the potential utility for new technologies

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362	Asphalion SL	Bespoke Tabulation; HES Inpatient	Aggregated - Anonymised	Non-Sensitive	Health and Social Care Act 2012	TiGenix is a leading European cell therapy company responsible for developing and marketing one of the few approved cell-based medicinal product in Europe, and has an advanced clinical stage pipeline of adult stem cell programs. As part of this pipeline, TiGenix is currently developing a new mesenchymal stem cell-based product for the treatment of anal fistulas which are aberrant connections between the perianal part of the gastrointestinal tract and either the skin or other internal organs. Anal fistula remains an important challenge to gastroenterologists and surgeons, particularly in patients with Crohn's disease and new treatments are necessary. In order to seek marketing authorisation for this new cell-based product, TiGenix needs to develop a paediatric investigation plan (PIP) by demonstrating to the European Medicines Agency (EMA) the rarity and the severity of the condition in children and how this relates to the adult population. Most available data is from the USA or has not been recently updated. TiGenix currently has data from 2005 and 2006 from the UK on the incidence and frequency of anal fistula both in the general population (children and adults) and in Crohn's disease, but is now seeking an update to the most recently available data to support the PIP application. If approved the product will potentially provide a significant benefit to patients with this rare and severely debilitating condition
363	RedMed Consulting Ltd	Bespoke Tabulation; HES Inpatient	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	Purpose is not captured electronically. Tabulations provide customers with aggregate data, at various levels of aggregation. All customers are required to sign an agreement to abide by HSCIC terms and conditions. For example , where small numbers are supplied, customers must adhere to the HES Analysis Guide which strictly prohibits the release of small numbers meeting certain criteria, no persons other than those named can have permission to view such small numbers and the data should be suppressed accordingly before it is shared with any other parties.
364	Barts and the London School of Medicine and Dentistry	Bespoke Tabulation; HES Inpatient	Aggregated - Anonymised	Non-Sensitive	Health and Social Care Act 2012	Purpose is not captured electronically. Tabulations provide customers with aggregate data, at various levels of aggregation. All customers are required to sign an agreement to abide by HSCIC terms and conditions. For example , where small numbers are supplied, customers must adhere to the HES Analysis Guide which strictly prohibits the release of small numbers meeting certain criteria, no persons other than those named can have permission to view such small numbers and the data should be suppressed accordingly before it is shared with any other parties.
365	iCaps Health Ltd	Standard Monthly Extract Service; PbR APC Episodes, PbR APC Spells, PbR OP	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	iCaps Health aims to use this data to provide clinical commissioners with effective benchmarking information on the quality and cost of services in order to support patient choice and drive improvements in the quality and cost of services provided. The reason for requesting the data is to allow iCaps Health to provide clinical commissioners with national information in a way that is not readily available elsewhere. iCaps Health will use this data to calculate pathway costs for specific procedures as well as calculating waiting times and other useful information that will support GPs in facilitating choice for their patients. Non-identifiable data will be analysed, aggregated and shared with clinical commissioners via a secure web service to allow them to easily view and compare the quality and cost of procedure specific pathways. The output of the analysis will be a national comparison of specific clinical pathways that will support commissioners in making decisions about referrals. The final product will be a web based system which enables GPs to compare providers at a procedure level based on a rage of indicators including distance from the surgery, car parking charges, waiting times, infection rates and complete pathway cost. Providing this information, which is not readily available elsewhere, will allow clinical commissioners to make informed choices about referrals which, in turn, will improve quality, efficiency and drive down cost. Ultimately, the data will be used by iCaps Health to provide information to clinical commissioners in a new, innovative and engaging way to support patient choice and reduce costs. Clinical commissioners do not have easy access to waiting time and cost information at a procedure specific pathway level. Therefore, choice is currently based generic information at either a trust or specialty level. By providing information at a more granular, pathway based level, this analysis will allow clinical commissioners, GPs and patients to compare providers and make better informed choices about where to be treated.
366	Bristol City Council	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath - had a pilot user for HDIS hence earlier access
367	Cedar, Cardiff and Vale UHB	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath

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368	Central Midlands Commissioning Support Unit	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
369	Central Southern Commissioning Support Unit	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
370	Centre for Health Service Economics and Organisation	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
371	Cheshire West and Chester Council	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
372	Department for Transport	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
373	Department of Health	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath - had a pilot user for HDIS hence earlier access
374	Derby City Council	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
375	Greater East Midlands Commissioning Support Unit	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
376	Health Education East Midlands	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
377	Kingston Hospital NHS Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
378	Leeds Teaching Hospitals NHS Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
379	Newcastle upon Tyne Hospitals NHS Foundation Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
380	NHS England	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
381	NHS Improving Quality	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
382	NHS South Commissioning Support Unit	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
383	NHS Trust Development Authority	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath - had a pilot user for HDIS hence earlier access
384	NICE	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
385	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
386	Northumberland Tyne & Wear NHS Foundation Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
387	Nottingham University Hospitals	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
388	Public Health England	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath - had a pilot user for HDIS hence earlier access
389	Royal Borough of Greenwich	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
390	Royal Derby Hospital	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
391	Salford Royal NHS Foundation Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
392	St Helens & Knowsley Teaching Hospitals NHS Trust	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath
393	University Hospital of North Staffordshire	HES Data Interrogation System (HDIS)	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	To access and interrogate HES data for the purposes of work within Public Heath

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394	Southampton General Hospital	Medical Research Information Services; ONS Mortality	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC and for the release of ONS mortality data.	New EPOC: an open-label randomised trial, comparing OxMdG / IrMdG chemotherapy versus OxMdG / IrMdG chemotherapy plus cetuximab. Patients will be randomised at the start of chemotherapy to receive either: Arm A: OxMdG / IrMdG chemotherapy Arm B: OxMdG / IrMdG chemotherapy with cetuximab OxMdG: l-folinic acid (175 mg flat dose IV over 2 h) or d,l-folinic acid (350 mg flat dose IV over 2 h), concurrent administration of oxaliplatin (85 mg/m2 IV over 2 h) plus 5 minute bolus of 5FU (400 mg/m2) followed by a 46 h IV infusion of 5FU 2400 mg/m2 repeated every 2 weeks as used in the FOCUS trial Or IrMdG: irinotecan 180 mg/m2 IV over 30 minutes, l-folinic acid (175 mg flat dose IV over 2 h) or d,l-folinic acid (350 mg flat dose IV over 2 h) plus 5 minute bolus of 5FU (400 mg/m2) followed by a 46 h IV infusion of 5FU 2400 mg/m2 repeated every 2 weeks as used in the FOCUS trial in patients intolerant of Oxaliplatin. Cetuximab will be given as a fortnightly dose of 500 mg/m2 with OxMdG and IrMdG. Patients will receive 12 weeks of chemotherapy, undergo surgery and then complete a further 12 weeks of chemotherapy. The primary endpoint is progression-free survival. Secondary endpoints include pre-operative response rate, overall survival, quality of life and cost effectiveness.
395	University of Birmingham	Medical Research Information Services; ONS Mortality and Cancer	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC and for the release of ONS mortality data.	Primary objectives: To determine if endoluminal stenting for obstructing colonic cancers can result in: - Reduced perioperative morbidity as assessed by length of hospital stay - Reduced 30-day mortality Secondary objectives: To determine if endoluminal stenting for obstructing colonic cancers: - Reduces stoma formation - Improves quality of life - Increases ability to tolerate adjuvant chemotherapy - Has demonstrable benefits in the palliative and attempted curative settings - Improves overall survival
396	University of Oxford	Medical Research Information Services; ONS Mortality	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC. S42(4) and consent for the release of ONS mortality data.	The primary aim of PiPS is to test whether early probiotics reduce Necrotising Enterocolitis (NEC) and septicaemia which are common potentially lethal complications of prematurity with increased neurodevelopmental problems in survivors. PiPS is the first trial of probiotics in the newborn to be performed to GCP and as such presents a unique opportunity to address this issue. All surviving babies recruited into PiPS will be 'flagged' after discharge to confirm status using records held and maintained by the Health and Social Care Information Centre (HSCIC) and provided by the Medical Research Information Service (MRIS). MRIS will also verify a baby's name, area of residence, date of birth, date and cause of death. This will allow the trial team to contact the parents of infants who have participated in the trial with information about the trial (e.g. newsletters and notification of final results) and establish whether parents of deceased infants wish to continue receiving this information.

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397	Belfast Health and Social Care Trust	Medical Research Information Services; ONS Mortality (Fact of death)	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC. S42(4) and consent for the release of ONS mortality data.	The aim is to test the hypothesis that treatment with enteral simvastatin 80mg once daily for a maximum of 28 days will be of therapeutic value in patients with acute lung injury (ALI). The study has two distinct objectives: Objective 1: To conduct a prospective randomised, double-blind, placebo-controlled phase II multi-centre trial of simvastatin for the treatment of ALI. Objective 2: To study the biological effect of simvastatin treatment on: (2a) systemic markers of inflammation; (2b) systemic cell-specific indices of activation and injury to the alveolar epithelium and endothelium; (2c) lung extracellular matrix degradation; (2d) assess whether response to simvastatin is determined by genetic polymorphisms as well as link genotypic information to the phenotypic information recorded as part of this study.
398	University of Liverpool	Medical Research Information Services; ONS Mortality and Cancer	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC and for the release of ONS mortality data.	The overall aim of the trial is to provide data required for an informed decision about the introduction of population screening for lung cancer. This involves establishing the impact of screening on lung cancer mortality, determining the best screening strategy and assessing the physical and psychological consequences and the health economic implications of screening. A further objective is to create a resource for future improvements to screening strategies.
399	University of Glasgow	Medical Research Information Services; ONS Mortality and Cancer	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC and for the release of ONS mortality data.	The secondary objective of the study is to compare the gastrointestinal safety of celecoxib and traditional NSAIDs. The present proposal seeks to compare the cardiovascular and gastrointestinal safety and effectiveness of a strategy of initial randomisation to treatment with the selective COX-2 inhibitor celecoxib or to 'usual care' with their current non-selective NSAID therapy (with or without cyto-protection with ulcer healing drug use in either celecoxib or 'usual care' limbs).
400	Royal College of Physicians	Medical Research Information Services; ONS Mortality	Anonymised	Non-Sensitive	Section 251 approval ECC: 6-02 (FT3)/2012 to permit the receipt and processing of data by the HSCIC and S42(4) for the release of ONS mortality data. Health and Social Care Act 2012	Audit: Linkage of SSNAP patient records with MRIS death data, to determine patient outcomes (such as survival at 30 days, 6 months and 1 year post stroke), so that the quality of care delivered can be compared with the outcome for patients and linkage with HES data to identify readmissions and further strokes (again so that the quality of care can be compared with the outcome for patients) as well as the case ascertainment of audit participants (the proportion of their coded stroke patients which are recorded in the audit), which is important for contextualising the outcomes.
401	University of Manchester	Medical Research Information Services; ONS Mortality	Identifiable	Sensitive	Section 251 approval ECC: 7-05(g)/2011 to permit the receipt and processing of data by the HSCIC and S42(4) for the release of ONS mortality data.	Tarn is the national audit for trauma care across England and Wales and has been commissioned by the Department of Health to look at the long terms outcomes of injured patients.
402	University Hospital of Wales	Medical Research Information Services; ONS Mortality, Scottish Events	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC and for the release of ONS mortality data.	To assess the effect of adding dalteparin (FRAGMIN®) for 24 weeks to standard treatment (trial arm) compared to standard treatment alone (control arm) for patients with lung cancer.
403	University of Manchester	Medical Research Information Services; ONS Mortality and Cancer	Identifiable	Sensitive	Informed Patient Consent to permit the receipt and processing of data by the HSCIC and for the release of ONS mortality data.	To bench mark the short and long term of childhood-onset arthritis including; physical joint inflamation/damage, disability, growth, pain, uveitis; quality of life (education leisure/sports activities, psychological inpact; Treatment resonse/side affects; Co morbidity. To identify predictors of outcome of arthritis in children including; Socio demographic; Clinical; Psychological; Laboratory; Genetic factors; Treatment
404	Royal Brompton And Harefield NHS Trust	Medical Research Information Services; ONS Mortality	Identifiable	Sensitive	This audit is involving patients under the care of the clinical team. The Data Access Advisory Group have reviewed and approved the request for data. The legal basis for release of ONS mortality data is S42(4).	The aim of this audit is to explore the management and outcome in patients undergoing cardiac catherterization at our institution. We will look also into mortality, including cause of death.
405	Public Health England	Medical Research Information Services; List Cleaning	Identifiable	Sensitive	Regulation 3 of the Health Service (Control of Patient Information) Regulations 2002: (a) diagnosing communicable diseases and other risks to public health; (c) controlling and preventing the spread of such diseases and risks;	Access to the data is being requested to support the management of a national Level 3 public health incident dating back to the 1980s as a result of possible exposure during clinical procedures. An exercise has been undertaken to identify those at risk with a view to subsequently contacting and notifying them of their possible exposure. Access to HSCIC data is therefore being requested to facilitate contact (via General practitioners in the first instance to assess suitability for contacting).

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					(d) monitoring and managing	
406	Imperial College (Dr Foster Unit)	Secondary Uses Service Information. Patient-level, administrative records of healthcare activity.	Identifiable	Sensitive	Section 251 approval of the National Health Service Act 2006 and the Health Service (Control of Patient Information) Regulations 2002	Healthcare Research and Benchmarking
407	Public Health England (National Cancer Registration Service)	Patient level Diagnostic Imaging Dataset submission for specified patients based on NHS number and Date of Birth specified by the Cancer Registration Service	Identifiable	Sensitive	Section 251 approval of the National Health Service Act 2006 and the Health Service (Control of Patient Information) Regulations 2002 PIAG 03(a)/2001	To inform GP utilisation of diagnostic imaging tests, as part of the strategy to achieve earlier cancer diagnosis for English NHS patients set out in Improving Outcomes: A Strategy for Cancer (IOSC). To extend the information available for a cancer pathway, by linking data to Cancer Registry information To improve the data on frequency of x-ray exposure, as analysed by Public Health England To enable analysis of demographic and geographic variation in access to diagnostic imaging tests To provide data on the use of high-value equipment
408	Imperial College	Bespoke Extract; HES Outpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Please confirm the “Territory” that you wish to utilise the data in the end use of products or services supplied by you. – UKTo be used as part of a commercially funded research project"For sensitive data items; We will use the new HESID_Extract field to link date of death to the dataset. We would however, like to continue to hold DOB (date of birth) and NHS number. Increasingly our analyses are being used by NHS trusts and for validation purposes. We have been asked on numerous occasions to supply detailed information on cases back to the trusts (essentially giving their data back to them) to help validate our analyses and their own records. For this reason we also require HOMEADD, NEWNHSNO, DOB and LOPATID. We use HOMEADD to map admissions in light of ever changing administrative boundaries. We require DOBBABY as we have found that this is a useful field used to exclude poor quality data. We have found that Mothers' DOB is occasionally recorded in this field. We require CONSULT to feedback analyses by individual consultant and teams. Analyses by consultant would not be available to those outside the NHS. We require GPPRAC, REGGMP and REFERRER in order to feed analyses back to practices and PCTs on activity by practice. We also require Death Date to determine death rates which include out of hospital deaths."

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409	Royal College of Paediatrics and Child Health	Data Linkage and Bespoke Extract; HES Inpatient	Identifiable	Sensitive	Section 251 approval of the NHS Act 2006 granted by the Confidentiality Advisory Group (CAG) for this project which permits the processing of person confidential data and provision of the requested HES data by the HSCIC. CAG Ref: ECC: 2-03 (c) 2012. Confirmation received from CAG that Annual Review is in process.	The Royal College of Paediatrics and Child Health has been awarded funding by the Healthcare Quality Improvement Programme (HQIP) to carry out the paediatric component of the National Diabetes Audit, now called the National Paediatric Diabetes Audit (NPDA). The primary aims of this national audit are to facilitate health providers and commissioners to measure and improve quality of care and to contribute to the continuing improvement of outcomes for children and young people with diabetes and their families. This HES data is being requested in order to allow for report and trend analysis. The outputs of our analyses will take the form of a national annual report as well as individualised hospital level reports. Summary reports will also be produced for healthcare Commissioners and for laypeople. The patient information collected will inform the annual NPDA reports on 4 levels - profiles for individual hospitals comparing them to other hospitals or country as a whole; - profiles for NHS Trusts comprising of one or more hospitals comparing them to other trusts and country as a whole; - profiles for 10 geographical regions in England based on the regional networks and Wales as a whole comparing them amongst each other and with country as a whole - general country profile. The patient information will allow us to compare the care processes that are currently in place and the outcomes across the country and in turn will be able to help understand how care can be improved moving forward. By looking at the outliers the RCPCH and other stakeholders would be able to take steps towards the understanding of what drives the quality of care in children with diabetes. Overall the NPDA's purpose is to ensure policy and practice that will lead directly to improve patient outcome.
410	University of Oxford	Data Linkage and Bespoke Extract; HES Inpatient	Pseudonymised	Non-Sensitive	ECC: 8-02 (FT3)/2013 Understanding failure in Unicompartmental Knee Replacement - Linkage of HES/PROMs data to National Joint Registry data by the HSCIC trusted data linkage service. Health and Social Care Act 2012	We are requesting linkage of HES/PROMS data to an existing extract of NJR data which will be provided in an identifiable form to the HSCIC by HQIP. The applicant is conducting a study comparing total and unicompartmental knee replacement which will form part of his PhD and will be published in peer-reviewed journals. Outcomes of each procedure will be compared for matched patients; outcomes will include revision rate, mortality, functional outcome (PROMS), reoperation (aside from revision) and postoperative morbidity. HES/PROMS data is needed for three reasons: 1. To cross-check the data from the NJR extract. 2. To provide additional data for patient matching and stratification (eg Charlston index, IMD) 3. To provide additional outcome data (such as length of stay, readmission, reoperation details, and PROMS). The data will be linked using NHS number, date of birth and postcode. The Patient Identifiable data will be removed from the dataset prior to disclosure to the applicant and the identifiable data will be destroyed as soon as linkage is complete in accordance with the approval granted by the Ethics and Confidentiality Committee under the Health Service (Control of Patient Information) Regulations 2002.
411	Ssentif Ltd	Bespoke Extract, HES Inpatient	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	The data will be stored in a secure database which is only accessible by the named reciever of the data Stuart Lawton. We will analyse the data and produce indicators to be used for benchmarking purposes. The aggregated data we have created will then be available in our benchmarking system to subscribers to our online system
412	CHKS	HES/ONS Linked and SHMI derived fields	Identifiable	Non-Sensitive	Approval for ONS Mortality data up has been granted by the Office for National Statistics under the Statistics and Registration Service Act 2007 section 42(4) for the purposes of assisting the Secretary of State for Health or the Welsh Ministers in the performance of his or their functions in relation to the Health Service.	Commissioned by the Secretary of State for Health for 3rd party support of the Experimental Official Statistics, SHMI. SHMI record level data provided quarterly. For further details of the data provided, see Appendix B of Data Reuse Agreement

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413	Imperial College of Science, Technology and Medicine	HES/ONS Linked and SHMI derived fields	Identifiable	Non-Sensitive	Approval for ONS Mortality data up has been granted by the Office for National Statistics under the Statistics and Registration Service Act 2007 section 42(4) for the purposes of assisting the Secretary of State for Health or the Welsh Ministers in the performance of his or their functions in relation to the Health Service.	Commissioned by the Secretary of State for Health for 3rd party support of the Experimental Official Statistics, SHMI. SHMI record level data provided quarterly. For further details of the data provided, see Appendix B of Data Reuse Agreement
414	Central Manchester University Hospitals NHS Foundation Trust	HES and SHMI derived fields	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	One-off supply of SHMI record level data relating to Central Manchester University Hospitals NHS Foundation Trust only for quality assurance purposes.
415	Advancing Quality Alliance (AQuA)	SHMI	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	SHMI data provided quarterly at diagnosis group level required AQuA Mortality programme.
416	Methods Insight Analytics	SHMI	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	SHMI data provided quarterly at diagnosis group level required for the Acute Trust Dashboard, a freely available resource to the NHS and public featuring metrics on quality from various source in one place.
417	Bluespace Thinking Ltd	SHMI	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	One-off supply of SHMI aggregated level data for the research and evaluation of the SHMI methodology specifically to assess whether the SHMI results correlate with system variables related to age, deprivation of other parameters.
418	Registered Non-specialist acute trusts in England	HES and SHMI derived fields	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	SHMI record level data and 11 VLADs charts provided quarterly relating to own trust only. Recipient signs and returns declaration statement that they are duly authorised by their Caldicott Guardian to receive and share the data as required. As of 29th January 2014, there are 74 trusts registered to receive data from the SHMI Data Extract service.
419	Division of Epedemiology and Public Health - University of Nottingham	National Lung Cancer Audit data with ONS Death Date	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Research into lung cancer survival and use of active and palliative treatments
420	Division of Epedemiology and Public Health - University of Nottingham	National Lung Cancer Audit data with Radiotherapy Dataset	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Production of National Lung Cancer Audit report
421	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Peer Review Journals
422	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Peer Review Journals
423	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Peer Review Journals
424	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Peer Review Journals
425	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Peer Review Journals
426	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Peer Review Journals
427	Royal College of Surgeons - Clinical Effectiveness Unit	National Oesophogeal Cancer Data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Annual Reports
428	NAEDI - Cancer Research UK	National Lung Cancer Audit data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Production of report on early diagnosis of lung cancer
429	Royal College of Paediatrics and Child Health	Pauediatric Diabetes Audit data	Identifiable	Sensitive	Section 251 approval ECC: 2-03(c)/2012	Transfer of Paediatric Diabetes Audit Data
430	Royal College of Physicians	National Hip fracture database	Identifiable	Sensitive	Section 251 approval CAG 8-03(PR11)/2013	Transfer of Hip Fracture data
431	Royal College of Surgeons - Clinical Effectiveness Unit	Fracture Liaison Service Audit data	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Pilot of Fracture Liaison Service Audit

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432	University of York	National Cardiac Rehab database	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	Production of National Audit of Cardiac Rehabilitation (NACR) Audit report
433	Nuffield/Oxford University	2003-2012 individual level GP workforce census data	Identifiable	Non-Sensitive	The Health and Social Care Act 2012 places a duty, on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. In addition Information Governance is being reviewed as part of the wider Workforce Information Architecture programme of work in 2014 and improved where necessary with Fair Collection Notices in future.	The data will be used for academic research
434	Cambridge University	Extracts of individual level GP workforce census data	Identifiable	Non-Sensitive	The Health and Social Care Act 2012 places a duty, on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. In addition Information Governance is being reviewed as part of the wider Workforce Information Architecture programme of work in 2014 and improved where necessary with Fair Collection Notices in future.	The data will be used for academic research
435	Centre for Workforce Intelligence (CfWI)	Extracts of Individual level employee data from the medical/non-medical Census	Identifiable	Sensitive	Informed employee consent via the NHS contract and a Fair Collection Notice which sets out the basis of extracting data from Electronic Staff Record (ESR) into the ESR Data Warehouse and which sort of organisations may be granted access to it which was sent by the central ESR team to all ESR organisations for sending to staff when ESR was launched.	Analysis of the English NHS workforce, commissioned by DH to undertake commissions for DH, HEE and PHE
436	Oxford University	Bespoke extract of Medical and dental/ GP data	Identifiable	Non-Sensitive	Informed employee consent via the NHS contract and a Fair Collection Notice which sets out the basis of extracting data from Electronic Staff Record (ESR) into the ESR Data Warehouse and which sort of organisations may be granted access to it which was sent by the central ESR team to all ESR organisations for sending to staff when ESR was launched.	Part of a continuing cohort study of doctors
437	General Medical Council	Limited set of 3000 records Medical and Dental workforce records from the ESR with no sensitive data items included – however DoB, Gender and Payscale were included to determine their benefit to aid data linkage and the business case (although Gender (and Payscale to a lesser extent) are in the public domain) for a proof of concept	Identifiable	Non-Sensitive	Informed employee consent via the NHS contract and a Fair Collection Notice which sets out the basis of extracting data from Electronic Staff Record (ESR) into the ESR Data Warehouse and which sort of organisations may be granted access to it which was sent by the central ESR team to all ESR organisations for sending to staff when ESR was launched.	A proof of concept was undertaken in association with HEE and the GMC (NHS family?), whereby a limited set of 3000 individual level ESR records of Doctors were shared with a single named individual at the GMC to undertake a linkage operation with the GMC available datasets to determine if a more informative dataset could be provided for workforce planning purposes. The majority of data provided was no more personally identifiable than what was already considered to be in the public domain (with the exception of DoB to aid data linkage) and no sensitive data items were included in the data extract. The aim of the proof of concept was to determine if some data items that had been provided needed to be removed or if the perceived benefits of the linkage could be shown, this would support additional data items being added for greater known benefits and support the case for the project in its entirety.
438	University of Oxford	KC53, KC61 and KC65 data on cervical screening. KC62 and KC63 data on breast screening	Aggregated - Small numbers not suppressed	Non-Sensitive	Data are not patient identifiable but there are some small numbers.	Detailed evaluation of the breast and cervical screening programme performance for dissemination to NHS regional Quality Assurance Directors, radiologists and screening programme staff and for the publication of original research with the aim of improving programme performance.
439	Department of Health	Bespoke Tablulation, ONS births data	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	To calculate the CCG benchmarking data. Maternities - number of maternities, quarterly and annually by individual CCG broken down by Communal establishment code. Live births - number of live births, quarterly and annually by individual CCG.
440	Chartered Institute of Public Finance and Accountancy	Aggregate adult social care experndiure and unit costs data (PSS-EX1) for 2012-13 at council-level, unrounded and without	Aggregated - Small numbers not suppressed	Non-Sensitive	Health and Social Care Act 2012	CIPFA used to run the PSS-EX1 collection and have always received the data from us for publication on their website.

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		supression of small numbers.				
441	NHS England - CSUs, CCGs	Data linkage and processing for Risk Stratification via DSCROs	Pseudonymised or Identifiable, in line with CAG approval	Sensitive	CAG 7-04(1)/2013, HSCIC acting as Data Processor	Risk Stratification
442	NHS England - CSUs, CCGs	Data linkage and processing for Accredited Safe Havens via DSCROs	Pseudonymised or Identifiable, in line with CAG approval	Sensitive	CAG 2-03(a)/2013, CAG 7-07(a)	Accredited Safe Haven for commissioning purposes
443	NHS England - CSUs, CCGs	Data linkage and processing for Invoice Validation via DSCROs	Identifiable	Sensitive	CAG 7-07(b)/2013, CAG 7-07(c)/2013	Invoice Validation within CSU/CCG Controlled Environment for Finance
444	NHS England - CSUs, CCGs, NHS England	Data for Patient Consented processing via DSCROs	Identifiable	Sensitive	Explicit Patient Consent	Patient consented activities e.g. Care package approvals; Integrated Care Pioneer programmes
445	NHS England - CSUs, CCGs, PHE, LAPH	Data linkage and processing for Commissioning via DSCROs	Anonymised or Pseudonymised	Sensitive	Directions from NHS England for Data Services for Commissioners	Commissioning activities of: Validation of provider invoices; Pandemic emergency planning; Monitoring and audit; Provider performance management; Strategic delivery planning; Immunisation monitoring
446	NHS England - CSUs, CCGs	Data linkage and processing for Commissioning: SUS (via DSCROs)	Identifiable	Sensitive	PIAG 2-05 (b)/2007	Commissioning activities of: Validation of provider invoices; Pandemic emergency planning; Monitoring and audit; Provider performance management; Strategic delivery planning; Immunisation monitoring
447	University Hospitals Birmingham	HES/ONS Linked and SHMI derived fields	Identifiable	Non-Sensitive	Approval for ONS Mortality data up has been granted by the Office for National Statistics under the Statistics and Registration Service Act 2007 section 42(4) for the purposes of assisting the Secretary of State for Health or the Welsh Ministers in the performance of his or their functions in relation to the Health Service.	Commissioned by the Secretary of State for Health for 3rd party support of the Experimental Official Statistics, SHMI. SHMI record level data provided quarterly. For further details of the data provided, see Appendix B of Data Reuse Agreement
448	Dr Foster Intelligence	HES/ONS Linked and SHMI derived fields	Identifiable	Non-Sensitive	Approval for ONS Mortality data up has been granted by the Office for National Statistics under the Statistics and Registration Service Act 2007 section 42(4) for the purposes of assisting the Secretary of State for Health or the Welsh Ministers in the performance of his or their functions in relation to the Health Service.	Commissioned by the Secretary of State for Health for 3rd party support of the Experimental Official Statistics, SHMI. SHMI record level data provided quarterly. For further details of the data provided, see Appendix B of Data Reuse Agreement
449	parallel	SHMI	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	SHMI data provided quarterly at diagnosis group level to 3rd party publisher.
450	NHS England	SHMI	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	SHMI data at diagnosis group level for the 14 trusts being identified for further investigation for the Mortality Review requested by Sir Bruce Keogh following the Francis Inquiry 2013.
451	Atchai	SHMI	Pseudonymised	Non-Sensitive	Health and Social Care Act 2012	SHMI data at diagnosis group level provided for upload and testing on new Indicator Portal i.e. development cycle of the CI Replacement Project with Atchai
452	NHS England	IAPT	Pseudonymised	Sensitive	Health and Social Care Act 2012	The data will be used as part of the IAPT PbR extended pilot (April 2013 to March 2014) for which NHS England has additional analysis requirements to support PbR.
453	CQC	Learning Disabilities Census	Identifiable	Non-Sensitive	The Health and Social Care Act 2008 gives CQC specific powers to to obtain and use information to carry out their regulatory functions	The Winterbourne View Hospital failure for patient care and the subsequent publication of a detailed analysis of the entirety of the Count me In Census data held by the Care Quality Commission led to the learning disability census being reinstated for 2013/014 and 2014/15 until the data is collected routinely as part of the MHLDDS, with one year parallel running. We are developing a surveillance model for mental health, learning disability and autism services. The data from the LD Census is vital to help us deliver that now for the impending inspection programme. We collectively need to be aware that the data will have information where patients are now in very vulnerable situations in some services and we may need to be taking precipitant action immediately. We should be in no doubt that there will be individual patients in

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						circumstances that require immediate response to avoid them being made more vulnerable for any longer than necessary.
454	Public Health England	Learning Disabilities Census	Pseudonymised	Sensitive	Health and Social Care Act 2012	Further analysis to inform the Public Health England agenda in preparation for a final summary report for the Winterbourne View Joint Improvement Programme. The data is required to contribute to feedback meetings for service providers who contributed to the Learning Disabilities Census dataset. The requirement for legal status data is to look at the relationship between formal powers to detain people and the nature of accommodation in which they are held.
455	NHS England	Learning Disabilities Census	Identifiable	Non-Sensitive	Section 251 granted	Following the Winterbourne View scandal, one of the key deliverables through the concordat is a review of all learning disability patients in the system in inpatient care by running a Learning Disabilities Count Me In Census. The results of the Survey were published on 13th December 2013. Following this NHS England needs to assure that: a. ensure no individuals who were in-patients, as at 30 September 2013, (source LD census), have been excluded from registers or case management by the triangulation of the data collection exercise with commissioners; and b. that reporting to the public on progress following Winterbourne View is accurate and reliable This data will support NHS England to respond to concerns on assurance on progress raised with us by people with learning disabilities their families and carers. It will enable NHS England to achieve the outcomes as outlined above.
456	Department of Health	Aggregate adult social care expenditure and unit costs data (PSS-EX1) for 2012-13 at council-level	Aggregate - Small numbers not suppressed	Non-sensitive	Health and Social Care Act 2012	The data is being shared so DH can provide data to ONS for the National Accounts. This task was previously carried out by HSCIC analysts but was set as priority 3 during the priority setting exercise in 2010/11 and therefore the HSCIC will no longer be carrying out this work. The rounded data have all been published before but DH need to provide unrounded data to ONS. The product will be a spreadsheet of England level activity and expenditure data which will be shared with ONS. This exercise is completed by Government Departments and coordinated by ONS each year. The aim is to provide information to measure government's outputs and productivity which follows the Atkinson Review published in January 2005. Please note that similar data was provided in 2011 and 2012, as covered by Data Sharing Agreement refs IC351DS and IC423DS respectively.
457	Care Performance Partners Limited (CaPP)	Aggregate data at council level from adult social care collections. The survey from adult social care user and carers surveys have data at response level.	Aggregate - Small numbers not suppressed	Non-sensitive	Health and Social Care Act 2012	They will use it to prepare a Narrative of Progress report for Towards Excellence in Adult Social Care (TEASC) Board. This report, to be published in July 2013 (on or after the date the HSCIC publishes provisional data), will incorporate selected findings from the analysed data with other sources of evidence to assess the progress towards improvements made in 2012-13 and to highlight areas for further work. The report will not identify individual councils but will provide a national overview and identify significant regional variations in performance. The focus of the report will be on the outcomes for people who use services and carers. They will also use it to prepare analysis for councils for their own performance management purposes. Early access to the analysed data will assist those who commission services to take action in 2013, and to plan ahead for 2014-15.
458	Personal Social Service Research Unit (PSSRU)	Individual level survey data from the Adult Social Care User Survey conducted by councils	Anonymised	Non-sensitive	Health and Social Care Act 2012	Detailed analysis of the annual user survey data for DH related projects.
459	Personal Social Service Research Unit (PSSRU)	Individual level survey data from the Adult Social Care Carers Survey conducted by councils	Anonymised	Non-sensitive	Health and Social Care Act 2012	Every 2 years a Personal Social Services User Experience Survey of Carers is conducted by 152 Councils with Adult Social Service Responsibilities (CASSR's) in England and previously has been undertaken once in 2009 by 90 CASSRs on a voluntary basis. In 2012-13 this survey will be asking for the views of carers of adults (aged 18 and over) receiving social services funded fully or in part by Councils with Adult Social Services Responsibilities. PSSRU will analyse this data in more detail.

Care Bill (HC Bill 168)

PART 3 continued **CHAPTER 2** continued

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(7) The reference in subsection (6) to the old Health Research Authority is a reference to the Special Health Authority called the Health Research Authority (and abolished by section 108).

114 Establishment by the HRA

(1) The HRA may establish research ethics committees which have the following functions—

(a) approving research of the kind referred to in section 112(1);

(b) giving such other approvals as enactments require.

(2) The HRA must ensure that a research ethics committee established under this section complies with the requirements set out in the REC policy document.

(3) The HRA may abolish a research ethics committee established under this section.

115 Membership of the United Kingdom Ethics Committee Authority

In regulation 5 of the Medicines for Human Use (Clinical Trials) Regulations 2004 (S.I. 2004/1031S.I. 2004/1031) (United Kingdom Ethics Committee Authority)—

(a) in paragraphs (1), (2) and (3), for "the Secretary of State for Health", in each place it appears, substitute "the Health Research Authority", and

(b) in paragraph (2), for "the Secretary of State" substitute "the Health Research Authority".

Patient information

116 Approval for processing confidential patient information

(1) The Health Service (Control of Patient Information) Regulations 2002 (S.I. 2002/1438) are amended as follows.

(2) In regulation 5 (the title to which becomes "Approval for processing information")—

(a) the existing text becomes paragraph (1), and

(b) in sub-paragraph (a) of that paragraph, for "both the Secretary of State and a research ethics committee" substitute "the Health Research Authority".

(3) After paragraph (1) of that regulation insert—

"(2) The Health Research Authority may not give an approval under paragraph (1)(a) unless a research ethics committee has approved the medical research concerned."

(4) After paragraph (2) of that regulation insert—

"(3) The Health Research Authority shall put in place and operate a system for reviewing decisions it makes under paragraph (1)(a)."

(5) In regulation 6 (registration requirements in relation to information), in paragraph (1)—

(a) before "the Secretary of State" insert "the Health Research Authority or", and

(b) before "he" insert "it or".

(6) In paragraph (2)(d) of that regulation, before "the Secretary of State" insert "the Health Research Authority or (as the case may be)".

(7) In paragraph (3) of that regulation, for the words from the beginning to "in the register" substitute "The Health Research Authority shall retain the particulars of each entry it records in the register, and the Secretary of State shall retain the particulars of each entry he records in the register,".

(8) For paragraph (4) of that regulation substitute—

"(4) The Health Research Authority shall, in such manner and to such extent as it considers appropriate, publish entries it records in the register; and the Secretary of State shall, in such manner and to such extent as he considers appropriate, publish entries he records in the register."

CHAPTER 3

CHAPTERS 1 AND 2: SUPPLEMENTARY

Miscellaneous

117 Transfer orders

(1) An order under section 95 (establishment of Health Education England) or section 108 (establishment of the Health Research Authority) (a "transfer order") may make provision for rights and liabilities relating to an individual's contract of employment.

(2) A transfer order may, in particular, make provision the same as or similar to provision in the Transfer of Undertakings (Protection of Employment) Regulations 2006 (S.I. 2006/246S.I. 2006/246).

(3) A transfer order may provide for the transfer of property, rights or liabilities—

(a) whether or not they would otherwise be capable of being transferred;

(b) irrespective of any requirement for consent that would otherwise apply.

(4) A transfer order may create rights, or impose liabilities, in relation to property, rights or liabilities transferred.

(5) A transfer order may provide for things done by or in relation to the transferor for the purposes of or in connection with anything transferred to be—

(a) treated as done by or in relation to the transferee or its employees;

(b) continued by or in relation to the transferee or its employees.

(6) A transfer order may in particular make provision about continuation of legal proceedings.

General

118 Chapters 1 and 2: interpretation and supplementary provision

(1) For the purposes of Chapters 1 and 2

, an expression in the first column of the following table is defined or otherwise explained by the provision of this Act specified in the second column.

Expression	*Provision*
Appointment criteria	Section 103
Commissioner of health services	Section 104
Devolved authority	Section 124
Devolved legislature	Section 124
Direct or direction	Subsection (2) below
Enactment	Section 124
Financial year	Section 124
Health care workers	Section 96
Health research	Section 109
The health service	Section 124
Health services	Section 98
HEE	Section 95
The HRA	Section 108
LETB	Section 102
Social care research	Section 109

(2) A power under Chapter 1 or 2 to give a direction—

(a) includes a power to vary or revoke the direction by a subsequent direction, and

(b) must be exercised by giving the direction in question in writing.

(3) The amendments made by sections 115 and 116 and Schedule 8 to provisions of subordinate legislation do not affect the power to make further subordinate legislation amending or revoking the amended provisions.

CHAPTER 4

TRUST SPECIAL ADMINISTRATION

119 Powers of administrator etc.

(1) In section 65O of the National Health Service Act 2006 (Chapter 5A of Part 2:

interpretation) (the existing text of which becomes subsection (1)) at the end insert—

"(2) The references in this Chapter to taking action in relation to an NHS trust include a reference to taking action, including in relation to another NHS trust or an NHS foundation trust, which is necessary for and consequential on action taken in relation to that NHS trust.

(3) The references in this Chapter to taking action in relation to an NHS foundation trust include a reference to taking action, including in relation to another NHS foundation trust or an NHS trust, which is necessary for and consequential on action taken in relation to that NHS foundation trust."

(2) In section 65F of that Act (administrator's draft report), in subsection (1), for "45 working days" substitute "65 working days".

(3) After subsection (2C) of that section insert—

"(2D) Where the administrator recommends taking action in relation to another NHS foundation trust or an NHS trust, the references in subsection (2A) to a commissioner also include a reference to a person to which the other NHS foundation trust or the NHS trust provides

services under this Act that would be affected by the action."

(4) After subsection (7) of that section insert—

"(8) Where the administrator recommends taking action in relation to another NHS foundation trust or an NHS trust, the references in subsection (5) to a commissioner also include a reference to a person to which the other NHS foundation trust or the NHS trust provides services under this Act that would be affected by the action."

(5) In section 65G of that Act (consultation plan), in subsection (2), for "30 working days" substitute "40 working days".

(6) After subsection (6) of that section insert—

"(7) Where the administrator recommends taking action in relation to another NHS foundation trust or an NHS trust, the references in subsection (4) to a commissioner also include a reference to a person to which the other NHS foundation trust or the NHS trust provides services under this Act that would be affected by the action."

(7) In section 65H of that Act (consultation requirements), in subsection (4)—

(a) after "trust special administrator must" insert "—

(a)", and

(b) at the end insert ", and

(b) in the case of each affected trust, hold at least one meeting to seek responses from staff of the trust and from such persons as the trust special administrator may recognise as representing staff of the trust."

(8) In subsection (7) of that section, after paragraph (b) (but before paragraph (ba) inserted by section 84(10)(a) of this Act) insert—

"(bza) any affected trust;

(bzb) any person to which an affected trust provides goods or services under this Act that would be affected by the action recommended in the draft report;".

(9) In subsection (9) of that section—

(a) after "trust special administrator must" insert "—

(a)",

(b) after "subsection (7)(b)," (but before the insertion made by section 84(10)(b) of this Act) insert "(bzb),", and

(c) at the end insert ", and

(b) hold at least one meeting to seek responses from representatives of each of the trusts from which the administrator must request a written response under subsection (7)(bza)."

(10) After subsection (11) of that section, insert—

"(11A) In this section, "affected trust" means—

(a) where the trust in question is an NHS trust, another NHS trust, or an NHS foundation trust, which provides goods or services under this Act that would be affected by the action recommended in the draft report;

(b) where the trust in question is an NHS foundation trust, another NHS foundation trust, or an NHS trust, which provides services under this Act that would be affected by the action recommended in the draft report.".

(11) In subsection (12)(a) of that section, after "subsection (7)(b)", insert "and (bzb)".

(12) In section 65N of that Act (guidance), after subsection (1) insert—

"(1A) It must, in so far as it applies to NHS trusts, include guidance about—

(a) seeking the support of commissioners for an administrator's recommendation;

(b) involving the Board in relation to finalising an administrator's report or draft report."

(13) In section 13Q of that Act (public involvement and consultation by NHS Commissioning Board), at the end insert—

"(4) This section does not require the Board to make arrangements in relation to matters to which a trust special administrator's report or

draft report under section 65F or 65I relates before the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be)."

(14) In section 14Z2 of that Act (public involvement and consultation by clinical commissioning groups), at the end insert—

"(7) This section does not require a clinical commissioning group to make arrangements in relation to matters to which a trust special administrator's report or draft report under section 65F or 65I relates before the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be)."

(15) In section 242 of that Act (public involvement and consultation by NHS trusts and foundation trusts), in subsection (6)—

(a) for "65I, 65R or 65U" substitute "or 65I", and

(b) for the words from "the decision" to the end substitute "the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be)."

(16) In Schedule 14 to the Health and Social Care Act 2012 (abolition of NHS trusts in England: consequential amendments)—

(a) after paragraph 4 insert—

"4A In section 13Q(4) (public involvement and consultation by Board), omit "makes a decision under section 65K(1),".

4B In section 14Z2 (public involvement and consultation by clinical commissioning groups), omit "makes a decision under section 65K(1),".",

(b) in paragraph 15, after sub-paragraph (3) insert—

"(3A) In subsection (2D), omit "or an NHS trust" and "or the NHS trust.",

(c) in that paragraph, after sub-paragraph (7) insert—

"(8) Omit subsection (8).",

(d) in paragraph 16 (the text of which becomes sub-paragraph (1)) at the end insert—

"(2) In subsection (7) of that section, omit "or an NHS trust" and "or the NHS trust".",

(e) in paragraph 17, in sub-paragraph (2)(a), for "paragraph (b)" substitute "paragraphs (b) and (bzb)",

(f) in that paragraph, after sub-paragraph (4) insert—

"(4A) In subsection (11A)—

(a) omit paragraph (a), and

(b) in paragraph (b), omit "where the trust in question is an NHS foundation trust," and ", or an NHS trust,".",

(g) in paragraph 24, after sub-paragraph (2) insert—

"(2A) Omit subsection (1A).",

(h) after that paragraph insert—

"24A In section 65O (interpretation)—

(a) omit subsection (2), and

(b) in subsection (3), omit "or an NHS trust".", and

(i) in paragraph 35, omit the "and" preceding paragraph (d) and after that paragraph insert ", and

(e) in subsection (6), omit "makes a decision under section 65K(1),"."

PART 4

INTEGRATION FUND

120 Integration of care and support with health services etc: integration fund

(1) At the end of section 223B of the National Health Service Act 2006 (funding of the National Health Service Commissioning Board) insert—

"(6) Where the mandate specifies objectives relating to service integration, the requirements that may be specified under section 13A(2)(b) include such requirements relating to the use by the Board of an amount of the sums paid to it under this section as the Secretary of State considers it necessary or expedient to impose.

(7) The amount referred to in subsection (6)—

(a) is to be determined in such manner as the Secretary of State considers appropriate, and

(b) must be specified in the mandate.

(8) The reference in subsection (6) to service integration is a reference to the integration of the provision of health services with the provision of health-related services or social care services, as referred to in sections 13N and 14Z1."

(2) After section 223G of that Act (meeting expenditure of clinical commissioning groups out of public funds) insert—

"**223GA Expenditure on integration**

(1) Where the mandate includes a requirement in reliance on section 223B(6) (requirements relating to use by the Board of an amount paid to the Board where mandate specifies service integration objectives), the Board may direct a clinical commissioning group that an amount (a "designated amount") of the sums paid to the group under section 223G is to be used for purposes relating to service integration.

(2) The designated amount is to be determined—

(a) where the mandate includes a requirement (in reliance on section 223B(6)) that designated amounts are to be determined by the Board in a manner specified in the mandate, in that manner;

(b) in any other case, in such manner as the Board considers appropriate.

(3) The conditions under section 223G(7) subject to which the payment of a designated amount is made must include a condition that the group transfers the amount into one or more funds ("pooled funds") established under arrangements under section 75(2)(a) ("pooling arrangements").

(4) The conditions may also include—

(a) conditions relating to the preparation and agreement by the group and each local authority and other clinical commissioning group that is party to the pooling arrangements of a plan for how to use the designated amount (a "spending plan");

(b) conditions relating to the approval of a spending plan by the Board;

(c) conditions relating to the inclusion of performance objectives in a spending plan;

(d) conditions relating to the meeting of any performance objectives included in a spending plan or specified by the Board.

(5) Where a condition subject to which the payment of a designated amount is made is not met, the Board may—

(a) withhold the payment (in so far as it has not been made);

(b) recover the payment (in so far as it has been made);

(c) direct the clinical commissioning group as to the use of the designated amount for purposes relating to service integration or for making payments under section 256.

(6) Where the Board withholds or recovers a payment under subsection (5)(a) or (b)—

(a) it may use the amount for purposes consistent with such objectives and requirements relating to service integration as are specified in the mandate, and

(b) in so far as the exercise of the power under paragraph (a) involves making a payment to a different clinical commissioning group or some other person, the making of the payment is subject to such conditions as the Board may determine.

(7) The requirements that may be specified in the mandate in reliance on section 223B(6) include requirements to consult the Secretary of State or other specified persons before exercising a power under subsection (5) or (6).

(8) The power under subsection (5)(b) to recover a payment may be exercised in a financial year after the one in respect of which the payment was made.

(9) The payments that may be made out of a pooled fund into which a designated amount is transferred include payments to a local authority which is not party to the pooling arrangements in question in connection with the exercise of its functions under Part 1 of the Housing Grants, Construction and Regeneration Act 1996 (disabilities facilities grants).

(10) In exercising a power under this section, the Board must have regard to the extent to which there is a need for the provision of each of the following—

(a) health services (see subsection (12)),

(b) health-related services (within the meaning given in section 14Z1), and

(c) social care services (within the meaning given in that section).

(11) A reference in this section to service integration is a reference to the integration of the provision of health services with the provision of health-related services or social care services, as referred to in sections 13N and 14Z1.

(12) "Health services" means services provided as part of the health service in England.".

PART 5
GENERAL

121 Power to make consequential provision

(1) The Secretary of State may by order make provision in consequence of a provision of this Act.

(2) An order under this section may amend, repeal, revoke or otherwise modify an enactment.

(3) The power conferred by this section is not restricted by any other provision of this Act.

(4) A saving or a transitional or transitory provision in an order under this section by virtue of section 123(7) may, in particular, modify the application of a provision made by the order pending the commencement of—

(a) another provision of the order,

(b) a provision of this Act, or

(c) any other enactment.

(5) Before making an order under this section that contains provision which is within the legislative competence of a devolved legislature, the Secretary of State must consult the relevant devolved authority.

(6) A reference to an enactment includes a reference to an enactment passed or made after the passing of this Act.

122 Power to make transitional etc. provision

(1) The Secretary of State may by order make transitional, transitory or saving provision in connection with the commencement of a provision of this Act.

(2) An order under this section may modify the application of a provision of this Act pending the commencement of—

(a) another provision of this Act, or

(b) any other enactment (including one passed or made after the passing of this Act).

123 Regulations and orders

(1) A power to make regulations under this Act is exercisable by the Secretary of State.

(2) Regulations and orders under this Act must be made by statutory instrument.

(3) Subject to subsections (4) and (5), a statutory instrument containing regulations or an order under this Act is subject to annulment in pursuance of a resolution of either House of Parliament.

(4) A statutory instrument which contains (whether alone or with other provision) any of the following may not be made unless a draft of the instrument has been laid before, and approved by a resolution of, each House of Parliament—

(a) regulations under section 13(7) (the eligibility criteria);

(b) regulations under section 15(4) (the cap on care costs) other than those made in discharge of the duty under section 16(1);

(c) the first regulations under section 15(8) (the amount attributable to an adult's daily living costs);

(d) regulations under section 22(2)(b) (services or facilities which a local authority may not provide or arrange);

(e) regulations under section 35(9) or 36(3) (deferred payment agreements and loans and alternative financial arrangements) which include provision that amends or repeals a provision of an Act of Parliament;

(f) the first regulations under section 52(12) (meaning of references to business failure);

(g) the first regulations under section 53(1) (criteria for application of market oversight regime);

(h) the first regulations under section 53(4) (disapplication of market oversight regime in particular cases);

(i) the first regulations under section 62(2) (exercise of power to meet child's carer's needs for support);

(j) an order under section 78(9) (delegation of local authority functions);

(k) regulations under section 91 (offence of supplying etc false or misleading information);

(l) an order under section 121 (consequential provision) which includes provision that amends or repeals a provision of an Act of Parliament;

(m) regulations under paragraph 17 of Schedule 7 (fees chargeable by the HRA).

(5) Subsection (3) does not apply to—

(a) an order under section 95 (transfer order to new HEE);

(b) an order under section 108 (transfer order to new HRA);

(c) an order under section 122 (transitional etc. provision);

(d) an order under section 125 (commencement).

(6) A power to make regulations or an order under this Act—

(a) may be exercised for all cases to which the power applies, for those cases subject to specified exceptions, or for any specified cases or descriptions of case,

(b) may be exercised so as to make, for the cases for which it is exercised—

(i) the full provision to which the power applies or any less provision (whether by way of exception or otherwise);

(ii) the same provision for all cases for which the power is exercised, or different provision for different cases or different descriptions of case, or different provision as respects the same case or description of case for different purposes of this Act;

(iii) any such provision either unconditionally or subject to specified conditions, and

(c) may, in particular, make different provision for different areas.

(7) A power to make regulations or an order under this Act (other than the power

to make an order under section 122 or 125) includes —

(a) power to make incidental, supplementary, consequential, saving, transitional or transitory provision, and

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Royal College of Nursing

Beyond breaking point?

A survey report of RCN members on health, wellbeing and stress

Acknowledgements

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To provide feedback on the contents of this publication or on your experience of using it, please email publications.feedback@rcn.org.uk

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Executive summary and recommendations

Executive summary

The RCN regularly surveys its membership on many aspects of their working lives; their pay and rewards, workloads, training and development and how they feel about their job. Recent surveys have indicated worryingly high and increasing levels of stress among the nursing workforce who are dealing with heavy workloads, the impact of targets and the challenge of being asked to do more with fewer resources. Our *At breaking point survey* in 2005 was the last time we asked our membership specifically about stress in the workforce; this latest survey reveals what, if anything, has changed.

This *Beyond breaking point* 2012 survey of 2,008 RCN members working across the NHS, GP practice, the private sector, voluntary sector, universities and other public bodies examines the factors influencing health, wellbeing and stress, including management and peer support, sickness absence policies, bullying and harassment and occupational health service provision. It also details recommendations for UK governments, health departments, regulators, managers and union representatives to take forward in the promotion of health and wellbeing in the workplace.

HSE management standards

The Health and Safety Executive's (HSE's) stress indicator tool provided the starting point for the 2012 RCN membership survey. Part of the HSE's management standards for work-related stress, the tool enables the measurement of stress against six primary stressors: demands, control, role, management support, peer support and change. As in 2005, the demands of the job and experience of change represent the biggest stress factors for nursing staff, but lower scores relating to work stressors indicate that things have significantly deteriorated in the intervening years since our previous survey.

The 2012 survey findings paint a picture of a nursing workforce struggling with both high workloads and the fast pace of work, while feeling unsupported and detached from the changes being implemented within their workplace. Respondents report working long hours, combined with unrealistic time pressures and unachievable deadlines.

Respondents are, however, much more confident about their own roles and how they fit with wider organisational objectives. While this is a welcome finding, jobs must also be rewarding and well designed. Ever increasing demands and workloads and uncertainties about organisational change will only negate any efforts to improve staff health and wellbeing.

Faced with work pressures, it is essential that staff motivation and engagement are developed and improved in order to support the workforce's contribution to delivering better and effective patient care. This must include creating a healthy workplace; it is essential to improving productivity, staff motivation, ensuring quality patient care and improving patient outcomes.

Healthy workplaces only come about through high quality employment practices and procedures that promote work-life balance, dignity at work, health and safety, and good job design where employees have autonomy, control and task discretion, access to training and development and fair pay and rewards.

Stress in the workplace

We heard from nursing staff that they face a wide range of issues that get in the way of being able to provide the high level of care they wish to. As well as heavy workloads and staff shortages, nursing staff are often fatigued by shift working and very few manage to get the number or length of breaks they need. Others feel that pressure to do more and more work is testing their ability to their job well and some even feel pressured to work beyond their scope. Frustrations also come from paperwork, targets and a lack of resources such as equipment and IT.

Support from managers and team mates is important and most appreciate a simple 'thank you' or 'well done', while senior nurses get the 'middle management squeeze' and often feel under pressure from higher levels of managers as well as their team members.

Nursing staff across all sectors are worried about job security and cuts to terms and conditions and many are anxious about recent perceived challenges to the image of nursing and questions about levels of compassion in nursing.

We also heard from many respondents that they feel patient demands are increasing and that this can even mean verbal or physical violence. Meanwhile, bullying and harassment in the workplace is becoming a problem and is often seen as an indicator of organisational culture.

Recommendation – safe staffing levels

The RCN is clear that good nursing care starts with safe staffing levels. Insufficient staffing results in increased pressure, stress, burnout, lower job satisfaction and a greater inclination to leave among the workforce. A downward spiral often follows as morale declines and sickness absence increases, leaving fewer staff available to work and creating even more pressure on existing staff.

RCN members tell us that workload and safe staffing levels are the most pressing problems they face on a daily basis. Yet despite the evidence linking staff levels to patient outcomes, there has been a failure to act.

The RCN is clear that the time has come to for providers, regulators and commissioners of services to set clearly defined standards and adopt mandatory staffing levels. The RCN is committed to working with governments, health departments and key stakeholders on developing and implementing staffing level recommendations.

Recommendation – shift working

A high proportion of nursing staff are working long hours without sufficient rest breaks. This can lead to exhaustion and fatigue and damages health and wellbeing. Employers have a duty to implement safe shift patterns compliant with the Working Time Regulations, and the RCN calls on employers and regulators to pay attention to the impact of working hours on health and wellbeing, and the importance of rest breaks.

There is a need for more research evidence to understand the impact of shift working on patient safety. In particular, the RCN believes more research is needed on the differential impact of working long (12 hour) shifts which are planned; working long hours through back to back shifts, overtime or additional jobs; and shorter shifts.

Recommendation – workplace stress risk assessments

The Management of Health and Safety at Work Regulations 1999 set out duties on organisations to carry out suitable and sufficient risk assessments on workplace stress. The HSE's management standards (available at www.hse.org.uk) provide a framework for organisations to use to prevent and reduce the risks of the work-related causes of stress. The RCN calls on all health care organisations to use the HSE framework to support staff and identify and manage sources of stress, including all NHS staff surveys, and for the HSE framework to be regularly updated so that it continues to be an effective benchmark in the measurement and management of stress.

The RCN would like to see the HSE take a robust approach to organisations that fail to meet the legal requirement to assess and manage the risk of work-related stress. In such cases, we call on the HSE to take enforcement action. Stress can damage individual health and wellbeing, team relationships and ultimately affect patient care.

Recommendation – staff engagement and consultation

Staff are anxious about the level of change and the lack of consultation and communication about changes made in their workplace. Poor staff engagement is linked to increased absenteeism, presenteeism, lower levels of performance and productivity. Health and social care organisations should consult and involve staff and trade unions around the management of change. In addition, they should also engage and consult with RCN and other trade union safety representatives to identify and address the possible health and safety impacts of any planned changes.

Presenteeism

In any work setting there are obvious risks to employees being at work when they are unfit or unwell – including risks to health and safety and to productivity. In a health care setting such risks become even more acute as these will impact heavily on patients, service users and their families. The pressure for nursing staff to attend work when unfit or unwell is often self-directed, as they are aware of the impact of being away from work on colleagues and patients/service users.

This survey found that in the previous 12 months the majority of nursing staff (82 per cent) had gone to work despite feeling ill and that presenteeism is widespread, regardless of where respondents worked or their job title. Many respondents told us that stringent use of sickness

absence policies was placing undue pressure on staff to attend work when unwell or unfit, and to return to work before they are ready. A description often used about the sickness management process was 'intimidating.' In addition, many nursing staff are fearful that poor absence records may be used against them when decisions about future staffing levels are made in relation to organisational change.

Respondents often feel they let down colleagues and patients/service users if they take sick leave. All too aware of tight staffing levels in their teams or departments, nursing staff are reluctant to be away from work even when they are ill or unfit. In some cases RCN members told us they were made to feel guilty by managers or colleagues if they were away from work through illness.

Recommendation – presenteeism

Presenteeism should be given full recognition as a health and wellbeing issue; it can lead to negative health and wellbeing outcomes for staff and can impact on patient outcomes, particularly if staff members are infectious or suffer from fatigue. Staff surveys and other tools should be used to identify 'hot spots' of presenteeism and explore trends and drivers. We also urge organisations to follow the Acas guidance on absence and attendance management at work which states that 'it is important to create a culture where people are able to inform their employer that they are unwell and take the necessary time off to recover.'

Working life and wellbeing

A third (30 per cent) of respondents reported that work *often* or *always* has a negative impact on their health and wellbeing, with half stating it *sometimes* has an impact. Nursing can be a physically demanding job, with high levels of musculoskeletal stress and a high risk of infection. It can also be mentally demanding, thanks to the need to be constantly 'on the ball', as well as emotionally draining.

Work stressors and hazards can have an impact on health outcomes. Around half of the survey respondents stated they have felt unwell due to stress (55 per cent) or workload (46 per cent) over the previous 12 months, while a third (32 per cent) said they had felt unwell due to relationships with co-workers. One in nine (11.5 per cent) had been injured by moving and handling, and four per cent had experienced needlestick injuries.

Recommendation – managing sickness absence

Effective management practices can reduce sickness absence. This includes the consistent use of appraisals, a supportive approach to staff and fast access to care and support.

Recommendation – staff with disabilities and long-term conditions

The survey identified a number of difficulties encountered by staff with long-term health conditions and disabilities in managing their working life. Some problems are associated with punitive approaches to sickness absence management and it is therefore important that organisations are mindful of the Equality Act 2010 in relation to disabled employees and make appropriate adjustments to support employment.

The Equality Act states that it is against the law for employers to discriminate against anyone because of a disability, and that employers have to make 'reasonable adjustments' to avoid employees being put at a disadvantage compared to non-disabled people in the workplace. This could include adjusting working hours or providing a special piece of equipment to help people undertake their job.

Note: The RCN runs a Peer Support service for injured, ill and disabled RCN members to share experiences and knowledge. It is a membership group for members affected by physical or psychological injury, ill health or disability – whether work-related or not. The group exists to assist members in making connections with peers to give and receive support.

Recommendation – mental health

A growing proportion of the working population have mental health conditions, highlighting the need for support and appropriate adjustments within the workplace. Health and social care organisations should be exemplar employers in this area; by demonstrating healthy work environments and successful employment policies they can then convince others to do the same.

Recommendation – emotional support

Nursing staff are vulnerable to burnout but opportunities to talk through difficult issues can help. Formal supervision, mentorship or peer support can help staff cope with the emotional experiences and demands of the nursing work environment. It is important that employers and nursing staff themselves recognise the impact of emotional work.

Recommendation – older workers

Older workers form a large part of the nursing workforce and a high physical workload means any reduced physical capacity can be a problem. Older workers should be supported with full risk assessments to evaluate individual differences between workers in terms of their capacities and health, and the redesign of work tasks to suit older workers – for example, through the reduction of physical workloads, or regular short breaks through the working day. Since the normal retirement age for all workers is set to increase and may be extended even further, it is vital that age-appropriate plans are put in place now in order to avoid difficulties in the future.

Recommendation – physical hazards

Significant numbers of the nursing workforce continue to be exposed to risks from moving and handling activities, needlestick/sharps injuries, slips, trips and falls and exposure to harmful substances which could lead to dermatitis or asthma. Organisations must follow the appropriate legal frameworks to ensure risks are managed.

Bullying, harassment and violence

Over the previous year well over half (56 per cent) of respondents have experienced verbal or physical violence from patients or service users and almost half (48 per cent) have done so from relatives of patients/service users. Around a fifth of respondents stated that they had experienced bullying from either a manager (23 per cent) or colleague (21 per cent).

Physical and verbal violence from patients, service users or their relatives is almost expected, especially in such settings as dementia care. While a significant proportion of respondents stated that they received good support from their managers and had been provided with training, others feel let down as physical or verbal violence is accepted as the norm.

RCN members described incidents of both overt bullying within their workplace, such as arguments and rudeness, and covert bullying which can include more subtle cases of excluding and ignoring people and their contribution, unacceptable criticisms and overloading people with work.

Many respondents referred to corporate bullying within their organisation, where bullying has become entrenched in the culture. This is often described as linked to organisational change, as well as an increased emphasis on performance within tight budgetary constraints.

Others described their inability to perform their job to the standard they would wish to achieve and their frustrations in a perceived lack of support from their managers. In many cases, nursing staff equated this to a form of bullying.

Responses from senior nurses, matron and sisters reveal the extent of pressure they feel from all sides – from members of their team and senior managers. This middle management squeeze can mean anxiety about passing on the pressure they feel from senior managers on to the members of their teams. We also heard about anxieties around managing bullying by colleagues within the team they lead or even feeling personally bullied by their team.

Recommendation – violence and aggression

Violence and aggression should never be seen as part of the job for health and social care workers. The RCN regularly works with employers to ensure robust risk assessments are in place to address the underlying causes of violence and aggression, and has developed a tool to address risks and identify necessary changes to the physical environment, safe staffing levels and training.

In cases where staff are assaulted at work, we call on employers to fully support staff; this support should include effective liaison with the police. In turn, staff must be encouraged to report all instances of physical and verbal abuse, even where it is not appropriate to prosecute an individual with limited or no capacity.

Recommendation – bullying and harassment

The RCN endorses an active approach to reducing bullying and harassment to encourage 'a workplace culture in which everybody treats their colleagues with dignity and respect, and where all steps are taken to minimise the occurrence of bullying and harassment' (RCN, 2005a).

The RCN calls on all health and social care organisations to ensure they regularly carry out suitable and sufficient risk assessments on workplace stress, as directed by the Management of Health and Safety at Work Regulations 1999. The HSE management standards provide a framework for health care organisations to use to prevent and reduce the risk of the work-related causes of stress.

Bullying and harassment – black and minority ethnic nurses

A higher proportion of BME respondents reported having experienced bullying from managers and colleagues than white respondents. The research also revealed how some

BME nurses feel that they are not given support in career progression and in some cases feel marginalised among their own teams.

Recommendation – black and minority ethnic nurses

The RCN calls for improved data collection on the employment experience of BME nursing staff as a basis for effective action and support, as well as investment in development and training which pays particular consideration to the needs of BME staff.

Occupational health

The majority (86 per cent) of respondents stated they have access to services at work, yet just over half (54 per cent) felt confident these would be helpful. In addition, just under two-thirds (61 per cent) said that they could access occupational health (OH) services without a referral.

Where good quality services are provided these are evidently valued by RCN members, particularly when they can easily access local services. However, many described difficulties in accessing OH services either due to long waiting lists, services being in inconvenient locations or a lack of information on services provided. In some cases respondents stated that their employer offered no OH services at all.

Several described how they were unable to refer themselves to OH services, but had to go through their line manager. In some cases members did not feel they could ask their manager for help, while in others they were actively blocked from accessing services by the manager. Other concerns were expressed relating to a perception that services are not confidential and in some cases that using occupational health would be used against them.

Recommendation – occupational health services

The reduction of working-age ill health can only be achieved through adequate resourcing of OH services; employers should ensure that they implement proactive measures and do not simply engage in attendance management and reactive services. Staff must be reassured that their use of OH services is confidential and independent of undue influence from employers.

The RCN supports the implementation of SEQOH – or Safe Effective Quality Occupational Health Service (www.seqohs.org) – standards and a process of voluntary accreditation. Investment in good OH support, which is valued by staff, will contribute to patient outcomes through its role in supporting the health of staff.

Health and social care staff should be able to self refer to OH services. Self referral provides an opportunity for staff to commence early interventions, as well as protecting confidentiality and promoting trust in OH services. And above all, it sends a clear message that staff are valued.

The RCN calls for the universal implementation of early intervention programmes for the nursing workforce. These programmes which allow prompt access to treatment and rehabilitation services ensure that staff absence (and time away from patient care) is minimised and the risk of conditions such as musculoskeletal disorders developing into long-term conditions is reduced.

Pre-registration students

The research looked at the experience of pre-registration students on placement, which forms a major part of nursing courses. Student retention has been an issue for concern for many years, and since placements made up around half of the course, a positive experience for students can often make the difference to whether they leave or stay and whether they develop compassionate practice. While placements are vital for allowing students to develop clinical and interpersonal skills, organisational cultures within the workplace can also be highly influential in affecting both the quality of the placement, and learned behaviours of the students. It is important therefore that these cultures do not undermine efforts to provide high-quality learning experiences for the next generation of nurses.

Recommendations – students

The RCN calls for improvements to the quality of many practice learning experiences so that students are supported in learning to care in real-life settings. Employers and universities must together identify positive practice environments in a wide range of settings, including community settings. We also call on employers to that ensure mentors have dedicated time for mentorship, and that universities actively train and update mentors.

Conclusions

The 2012 survey findings highlight the high levels of stress among the nursing workforce. Stress can be a causal factor for health problems, physical injuries, psychological effects

and burnout. In addition to the high personal toll, stress is a major cause of both sickness absence and presenteeism and affects the ability of workers to be effective.

The survey reveals that the main causes of stress are high workloads, long hours, unrealistic expectations, lack of job control, conflicting roles, bullying and violence, poor working relationships and a lack of engagement in workplace change. Addressing these problems is an obvious way to improve nurses' working experience, and in turn improve the safety and quality of care for patients.

Issues of workload, stress and working life are, however, often symptomatic of systemic organisational problems. Poor work environments and working relationships damage the ability of nursing staff to provide safe care and there is a direct correlation between job satisfaction and patient satisfaction.

Nursing staff concerned about their inability to meet their professional standards of care must be able to raise their concerns in a safe and protected way.

The Francis Inquiry into care at the Mid Staffordshire Foundation Trust reinforced the importance of an open culture which enables concerns to be raised and disclosed freely without fear, and for questions to be answered. While this inquiry raises acute questions about whistle blowing and the importance of preventing and eliminating wrongdoing at work, the RCN believes that nursing staff should also be able to raise concerns about the issues raised in this survey – workload, staffing levels, bullying, violence and working relationships.

Raising concerns

It is essential that organisations put in place effective mechanisms to enable staff to raise concerns on issues such as staffing levels and pressure of work, particularly when these get in the way of delivering patient care. Health and social care organisations should have policies in place outlining the processes to follow when raising concerns.

RCN members can also draw on resources for members and RCN representatives on raising concerns; RCN workplace representatives can play an important role in supporting members in raising concerns and highlight issues to management. The RCN guidance encourages its members to raise matters or issues and ask the RCN to discuss and decide if these should be considered as a concern that requires a collective response. By raising concerns early, before there is any impact on patient care, unions can offer support in finding pragmatic and workable solutions.

Checklist for representatives

1. Regularly monitor the NHS staff survey and compare findings across trusts/regions.
2. Jointly work with employers to undertake regular stress surveys, anchored on the legal obligation for employers to complete risk assessments on all health and safety hazards in the workplace, including stress.
3. Encourage members to monitor their hours and workload and to report stress-related issues to the RCN and their employer.
4. Identify where members are suffering from work-related stress. Work with employers to collect and present sickness absence figures to identify 'hot spots' and analyse causes.
5. Undertake accurate recording of reasons for absence, including 'work-related stress' or 'stress-related illness'.

1

Introduction

This survey of the health and wellbeing of RCN members and the factors at work impacting on their health and wellbeing was conducted in the autumn of 2012. In one sense, the outlook could not appear bleaker; efficiency measures in the private and public sectors mean there are fewer people in the workplace doing more work, working longer hours, feeling less secure and under tighter management.

However, there have been positive and mitigating developments in recent years which have pushed employee health and wellbeing further up the management and employment relations agenda. One of the most important drivers has been the Dame Carol Black review which in 2008 looked at the health of working age people with a 'concern to remedy the human, social and economic costs of impaired health and wellbeing in relation to working life in Britain.'

This was followed by the Boorman review which in 2009 undertook a detailed study of the health and wellbeing of the NHS workforce. This study was the first to identify a clear link between staff health and wellbeing and service quality.

While conducted for the NHS, the findings of the Boorman reviews are transferable to any organisation operating in a health care setting. The study demonstrated the relationship between staff health and wellbeing and performance, and set out a strong business case for investing in staff health and wellbeing. It called on NHS bodies and other public sector organisations to lead the way in improving staff health – to show leadership on health improvement and promoting healthy lifestyles amongst staff.

Even in times of economic uncertainty, managers in any workplace cannot afford to take their eye off staff health and wellbeing. Maintaining and improving engagement and wellbeing is crucial for meeting the increasing demand for safe, high quality patient care.

1.1 Current workforce indicators

A review of recent health and wellbeing indicators paints a complex and worrying picture of the UK workforce. Starting with sickness absence figures, the Chartered Institute of Personnel and Development (CIPD) *Absence management 2012* survey showed an annual fall in absence levels from 7.7 days to 6.8 per employee a year. This good news is tempered by the additional finding that almost a third of employers reported an increase in the number of people going to work ill, also known as 'presenteeism.' The main reasons for this are the threat of redundancy and concerns over job security. Stress-related absence had also increased, with two-fifths of employers reporting a rise over the previous year. Stress is the number one cause of workplace absence and is accompanied by a rise in mental health problems such as anxiety and depression. In 2009, a fifth (21 per cent) of employers reported a rise in mental health problems – by 2012 this figure had doubled to 44 per cent.

The most common cause of stress is workload. Other major causes of stress at work include management style, non-work factors such as relationships and family, relationships at work and considerable organisational change/restructuring.

The CIPD *Employee outlook: summer 2012* survey found that 51 per cent of all employees and 65 per cent of employees in the public sector reported that the economic downturn has resulted in increased stress among employees.

The CIPD reports that organisations that have noted an increase in presenteeism over the past year are more likely to report an increase in stress-related absence over the same period. The World Health Organization (WHO) has found that UK workers are the most depressed in Europe, with just over a quarter having been diagnosed with a condition. Meanwhile, a survey conducted by Ipsos MORI on behalf of the European Depression Association in October 2012 found that one in ten UK employees has taken time off work at some point suffering from depression; one in four of those suffering from depression chose not to tell their employer, with a third reporting they were worried it could put their job at risk.

Stress has consistently been one of the most commonly reported types of work-related illness, cited in the national Labour Force Survey (LFS) conducted by the Office for

National Statistics (ONS). The occupations that reported the highest prevalence of work-related stress (three-year average) were health professionals (in particular nurses), teaching and educational professionals and caring personal services.

The human cost of stress is huge. Since the recession began in 2008 there has been a 47 per cent increase in hospital admissions in England due to stress. According to the Health and Social Care Information Centre, hospitals in England dealt with 6,370 admissions for stress in the 12 months to May 2012. In 2012 alone, the increase was seven per cent but this does not include those diagnosed with depression, anxiety and a range of other physical conditions linked to stress. Nor does it take into account people turning up at GP surgeries for help.

1.2 The impact of wellbeing on patient care

Research led by Professor Jill Maben for the National Institute for Health Research (NIHR, 2012) demonstrated that there is a clear relationship between staff wellbeing and patient care performance. In short, where patient experience is good, staff wellbeing is good. The report explains that 'individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance; seeking to enhance staff wellbeing is not only important in its own right but also the quality of patient experiences.'

The research also showed that the effect of staff wellbeing on performance depends on the climate for patient care and that a strong climate at local or team level can help reinforce some of the positive effects of individual wellbeing on patient care. The researchers state that the local climate can act as a substitute for individual wellbeing, 'making up' for the absence of high levels of wellbeing.

The independent inquiry into care provided at the Mid Staffordshire NHS Foundation Trust led by Robert Francis (www.midstaffsinquiry.com) highlighted the fact that nursing is demanding and difficult work requiring emotional investment. When nursing staff no longer feel able to do the job properly they can withdraw and behave in negative and defensive ways, leading to poor practice. This phenomenon was described by the psychoanalyst Isabel Menzies Lyth (1960) who stated that that organisations as social systems can create anxiety and feelings of fragmentation for nurses working within them, and this can lead to failures of care. Robert Francis also described this process as a 'loss of a moral compass' aggravating the distress associated with low job satisfaction.

1.3 The working environment for nursing staff

Nursing staff work in a wide range of different environments. In addition to the NHS, many work for private and independent sector health care providers, charity and voluntary sector organisations, hospices, as well as criminal justice organisations, universities and the armed forces. Others work in industry as occupational health advisers, and in many other settings.

The NHS is the main employer for nursing staff, and is also the largest employer in the UK. Commitment to the health and wellbeing of the NHS workforce in itself is therefore important as it represents a large proportion of the working population; a healthy and resilient workforce is necessary to look after the overall health and wellbeing of the UK. As an employer the NHS also plays an important role in setting a good example for other employers.

Worries about living standards, job security, staffing levels and the future direction of the NHS is driving anxiety and uncertainty among the NHS workforce. Over recent years the NHS has undergone a myriad organisational changes, the latest resulting from the Health and Social Care Act 2012 in England. The outcome of this seemingly endless restructuring is 'change fatigue' among many members of the NHS workforce. This comes on top of a two-year pay freeze for all public sector staff lasting from 2010 to 2012, followed by ongoing pay restraint set against high inflation. Nursing numbers in the NHS have been falling steadily since 2010, while commissioned places for students are also being reduced.

Research conducted for the NHS trade unions (IDS, 2012) involved a comprehensive survey of NHS employees across all Agenda for Change occupations, exploring their working hours, job satisfaction and levels of morale and motivation. The survey paints a picture of a workforce badly affected by staff shortages, high levels of stress, long working hours and low levels of morale, with around two-thirds considering leaving their job.

The RCN's *Views from the frontline* 2011 employment survey (RCN, 2011b) provides further insight into the state of morale and motivation of nursing staff across the nursing workforce both within the NHS and other organisations in public, private and voluntary sectors. In common with the previously mentioned research conducted on behalf of the NHS trade unions, nursing staff across all sectors reported extensive unpaid overtime working, high levels of stress, anxiety about both their job and their financial security and declining levels of morale. In addition, the report revealed worryingly high and increasing levels of bullying from managers and colleagues and violence and harassment from patients or service users and/or their families.

The Boorman review provided expert evidence on the health and wellbeing of NHS staff and showed that almost half of all NHS staff absence is accounted for by musculoskeletal disorders such as back pain and more than a quarter by stress, depression and anxiety. These findings are likely to be similar for nursing staff in other health and social care environments.

1.4 The importance of employee engagement

The Boorman review recommended a range of policies to improve health and wellbeing including line management, counselling and occupational health services. However, it is vital that health and wellbeing is allied to staff role engagement; the failure of staff to engage with their role can affect employee attitudes, absence and turnover levels.

A lack of engagement has been linked to increased absenteeism and presenteeism and lower levels of performance and productivity. Conversely, strong engagement can enable individuals to invest themselves fully in their work and a positive impact upon their health and wellbeing, which in turn induces increased employee support for the organisation. Moreover, staff engagement and involvement can help build sustainability for any health and wellbeing initiatives. In fact, many organisations try to merge their staff engagement and health and wellbeing work streams together.

1.5 The importance of trade union engagement

The contribution of union representatives to health and safety has been well documented and well acknowledged as significantly reducing the likelihood of workers experiencing an accident or suffering an occupational illness. Trade union representatives also facilitate dialogue between workers and employers about ways to address concerns and improve working conditions. Increasingly union representatives are taking the lead on promoting broader health and wellbeing in the workplace, raising awareness and working with employers and employees to improve health and wellbeing.

1.6 The RCN health and wellbeing survey

Given the highly complex environment described above, in 2005 the RCN decided to undertake a survey of the state of members' health and wellbeing; the findings of the 2005 *At breaking point* survey revealed that nurses' psychological wellbeing was lower than the general working population. This survey updates this previous work.

While there is more awareness of the need to improve staff health and wellbeing, all the indicators suggest increasing levels of stress, depression and presenteeism. We regularly survey our members about their opinions and their working conditions, but this latest research concentrates on how members feel about their own health and stress levels, and how this impacts on their ability to do their job and how well they are supported at work.

1.7 How do we measure good health and wellbeing at work?

While it is relatively straightforward to measure the occurrence of accidents at work, the number of work-related illnesses and injuries and levels of sickness absence, preventative action can only be taken by understanding and measuring causal factors – particularly if these are related to job characteristics or work environment.

2

Methodology

Sir Michael Marmot has led seminal research on the link between social class and health, including the Whitehall studies which examines the health of civil servants. This identified the key workplace factors that predict employees' health outcomes and clearly sets out what constitutes a good job:

- employment security
- autonomy, control and task discretion
- appropriate balance between effort and rewards (beyond financial rewards)
- appropriate match between skills and work demands
- procedural fairness at work
- strength of workplace relationships (social capital).

These factors align with measurements in the HSE management standards indicator, which forms a major part of this 2012 RCN research. The indicator was designed to help employers identify and manage the causes of work-related stress in six areas of work that can have a negative impact on employee health if not properly managed. These are factors over which managers have some degree of influence; in other words, it is important that these are measured, monitored and acted on.

The six HSE management standards

Demands – includes workload, work patterns and the work environment.

Control – how much say a person has in the way they do their work.

Support – includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

Role – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles.

Change – how organisational change is managed and communicated in the organisation.

Relationships – promoting positive working to avoid conflict and dealing with unacceptable behaviour.

In September 2012, approximately 28,000 RCN members were sent an email asking them to respond to an online survey on health, wellbeing and stress. A total of 2,008 members responded, indicating a response rate of around 7.2 per cent.

At three distinct survey stages respondents were given the opportunity to provide comments on their experiences of: working when unfit or unwell; violence, bullying or harassment in the workplace; and occupational health services.

Where possible, these comments have been grouped into themes, and particular comments have been selected that illustrate these themes. Most respondents were keen to give at least a short description of their experiences or concerns. While several respondents had positive stories to tell about good management practice and good working relationships, these were far outweighed by the number of negative comments. It is acknowledged that some degree of self-selection bias may be at play, leading to over-representation of those who have strong opinions. However, comparisons with other RCN surveys suggest that these comments broadly reflect the experiences and opinions of the nursing workforce.

Respondents were asked whether they would be prepared to take part in further research, in the form of a telephone interview, to follow up some of the issues raised in the survey. Respondents were assured that the interviews would be confidential and that all details from the research would be anonymised. A sample group of those willing to participate in this additional research stage was created and contained a reflective cross-section in terms of place of work and biographical details. 'Pen pictures' of each interview conducted can be found in Appendix 1; details and quotes are also included within the main report to illustrate key themes and findings.

3

Demographics

In total 2,008 RCN members completed the 2012 survey. This section presents the key demographic data for all respondents with the exception of nursing students (which can be found at Section 12).

- Around two-thirds (68 per cent) work full-time; just less than a third (30 per cent) work part-time; the remainder work occasional or various hours or do not currently work.
- Around 40 per cent describe themselves as a staff nurse, with others working in various occupations, including senior nurses, community and district nurses, practice nurses and clinical nurse specialists.
- The majority of respondents work in the NHS and in hospital settings.
- The largest group of respondents are between 45-54 years of age.
- 143 respondents (7.2 per cent) reported that they have a disability.

Table 1: Working patterns

	n	%
Full-time	1,334	68.3
Part-time	578	29.6
Occasional/various hours	29	1.5
Not currently working/retired	11	0.6
Total	**1,952**	**100**

Table 2: Job title

	n	%
Staff nurse	775	39.7
Sister/charge nurse/ward manager	240	12.3
Clinical nurse specialist	188	9.6
Community nurse	168	8.6
Senior nurse/matron/nurse manager	118	6.0
Practice nurse	77	3.9
Nurse practitioner	75	3.8
District nurse	56	2.9
Occupational health nurse	43	2.2
Manager/director/owner	36	1.8
Health care assistant/health care support worker	34	1.7
Researcher	27	1.4
Educator	23	1.2
Health visitor/SCPHN	16	0.8
School nurse	16	0.8
Non-nursing role	14	0.7
Public health practitioner	13	0.7
Not currently working/retired	11	0.6
Consultant nurse	9	0.5
Lecturer/tutor	9	0.5
Midwife	5	0.3
Total	**1,952**	**100**

Table 3: Place of work		
	n	%
NHS (excluding GP practice)	1,448	74.2
Independent/private sector	170	8.7
GP practice	115	5.9
Charity/voluntary sector group	55	2.8
NHS Bank/nursing agency	35	1.8
Social enterprise	27	1.4
Local authority/other public sector	21	1.1
Other NHS employer	18	0.9
University/research	18	0.9
Not currently working/retired	11	0.6
NHS Direct/NHS24/helpline	8	0.4
School/education	8	0.4
Criminal justice	6	0.3
Care/nursing home	6	0.3
Self employed	3	0.2
Occupational health	3	0.2
Total	**1,952**	**100**

Table 4: Main place of work		
	n	%
Hospital ward	562	29.2
Hospital unit	305	15.8
Hospital outpatients or daycare	136	7.1
Other hospital setting	113	5.9
All NHS hospital settings	**1,116**	**58.0**
Community	429	22.3
GP practice	107	5.6
Care home	95	4.9
Office	37	1.9
Hospice	31	1.6
Private clinic or hospital	28	1.5
Across different sites/settings	28	1.5
Workplace	21	1.1
University	16	0.8
School	11	0.6
Not currently working	8	0.4
Total	**1,927**	**100**

Table 5: Area of practice		
	n	%
Acute/urgent care	385	19.8
Primary/community care	375	19.3
Adult general/medical/surgical	193	9.9
Mental health	172	8.8
Older people	156	8.0
Children and young people	131	6.7
Surgery	79	4.1
Outpatients	61	3.1
Long-term conditions	57	2.9
Cancer care	56	2.9
Palliative care	48	2.5
Workplace/environmental health	44	2.3
Women's health	31	1.6
Learning disabilities	31	1.6
Quality improvement/research	25	1.3
Management/leadership	24	1.2
Education	21	1.1
Public health	17	0.9
School nursing	17	0.9
Not currently working	11	0.6
e-health/telecare	7	0.4
Various areas	7	0.4
Total	**1,948**	**100**

Table 6: Age		
	n	%
25 or under	98	4.9
26-34	196	9.8
35-44	487	24.3
45-54	852	42.4
55-64	354	17.6
65 or over	16	0.8
Prefer not to say	5	0.2
Total	**1,948**	**100**

Table 7: Ethnicity		
	n	%
White	1,752	90.1
Black/African/Caribbean	80	4.1
Asian/Asian British	56	2.9
Mixed/multiple ethnic groups	21	1.1
Prefer not to say	23	1.2
Other – not specified	12	0.6
Total	**1,944**	**100**

4

Stress in the nursing workforce

Stress is the single biggest cause of sickness absence in the UK and its prevalence is particularly high among nursing staff. Pressure at work can be motivating and stimulating, but when it exceeds an individual's ability to cope this can lead to ill health. The subjective nature of stress makes it difficult to measure, but it is important that stress and its causes are identified in order to reduce stress-related absences and help staff return to work from stress-related illness.

4.1 HSE management standards

The Health and Safety Executive (HSE) has developed management standards and guidelines on work-related stress. These are an important tool in helping employers, employees and their representatives to assess the risk and potential causes of stress.

The HSE management standards approach assesses six elements of work activity that are associated with wellbeing and organisational performance: demands, control, social support, interpersonal relationships, role clarity, and involvement in organisational change.

HSE management standards	
Demands	*Demands* made of workers including issues such as workload, work patterns and the work environment.
	Demands on the individual are often quoted as the main cause of work-related stress.
Control	*Control* exercised by workers, including how much say the worker has in the way they do their work.
	Where an individual has little *control* in how their work is carried out, this can be associated with poor mental health.
	Where there are greater opportunities for decision making there is better self-esteem and job satisfaction.
Support	*Support* given to workers, including the encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
Relationships	*Relationships* with and between workers, including promoting a positive working environment to avoid conflict and dealing with unacceptable behaviour such as bullying.
	Relationships is the term used to describe the way people interact at work. Other people can be important sources of support but they can also be sources of stress.
	At work *relationships* with colleagues at all levels can dramatically affect the way we feel. Two potential aspects of these relationships that could lead to work-related stress are bullying and harassment.
Role	*Role* certainty among workers. Whether all workers at every level understand their role within the organisation and whether the organisation ensures they do not have conflicting roles.
	The potential for developing work-related stress can be greatly reduced when a *role is clearly defined* and understood and when expectations do not produce areas of conflict.
	The main potentially stressful areas are *role conflict and role ambiguity*, together with the burden of responsibilities.
Change	*Change* to the conditions of workers. How organisational change (large or small) is managed and communicated within the organisation.
	Poor management of *change* can lead to individuals feeling anxious about their employment status and reporting work-related stress.

A key feature of the HSE approach is a survey called the *HSE management standards indicator tool* which is filled in by employees. The survey is based around the six management standards which help measure levels of key stressors and enable comparison with benchmark data. The HSE has identified that, if not appropriately managed, these areas have a negative impact on employee wellbeing.

There are 35 items in total, and survey respondents are asked about their health and wellbeing at work. The results are ranked using four colour codes to denote performance relative to the benchmark data.

	Doing very well – need to maintain performance Represents those at, above or close to the 80th percentile.
	Good, but need for improvement Represents those better than average but not at, above or close to the 80th percentile.
	Clear need for improvement Represents those likely to be below average but not at, below or close to the 20th percentile.
	Urgent action needed Represents those at, below or close to the 20th percentile.

The HSE management standards approach is designed to help simplify risk assessment for work-related stress; encourage employers, employees and their representatives to work in partnership to address work-related stress throughout the organisation; and provide the yardstick by which organisations can gauge their performance in tackling the key causes of work-related stress.

The 2012 RCN survey incorporated 22 of the 35 measures into the questionnaire and the results are presented grouped into the six management standard categories. Score comparisons are provided with the 2005 RCN *At breaking point* survey and the HSE benchmark data for 2008.

Table 8: Management standards – demands

	1=low wellbeing 5=high wellbeing
I have to work very intensively	**1.83**
I have to work very fast	**2.15**
Different groups at work demand things from me that are hard to combine	**2.48**
I have unachievable deadlines	**2.83**
I have unrealistic time pressures	**2.63**
I am pressured to work long hours	**3.04**
Overall	**2.50**

It is clear from these results that RCN members are under a great deal of pressure at work and the level of wellbeing relating to demands made of them is far below the average for Britain's working population. The average score is **2.50** compared to the HSE working population score of **3.44** in 2008, and below that of the RCN 2005 survey (3.0). These results indicate that **urgent action is needed**.

The greatest source of pressure comes from working long hours, combined with unrealistic time pressures and unachievable deadlines, meaning that nursing staff have to work very intensively. A community nurse stated there is just *"one nurse to cover a large geographical area at the weekend with little support and high caseload while also being on call for referrals"*. Another respondent described the *"fear of making mistakes/patient safety issues/losing registration due to busy department"*.

Table 9: Management standards – control	1=low wellbeing 5=high wellbeing
I have a choice in deciding what I do at work	2.65
I have a say in my own work speed	2.94
I can decide when to take a break	3.25
I have a choice in deciding how I do my work	3.29
I have some say over the way I work	3.30
Overall	3.08

The overall level of wellbeing relating to control (**3.08**) is below the UK average (**3.32** in 2008) and lower than the RCN 2005 survey (**3.5**) and indicates that **urgent action is needed**. Respondents are more likely to be able to decide when to take a break, *how* they do their work and the way they work than they are able to decide *what* they do at work or their own work speed.

One staff nurse on a NHS hospital ward told us they were *"ill constantly due to lack of breaks, switching shift patterns too quickly, e.g. from lates to early shifts and long stretches of days in a row. Getting off late from shift most days due to ill patients, lack of staff and catching up with paperwork because workload is too big. Work makes you ill but then you're told off for having time off. They don't make the link between the two".*

Table 10: Management standards – managerial support	1=low wellbeing 5=high wellbeing
I am given supportive feedback on the work I do	2.74
I can rely on my line manager to help me out with a work problem	3.25
Overall	3.08

While there are just two questions on manager support at work, the picture painted by these questions is generally encouraging, with the scores indicating a **good level, but with room for improvement**. The score for the UK working population in 2008 was higher at **3.77** and the 2005 RCN survey score was **3.3**.

Our telephone interviews generally revealed that most nursing staff had a good relationship with their line managers. However, descriptions of problems with senior managers were more common with some respondents telling us that there was a lack of understanding of their roles and support from senior management.

Table 11: Management standards – peer support	1=low wellbeing 5=high wellbeing
If work gets difficult, my colleagues will help me	3.47
I get the help and support I need from colleagues	3.58
I receive the respect at work I deserve from my colleagues	3.63
Overall	3.56

Confidence in peer support is below the average for the working population and the score (**3.56**) indicates a **clear need for improvement**. In 2008 the average score for the UK working population was **4.03** and the 2005 RCN score was **3.3**.

Our telephone interviews reveal that peer support is very important to nursing staff, particularly when they face heavy workloads and staff shortages. Many also pointed to the value they place on clinical supervision and the emotional support derived from colleagues. All too often, though, we heard examples of cliques forming in the workplace causing disruption and anxiety as well as examples of bullying behaviour between colleagues.

Table 12: Management standards – role	
	1=low wellbeing 5=high wellbeing
I am clear about the goals and objectives for my department	**4.01**
I am clear what is expected of me at work	**4.30**
I am clear what my duties and responsibilities are	4.35
I understand how my work fits into the overall aim of the organisation	**3.87**
I know how to go about getting my job done	**4.41**
Overall	**4.20**

While the average score for wellbeing relating to role at work (**4.20**) appears to be quite high and unchanged from the 2005 RCN score, it is lower than the UK working population average in 2008 which stood at **4.61**, indicating a **good level, but with room for improvement**. Nursing staff appear to be more confident about what their own role entails and how to get their own job done, rather than the wider picture of how their role fits into wider organisational objectives.

An important issue emerging from the research is the extension and development of some nursing roles. For example 'Kathy', an emergency practitioner nurse, described how she and colleagues have undertaken extensive academic and practical training to develop their service. 'Sue', a district nurse, also described how she was taking on triage duties for the doctors in her practice in addition to her own duties. A survey respondent told us *"our roles are always extending under the PDP umbrella – more objectives set to achieve"*. Many nurses are justifiably proud of their skills and want to develop in their jobs. However, caution was also expressed that nurses should not be pressured into working too far beyond their scope or ambition.

Table 13: Management standards – change	
	1=low wellbeing 5=high wellbeing
I have sufficient opportunities to question managers about change at work	**2.78**
Staff are always consulted about change at work	**2.79**
Overall	**2.78**

RCN members were mostly negative about their engagement in workplace change, with the average score (**2.78**) for wellbeing at work relating to the management of change being substantially lower than average for Britain's working population (**3.54** in 2008) and lower than the RCN 2005 average score (**3.1**) indicating that **urgent action is needed**.

This latest research highlighted a high level of anxiety and uncertainty among nursing staff across all sectors, particularly about job security and personal finances. A school nurse told us *"the stress and the pressure is immense due to redundancies"*. Another staff nurse said that her employer's *"handling of employees, expecting them to adapt to massive change with little support, is very much like corporate bullying"*.

Among NHS nursing staff very clear concerns were expressed about career progression and promotion. For example, an experienced Band 5 nurse we interviewed told us that a matron had told him that *"if I wanted a Band 6 post, one of the requirements is to put up and shut up, and not make suggestions"*. A sister added that *"staff are uncertain of their futures, no one is getting promoted as there is sideways movement of Band 6/7 from one site to another. This is demoralising for Band 5s. I would not recommend anyone to join the nursing profession at this current time; I feel sorry for all the students who have just qualified and cannot get a job"*.

We interviewed two nurses who had qualified in the past five years and who also feel that career prospects are being limited. 'Richard,' a staff nurse, told us that opportunities for progression are slowing down and leading to resentment among band 5 nurses. 'Will' also told us he sees newly qualified nurses being increasingly employed on short-term contracts and says this is damaging for nurses' security and their own peace of mind.

4.2 Summary

Measuring wellbeing using the HSE management standards suggests that nursing staff in the UK are experiencing higher levels of stress than the UK working population in general, and at a higher rate than we last surveyed the RCN membership. In particular their wellbeing relating to the demands of the job and workplace change are low, indicating that urgent action is needed.

These findings paint a picture of a nursing workforce struggling with both high workloads and the fast pace of work, while feeling unsupported and detached from changes being implemented within their workplace.

Respondents report working long hours combined with unrealistic time pressures and unachievable deadlines, meaning that nursing staff have to work very intensively. They also report low levels of control over their work which impacts on their ability to decide when to take a break, how they do their work and the way they work.

These sources of stress appear to be somewhat offset by respondents' confidence and clarity about their own roles and how they fit with wider organisational objectives. This is likely to be a factor of the highly defined and regulated nature of the nursing role; while it is necessary that staff have clear roles and responsibilities, jobs must also be rewarding and designed in such as a way as to protect health and wellbeing. Ever increasing demands and workloads and uncertainties about organisational change will only negate any efforts to improve staff health and wellbeing.

The rest of this report examines in more depth the factors influencing health, wellbeing and stress among nursing staff including management and peer support, sickness absence policies, bullying and harassment and occupational health service provision. It also details recommendations for UK governments, health departments, regulators, managers and union representatives to take forward in the promotion of health and wellbeing in the workplace.

5 Sources of stress in the nursing workforce

The previous section used the HSE management standards to evaluate levels of stress among the nursing workforce against the general working population. The exercise established that the workforce is certainly experiencing particular high levels of stress, working long hours, facing tight deadlines and achieving little control over their workload.

This section explores the issue of stress in more detail and probes the reasons why nursing staff feel under so much pressure.

Using separate questions from the HSE management standards toolkit, we asked respondents to rate their levels of stress on a scale of 1-10, with 1 being lowest and 10 the highest. The average score was 6.3, and for students the score was 6.6. The average score for staff nurses and practice nurses is 6.2.

We looked at the scores to assess whether there was any difference according to respondents' ethnicity, workplace, job title and area of practice. There was no difference in scores according to respondent ethnicity. While there was very little variation in average scores according to sector, there was more variation according to job title and area of practice. Table 14 indicates that average scores are highest for district nurses and health visitors and sisters/charge nurses/ward managers and lowest for occupational health nurses and health care assistants.

In relation to area of practice Table 15 indicates that average stress scores are highest for those working in management or leadership, for those working with people with long-term conditions and with older people. Lowest scores occur among nursing staff working in palliative health and occupational health.

Table 14: Job title – average stress scores			
Highest		**Lowest**	
District nurses and health visitors	7.0	Occupational health nurses	5.4
Sisters, charge nurses, or ward managers	6.8	Health care assistants	5.7

Table 15: Area of practice – average stress scores			
Highest		**Lowest**	
Management/leadership	7.0	Palliative care	6.0
Long-term conditions	6.7	Occupational health	5.8
Older people	6.6		

Chart 1 shows that around a half (49 per cent) of all respondents told us that their own levels of stress have increased a *lot* in the last 12 months, and a quarter said they had increased a *little*. The main reasons for these increased levels of stress appear to be interrelated, as shown in Chart 2. It appears that staff shortages and high workload are combining to put so much pressure on nursing staff that they do not have enough time to perform their role. Other issues highlighted include not having enough time to take rest breaks and a lack of support from management.

Chart 1: Over the last 12 months, my personal level of stress has... (n=1,926)

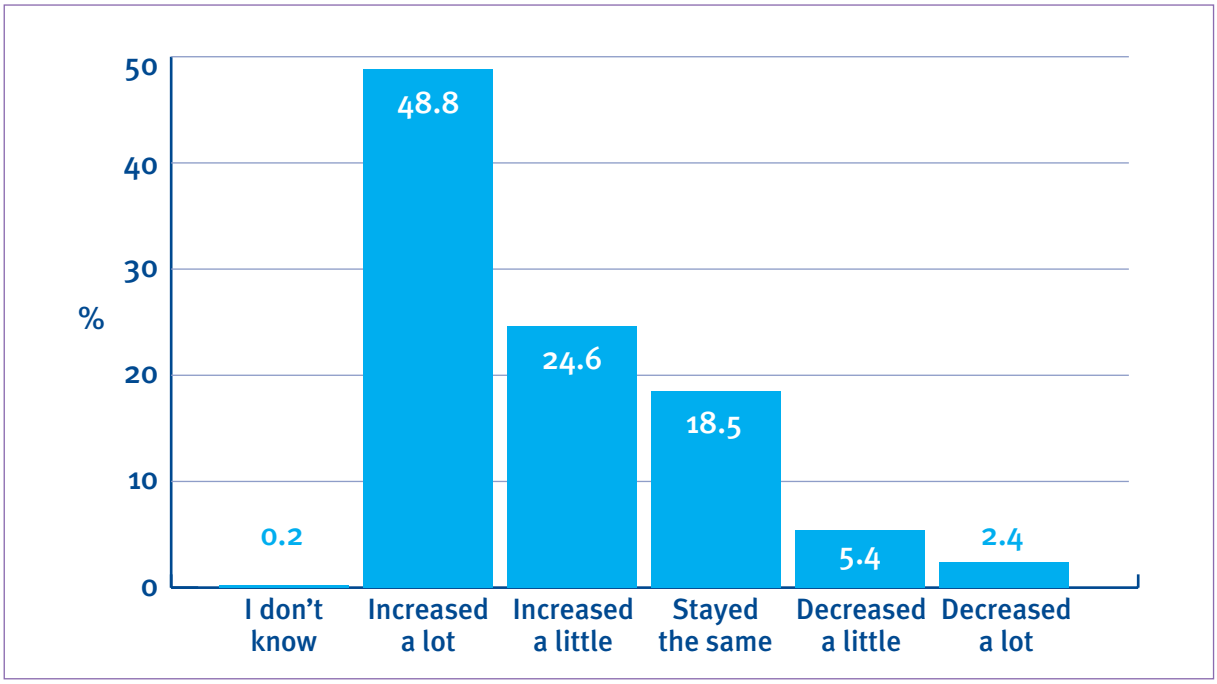
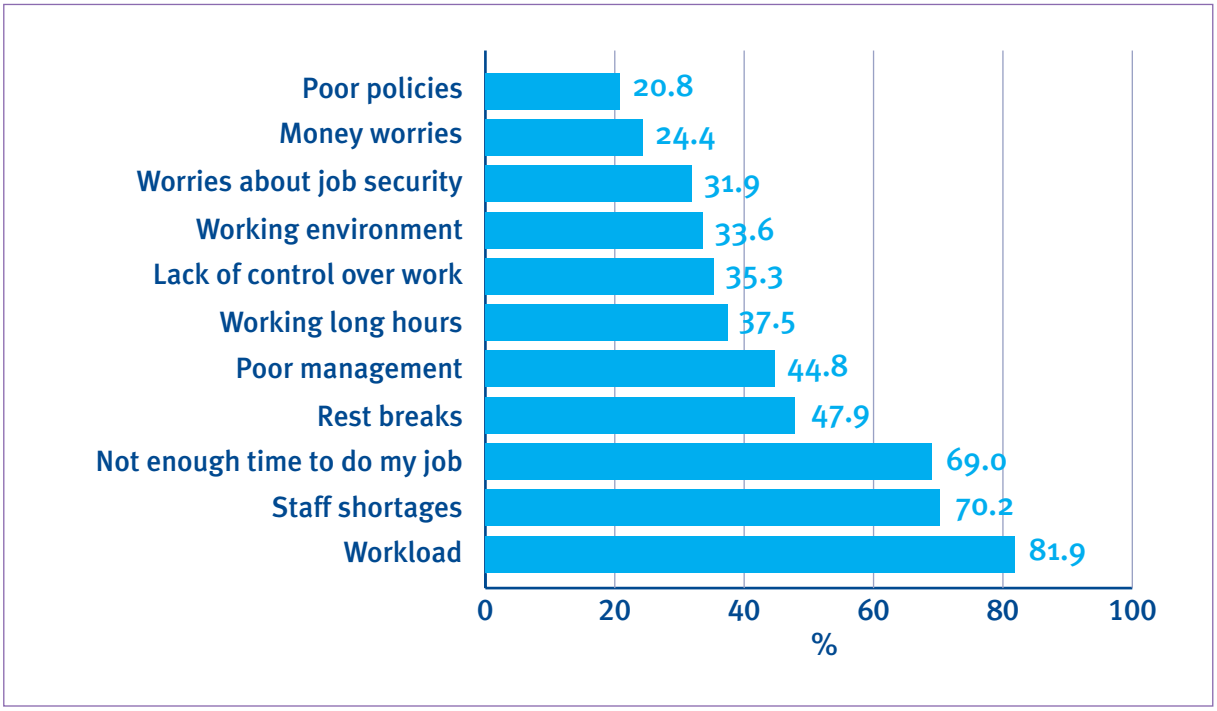


Chart 2: Reasons for high and/or increased levels of stress (n=1,588)



We gave members the opportunity to go into more detail about the factors contributing to their stress levels. These have been grouped into the themes listed below.

- **Workload and staffing levels** – this was the primary causes of stress among nursing respondents, standing in the way of them doing their job to the standard they would like. For example, one specialist nurse told us *"staff are stretched without employing additional help. When you are off on sick or annual leave there is no one to do your caseload. You strive to do your best but corporate needs to realise that teams need to be formed".*
- **Job role and content** – respondents pointed to intrinsic issues relating to their job role or content which cause stress, such as lack of rest breaks or facilities to take a break. Others pointed to shift working and particularly day to night rotations as contributing to high stress levels. One staff nurse working in the NHS told us: *"If we got breaks then maybe we wouldn't be unwell. Also if our shift patterns didn't change as much, with some days only 10 hours between shifts."*
- **Working beyond scope** – several respondents reported feeling stressed by being pushed to a level beyond their scope of practice. For example, one interviewee ('Kathy') described how emergency nurse practitioners are being *"used in a medical role, but we should be supplementary to medical staff not a replacement".* Another interviewee ('Sue') stated: *"I don't have a problem with doing the job I'm trained for [district nurse]. I just have a problem with being a doctor. I'm worried something will go wrong and it's my neck on the line."*
- **Management support or style** – feeling insufficiently supported by managers. For example, a staff nurse in an independent sector care home told us that *"when I have taken unwell at work and felt unable to carry on safely, there is very little understanding from managers who say to carry on as there is no one else to take over. There appears to be very little tolerance and understanding for genuine illness in the workplace".* Many respondents told us how much they appreciate a simple 'thank you' or 'well done' from management staff and feel upset when none is forthcoming.
- **Working relationships** – stressful working relationships with team members and feeling unsupported by colleagues or even facing bullying and harassment.
- **Organisational change** – stress from the impact of ongoing or planned change such as ward closures, service redesign or transfer to other organisations. Organisational change involves having to apply, often repeatedly, for jobs.

- **Job security and changes to terms and conditions** – worries about job security, employment status and pensions are sources of stress for many respondents. One interviewee ('Gill') stated *"We all feel very frightened. There are so many nurses and they don't want to pay us. So they're trying to downband our jobs and people feel very helpless and very demotivated. We are frightened for the future"*.
- **Challenges to the image of nursing** – respondents are conscious of how nursing and the image of nursing are being tested and state that this leaves them feeling under pressure. A telephone interview participant told us she feels there is a *"misconception that you can train people to do tasks and pay them less [in reality] you need well trained staff, able to understand and interpret as well as valuing 'basic' nursing care"*.
- **Targets and paperwork** – the time spent on paperwork, taking nursing staff away from direct patient care, causes concern. An NHS community nurse stated they face *"pressure to achieve targets, demands to follow procedures which duplicate practices and increased paper exercises which impact on practice and decision making"*. A mental health nurse told us they have *"targets to meet which are unrealistic, it appears stats are more important than quality time with clients"*.
- **Lack of resources** – including bed shortages, problems with IT, poor quality equipment or lack of office space.
- **Patient demands** – many respondents felt under pressure from increasing patient demands or even verbal or physical abuse from patients or members of their family. One staff nurse reported that her team *"frequently get verbally abused due to patients waiting for theatre, facing long waits, especially when we have no beds available or they get cancelled"*.
- **Personal issues** – personal circumstances such as death or illness among family members or friends make it difficult to cope at work. Personal health problems are also caused or aggravated by stress at work.
- **Emotional stress** – many respondents described their work as emotionally stressful, particularly dealing with dying patients. Several described their jobs as having led to post traumatic stress disorder.

5.1 The impact of stress on health and wellbeing

Many respondents described the impact of stress on their health and wellbeing in some detail. The quotes below clearly demonstrate the potential circularity of stress, with worsened health and wellbeing leading to higher rates of stress.

"The job is taking over my life. I take work home most nights. I have unachievable deadlines. My colleague took MARS [mutually agreed resignation scheme] two years ago and I got her responsibilities. I constantly feel stressed and it is getting worse not better. I feel tearful quite often and unwell due to work pressures."
NHS district nurse

"Diagnosed with inflammatory arthritis. Off sick for couple of months. No support on return from work from line manager or matron. Discussed difficulty in working nights and told tough and maybe I am in the wrong job."
NHS staff nurse, hospital ward

"I once came into work on a night shift when I was unwell. At the end of the shift I made a drug error involving a controlled drug and I vowed after this never to come into work when I was unwell again as it risked my registration."
Staff nurse, hospice

5.2 Summary and recommendations

Health and social care organisations within the public, private and voluntary sectors all face ever higher demands, leading to increased workloads and pressures of work for their staff.

Faced with these pressures, it is essential that staff motivation and engagement are developed and improved in order to support the workforce's contribution to delivering better and effective patient care. This must include creating a healthy workplace; it is essential to improving productivity, staff motivation, ensuring quality patient care and improving patient outcomes.

This must start with safe staffing levels. Insufficient staffing levels result in increased pressure, stress, higher levels of

burnout, lower job satisfaction and a greater inclination to leave among the workforce. A downward spiral often follows as morale declines and sickness absence increases, leaving fewer staff available to work and creating even more pressure on existing staff.

RCN members tell us that workload and safe staffing levels are the most pressing problems they face on a daily basis. Yet despite the evidence linking staff levels of patient outcomes, there has been a failure to act.

5.2.1 Safe staffing levels

At the heart of the RCN's *This is nursing* (www.rcn.org.uk/thisisnursing) initiative is a drive to improve and promote safe staffing levels. *This is nursing* makes it clear that the time has come to for providers, regulators and commissioners of services to set clearly defined standards and adopt mandatory staffing levels. The RCN is committed to working with governments, health departments and key stakeholders on developing and implementing staffing level recommendations.

The RCN's *Guidance on safe nurse staffing levels in the UK* (RCN, 2010) highlights the evidence between nurse staffing levels and patient outcomes. It does not advocate a universal nurse-to-patient ratio and recognises that nurse staffing levels must be set locally. Local factors such as nature of the service, specialty and patient needs have to be taken into account through a rational and systematic, evidence-based approach.

The guidance highlights and assesses the variety of methods for planning and reviewing nurse staffing and suggests ways they can be implemented and embedded within organisations. It is accompanied by a policy briefing (RCN, 2012b) which sets out the RCN position on mandatory staffing levels and provides an overview of the evidence relating to nurse staffing levels and outlines available guidance relating to staffing levels in different fields of nursing. It also includes an overview of the experiences of other countries which have introduced mandatory nurse-to-patient ratios.

The RCN has also developed guidelines (RCN, 2012c) on safe staffing levels for the care of older people. Designed to help support a review of staffing on hospital wards where older people are cared for, the guidelines can also be used to help address any associated leadership and workforce issues.

In Scotland, the Nursing and Midwifery Workload and Workforce Planning (NMWWP) Programme has developed a range of tools to measure workload to determine staffing levels and to be used in workforce planning for the NHS Scotland nursing and midwifery workforce. NHS boards are required to use these tools to develop annual plans from April 2013 (www.workforceplanning.scot.nhs.uk/home.aspx). The RCN supports the principle behind this programme and is negotiating how these tools effectively can be effectively implemented.

5.2.2 Time to care

In September 2012 the RCN in Wales launched the second year of its *Time to care* campaign which stresses the importance of ensuring that staff are given time to perform their role to their highest caring ability. The campaign highlights the experience of care that patients and the public expect and the significance, diversity and essential nature of the nursing contribution to caring of nursing.

5.2.3 Shift working

The HSE management standards revealed that nursing staff are working at high levels of demand and workloads. As a result they often work long hours without sufficient rest breaks; this can lead to exhaustion and fatigue and, in the longer term, damage health and wellbeing. Employers have a duty to implement safe shift patterns compliant with the Working Time Regulations and to ensure that staff are able to take rest breaks in a suitable environment with access to refreshments. The RCN calls on employers and regulators to pay attention to the impact of working hours on health and wellbeing and the importance of rest breaks.

There is a need for more research evidence to understand the impact of shift working on patient safety. In particular, the RCN believes more research is needed on the differential impact of working long (12 hour) shifts which are planned; working long hours through back to back shifts, overtime or additional jobs; and shorter shifts.

The RCN publication *A shift in the right direction* (RCN, 2012a) provides useful guidance and information to support shift workers' health and wellbeing. It states that service provision relies heavily on nursing staff working shifts and that adapting to shift patterns or changes in shift patterns can be difficult. It warns that if the associated risks are not managed properly, this can lead to ill health and fatigue, which in turn can have an impact on patient care.

5.2.4 Workplace stress risk assessments

Our research shows high levels of stress among nursing staff, particularly relating to the demands of the job and a feeling of lack of control over their work. The Management of Health and Safety at Work Regulations 1999 set out the duties on organisations to carry out suitable and sufficient risk assessments on workplace stress. The Health and Safety Executive's management standards provide a framework health care organisations can apply to prevent and reduce the risks of the work-related causes of stress. The RCN calls on all health care organisations to use the HSE's framework in order to support staff and identify and manage sources of stress including all NHS staff surveys. The RCN would also like to see the HSE framework regularly updated so that it continues to be an effective benchmark in the measurement and management of stress. In relation to workloads and demands the HSE expects organisations to:

- provide employees with adequate and achievable demands in relation to the agreed hours of work
- match people's skills and abilities to the job demands
- ensure jobs are designed to be within the capabilities of employees
- ensure employees' concerns about their work environment are addressed.

The RCN published guidance on work-related stress for RCN representatives (RCN, 2009) which goes through the HSE's management standards and the process of conducting a stress risk assessment. It details how RCN safety representatives can get involved in each stage of the risk assessment process and provides case studies that illustrate how RCN representatives have implemented the HSE management standards in their own workplaces.

Joint guidance produced by the CIPD, Acas, the HSE, and Health, Work and Wellbeing (CIPD, 2010) summarises the legal duties that employers have to reduce and, where possible, prevent work-related stress impacting on the health of their employees. It provides a starting point to help understand the legal requirements, and suggests actions that employers can take to help to not just comply with the law, but improve the working conditions for all employees. Designed for directors and managers in organisations of all sizes in the public, private and third sector, the publication will also be of interest to those in supporting professions such as health and safety practitioners, HR practitioners and occupational health practitioners.

5.2.5 Staff engagement and consultation

The research also found that nursing staff are anxious about the level of change and the lack of consultation and communication about changes made within their workplace. Poor staff engagement is linked to increased absenteeism, presenteeism, lower levels of performance and productivity. It is therefore important that health and social care organisations consult and involve staff and trade unions around the management of change. It is particularly important that organisations engage and consult with RCN and other trade union safety representatives to identify and address the possible health and safety impacts of any planned changes. Information about the RCN representative roles can be found on the RCN website at www.rcn.org.uk

The Acas guide to Trade union representation in the workplace (Acas, 2009) is for employers, trade unions and union workplace representatives. It gives advice on the provision of time off, training and facilities to enable union representatives to carry out their duties, and covers statutory and non-statutory representatives.

Finally, the RCN would like to see the HSE take a robust approach to organisations that fail to manage to meet the legal requirement to assess and manage the risk of work-related stress. Historically, NHS organisations have been subject to enforcement action in the form of improvement notices. We believe enforcement action is a proportionate response, as stress can impact negatively on individual health and wellbeing, team relationships and ultimately affect patient care.

6

Presenteeism

In any work setting there are obvious risks arising from employees being at work when they are unfit or unwell – including risks to health and safety and to productivity. In a health care setting these risks are even more acute as they can impact heavily on patients, service users and their families. For nursing staff the pressure to attend work when unfit or unwell is arguably mostly self-directed, as they are acutely aware of the impact of being away from work will have on colleagues and patients/service users. In addition the Boorman report (DH, 2009) found that 'presenteeism is greater in those who work long hours and experience managerial pressure to return to work'.

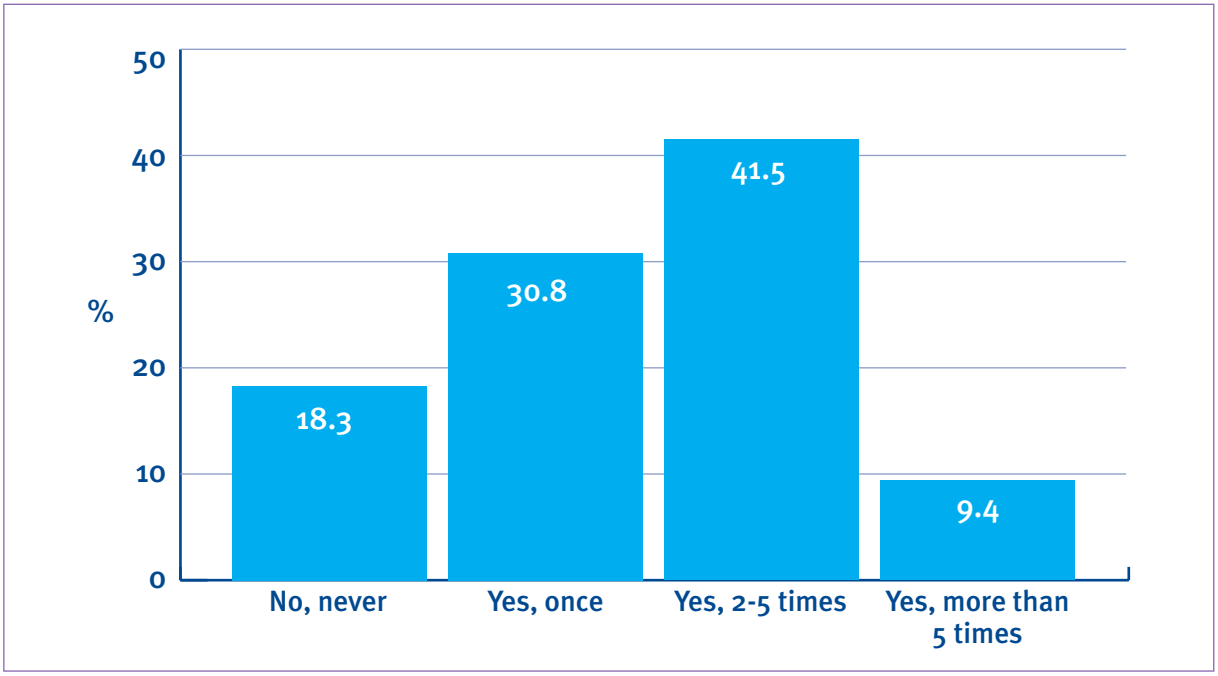
Professor Cary Cooper, a leading expert on stress, warns that the risk to mental health caused by presenteeism is potentially even greater as it is easier to hide than a physical ailment. He also warns that when competition for jobs is high people are even more wary about admitting to feeling stressed or giving any sign they may be struggling to cope, although heavier workloads and external pressures mean this might be perfectly reasonable.

The Sainsbury Centre for Mental Health has estimated that presenteeism accounts for 1.5 times more working time lost than absenteeism and that the costs to UK employers of mental health problems are around £15 billion a year (SCMH, 2007).

Research published by The Work Foundation (TWF, 2010) reveals a connection between sickness presence and poor performance, and established a significant link between presenteeism and personal financial difficulties, work-related stress and a perceived workplace pressure to attend work when unwell.

The RCN 2012 member survey asked whether nursing staff had gone to work despite feeling ill in the previous 12 months and found that the majority (82 per cent) had done so. Closer examination of these findings reveals little variation in nursing staff, reporting they had worked despite feeling unwell or unfit according to whether they worked full-time, part-time or occasional/various hours or according to ethnicity. Similarly, there was little difference in the likelihood of working unwell according to job title or type of organisation. This suggests a widespread problem of presenteeism.

Chart 3: Over the previous 12 months, have you gone to work despite feeling that you really should have taken sick leave due to your state of health? (n=1,926)



We can compare these figures to the NHS Staff Surveys for England and for Wales which both asked the same question, albeit in a slightly different way: "In the last three months have you ever come to work despite not feeling well enough to perform your duties?" The 2012 NHS Staff Survey for England showed that almost three-quarters (73 per cent) of registered nurses and midwives and a similar number of nursing/health care assistants (72 per cent) said they had done so. The 2013 NHS Staff Survey for Wales showed that 70 per cent of all staff had worked in the previous three months despite not feeling well enough.

We asked a follow up question about the amount of work that nursing staff are expected to catch up with if they are absent from work for any reason (Chart 4). Well over half (59 per cent) said they had to pick up half or all of their work, indicating one of the primary reasons behind a reluctance to take sick leave.

Nursing staff working in universities (94 per cent), in hospital outpatients departments (66 per cent) and in the community (63 per cent) were most likely to state that they had to pick up half or more of their work on their return.

The RCN survey went on to ask respondents whether they feel under pressure to go into work when they feel unwell. By far the biggest pressure comes from repondents themselves (84 per cent), with pressure also being felt from line managers (45 per cent), senior management (44 per cent) and colleagues (36 per cent).

The 2012 NHS Staff Survey for England also approached this issue, with similar findings. It asked respondents who said they had come into work despite not feeling well enough to do so in the last three months if they had felt pressure to do so from managers, colleagues or themselves. Around a third of registered nurses and midwives (32 per cent) and health care assistants (35 per cent) said they felt pressure from managers, while slightly fewer (26 per cent of nurses and midwives and 23 per cent of health care assistants) said they felt pressure from colleagues. The majority (93 per cent of nurses and 85 per cent of health care assistants) said they felt pressure from themselves. The 2013 survey for Wales showed that 39 per cent indicated that they had felt pressure from their manager to come to work and 26 per cent said that they had felt such pressure from colleagues, along with staff shortages.

Chart 4: If you are absent from work for up to a week what proportion of your tasks must you take up again on your return? (1,903)

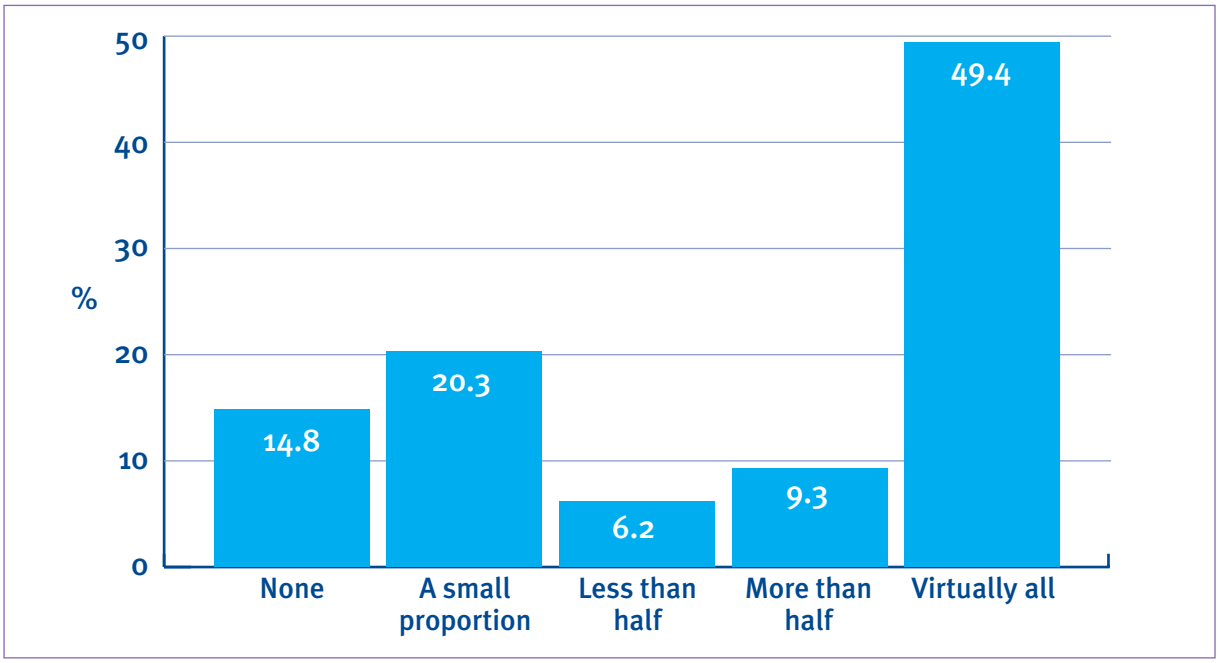
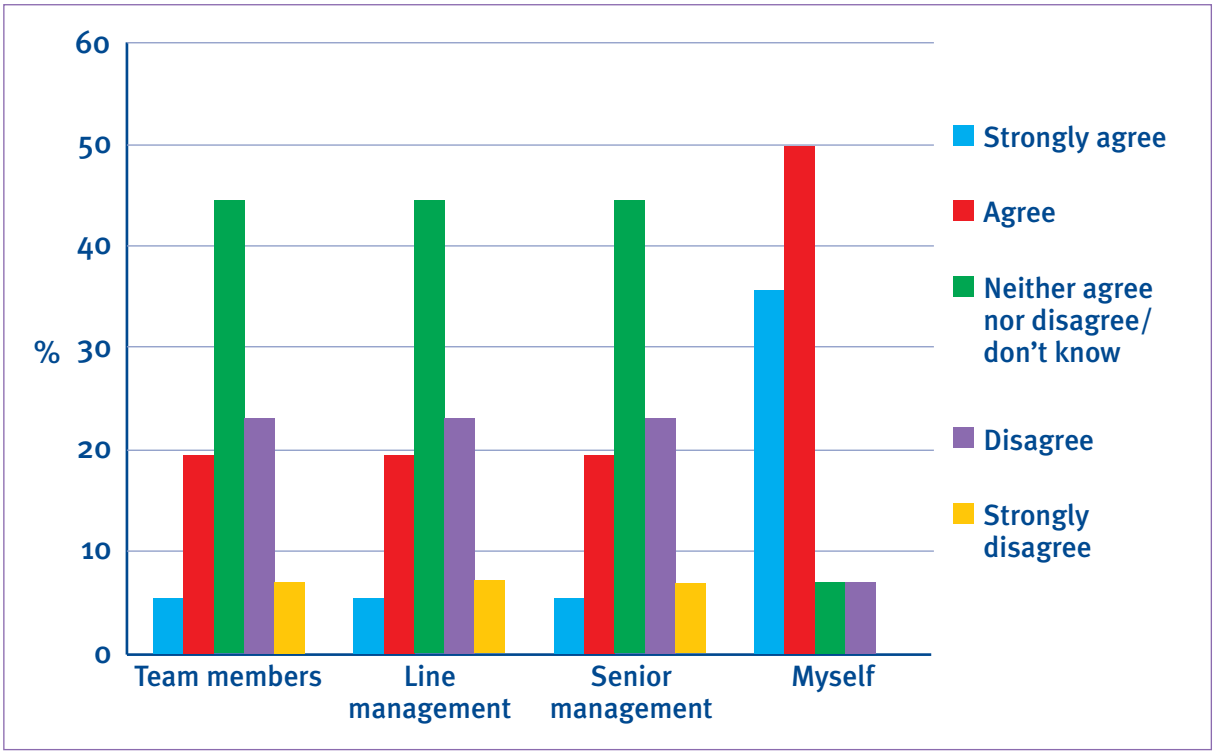


Chart 5: Do you feel under pressure (from other team members/line manager/senior managers/myself) to go into work when I feel unwell? (n=1,925)



We asked repondents to share their experiences about working well, unwell or unfit. Many nurses had positive stories to tell; that they are generally fit and healthy and rarely have to take time off work while others told us that if they did take sick leave, colleagues and managers are supportive. For example, one nurse said: *"I find that colleagues and management are generally supportive towards each other in times of sickness or difficulty – quite rightly so too, in the caring professions."*

However, a much higher number were negative and a common thread runs through their comments; they feel guilty about being off sick and were worried about the impact on colleagues, or feel under pressure from managers to return to work from sick leave, or do not to take sick leave in the first place despite feeling unwell or unfit.

6.1 Sickness absence policy

Many respondents told us that stringent use of sickness absence policies was placing undue pressure on staff to attend work when unwell or unfit and to return to work before they are ready. A description often used about the sickness management process was *intimidating.*

We heard from a wide range of respondents that they, and their colleagues, have taken sick leave then returned to work still unwell or unfit which has often made their health worse. This second period is treated as a new episode, but they face some form of disciplinary action if a certain number of episodes of absence are taken over a set period of time.

"I think it is unfair to use the NHS policy of no more than three absences in 12 months. It treats all episodes the same whether one day or one month. You come into work ill rather than have to face HR."
Staff nurse, hospital ward

"Our trust makes you take time off for counselling, hospital appointments or visiting the GP out of annual leave entitlement which means I avoid going to the GP until I hit crisis point. I have depression but turned down counselling for this reason."
Admiral nurse, NHS hospital ward

"We are threatened with disciplinary action if we go over three episodes of sickness over a 12-month period. The reasons for sickness are not taken into account."
NHS community nurse

"Due to Bradford Scoring, there is now pressure to come into work even if you are feeling unwell. Three episodes of sickness in three months can make you very aware you may be getting a written warning if sickness continues."
Staff nurse, hospice

6.2 Organisational change and restructuring

Other respondents made a link between the use of sickness absence monitoring policies and wider reorganisation or restructuring within their organisation. Nursing staff are clearly fearful that poor absence records may be used against them when decisions are made about future staffing levels.

"Due to current reorganisation staff are concerned they may have to reapply for their job so don't want sickness on their record."
NHS community nurse

"Ward rationalisations are pending, staff will have to be deployed and you don't want your attendance record to be affected so you work when you should really stayed at home."
Staff nurse, NHS hospital ward

"With redundancies high on the agenda and staff having to attend meetings where they have to pledge they won't be ill again, most people are terrified of going off sick. Patients complain we are working when ill and managers often turn a blind eye, especially on nights, to someone being unwell. Also it seems against the rules to swap a shift with another member of staff and work later in the week; it has to go down as a sick day which looks bad on your file."
Staff nurse, NHS hospital ward

6.3 Impact on colleagues and patients

Over and above any concerns about sickness absence policy, nursing staff voiced concerns about letting down colleagues and patients/service users if they take sick leave. All too aware of tight staffing levels in their teams or departments, nursing staff are reluctant to be away from work even when ill or unfit.

"I feel compelled to work, working on bare minimum of staff – I feel I can't let my colleagues down."
Staff nurse, NHS hospital ward

"I think habitually nurses come to work unwell to avoid shortages and support colleagues. We are a culture of people who look after others extremely well but not ourselves."
Staff nurse, NHS hospital ward

"Patients are inconvenienced if I take time off sick due to appointments having to be cancelled. No one else can do my areas of practice so this has a knock-on effect on future appointments."
GP Practice nurse

6.4 Staff shortages and workload

While many respondents spoke of a reluctance to take sick leave due to staffing levels and high workloads, others more directly described staff shortages and the impact on their workplace. They also explained that financial constraints mean that absences are less likely to covered by agency staff or through overtime, thus adding to staffing pressures.

"My area is so short staffed I feel compelled to work, as patient care is compromised."
Staff nurse, NHS hospital unit

"Because of staff shortages most staff feel pressured to work even when unwell. Should they not go into work there is no backup. Staff have to work short staffed."
Staff nurse, independent health care provider

"If I don't come into work there is just too much to do when I get back."
Senior nurse, charity/voluntary sector health care provider

"It isn't worth being off sick as the work is still waiting when you come back. It just puts added stress on you."
NHS community nurse

6.5 Feelings of guilt

While many talked about their reluctance or refusal to take sick leave due to the impact this would have on colleagues or patients/service users, others explicitly viewed these feelings of guilt as instilled by line managers or other senior managers.

"Sometimes I'm made to feel guilty by my ward manager if I'm off sick. I would get regular phone calls asking when I would be back and no questions asked to check about my wellbeing."
Staff nurse, NHS hospital ward

"You are made to feel guilty when you come back by the HR department."
Staff nurse, NHS hospital ward

6.6 Workplace culture

Closely linked to feelings of guilt are descriptions of a workplace culture in which people taking sick leave are poorly judged and commented on.

"There is a culture of talking about staff who are off sick. Even managers pass comment on staff, for example "she's never in"".
Staff nurse, NHS hospital unit

"Sickness targets make me feel I'm letting others down. Going off sick is seen as a weakness."
Staff nurse, NHS hospital ward

6.7 Long-term conditions and injuries

Many members of the workforce have long-term conditions and injuries, and workplace interventions can be put in place to support or rehabilitate them. However, these interventions require a sympathetic culture, where team members, managers and policies and procedures support staff with illnesses and injuries.

"I have recently been diagnosed with MS and feel under pressure to turn up otherwise work piles up. I go into work early every morning and often have to work late in order to complete my work."
General practice nurse

"I've been told that if I don't meet the 100 per cent attendance at work I will be up for a capability hearing. I had three admissions into hospital due to a cardiac problem, so if I get chest pain I have to ignore it because I have to go to work."
Staff nurse, NHS hospital unit

"I have asthma and neck problems. There have been occasions when colleagues have asked me go home, but knowing my Bradford score has exceeded 90 points, I feel I have to avoid being unwell. However, I have an extremely supportive matron and colleagues are also very supportive."
Staff nurse, NHS outpatients

6.8 Occupational health and work adjustments

Occupational health services play a vital role in promoting health and wellbeing at work, by controlling risks, helping adapt work to people and adapting people to their jobs. It is therefore of concern when staff feel let down or unsupported.

"I have returned to work with a back injury on admin duties. I have had to pay for private physio as the current OH provider no longer provides physio support and I would have to wait for a GP referral. OH previously provided six sessions of physio and counselling – this was stopped last year."
NHS community nurse

"I had an injury requiring a workplace assessment which identified equipment for me to do my job, but three months later I still don't have equipment."
NHS mental health nurse

6.9 Summary and recommendations

This research indicates that presenteeism is prevalent among the nursing workforce. It is linked to many different and overlapping factors, including types of illness, workload and level of cover; work-related stress and perceived pressure from colleagues; line managers and senior managers including HR.

It is important that presenteeism is given full recognition as a health and wellbeing issue; it can lead to negative health and wellbeing outcomes for staff and can also impact on patient outcomes, particularly if staff members are infectious or suffer from fatigue. Many organisations use

results from staff surveys or other tools to identify 'hot spots' of presenteeism and explore the underlying trends and drivers.

The Acas employer guidance (Acas, 2010a) on absence and attendance management at work states that 'it is important to create a culture where people are able to inform their employer that they are unwell and take the necessary time off to recover'. Another key message from Acas is that effective absence management depends on early intervention and communication with employees.

Along with staff shortages, punitive sickness absence policies have been identified as a factor which can lead to increased levels of presenteeism. Some degree of sickness absence should be expected amongst health care employees, particularly those exposed to a range of occupational hazards with public facing roles. But policies need to be fair and supportive.

In the NHS, the RCN strongly advocates the implementation of jointly agreed national guidelines on sickness absence policies at a local level:

- in England – see the NHS Staff Council's 2012 *Guidelines on the prevention and management of sickness absence* (available online at www.nhsemployers.org)
- in Scotland – see the NHS Scotland Managing health at work partnership information network (PIN) *Guideline 2: promoting attendance* (available online at www.scotland.gov.uk)
- in Wales – see the Welsh NHS Partnership Forum all Wales sickness absence policy (available online at www.wales.nhs.uk)
- in Northern Ireland – see the circular HSC AfC (1) 2013 advising health and social care employers of the sickness and annual leave policy (available at www.dhsspsni.gov.uk).

7

Working life and wellbeing

There are many factors that impact on an individual's health and wellbeing, including their lifestyle and personal characteristics. Other important factors include job design, workplace relationships, the working environment and workplace management practices.

Respondents were asked about the impact of working life on their health and wellbeing. A third (30 per cent) told us that work *often* or *always* has a negative impact, while almost half (49 per cent) said it does so *sometimes* (see Chart 6).

Nursing can be a physically demanding job, with high levels of musculoskeletal stress and a high risk of infection. It can also be mentally demanding – it requires individuals to be constantly on the ball – as well as emotionally draining.

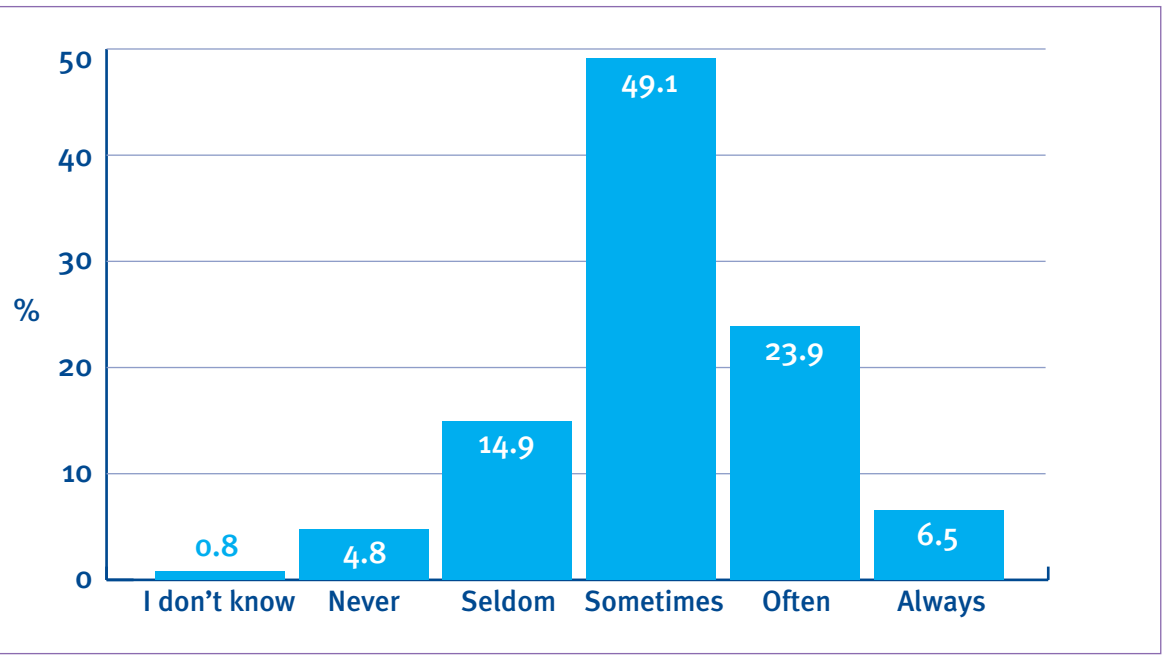
Work stressors and hazards can have an impact on health outcomes. Stressors can arise from the way the job is organised, such as shift working, overtime and long hours, while hazards can include needlestick injuries, exposure to harmful substances, patient violence and abuse and physical job demands.

When probed further about the causes of ill health or injury at work, the biggest culprits by far for nursing staff are the dual causes of stress and workload. Around a third of respondents also cite the impact of relationships with managers or colleagues, reinforcing the findings reported in Section 4 which covered the HSE stress management standards.

Table 16: During the last 12 months have you felt unwell or been injured as a result of any of the following at work?

	All %
Stress at work	54.8
Workload	45.9
Relationships with managers/colleagues	32.0
Moving and handling	11.5
Needlestick/sharps injuries	4.4
Slip, trip or fall at work	3.4
Exposure to harmful substances	0.9

Chart 6: My working life has a negative impact on my health and wellbeing (n=1,594)



7.1 Stress, depression and mental health

A literature review undertaken in 2011 (Mark and Smith, 2011) as part of a research project into mental health among nursing staff showed that health professionals as a group are at significant risk from the negative effects of stressful workplaces. The authors state that nurses in particular are at risk from stress-related problems, with high rates of turnover, absenteeism, and burnout, and go on to declare that 'nurses can be exposed on a daily basis to a large number of potent stressors, including conflict with physicians, discrimination, high workload, and dealing with death, patients, and their families… and that many situations encountered by nurses at work have a high cost in 'emotional labour.'

The high incidence of stress in the health care workforce has been well documented and widely acknowledged as having a major impact on recruitment and retention. Indeed, in the joint union survey submitted to the NHS Pay Review Body in 2012, 60 per cent of nurses responding to the survey stated that they had considered leaving the NHS in the previous 12 months. Among these respondents, 83 per cent identified stress as the main issue prompting them to consider leaving. This latest RCN health and wellbeing survey appears to show that nursing staff are highly concerned about the lack of appreciation or management of the issue, as many people's situations continue to just get worse.

"The service is under pressure and many staff are stressed, sickness levels are high and other staff have to take on the work of others leading to more stress. Targets are unrealistic... there doesn't seem to to be any regard about how staff will cope."
NHS Community nurse

"I have suffered from stress due to working conditions and was given no assistance to cope with ever increasing demands."
Staff nurse, NHS hospital unit

"I have depression. The lack of insight and appreciation of my health problems from management is a big stress for me."
Staff nurse, independent health care provider

"I've been seen by an MHP for stress and depression. Manager aware and mildly sympathetic but no change in workload."
NHS clinical nurse specialist

"Depression is not a tolerated illness despite reassurances otherwise."
Staff nurse, NHS outpatients

7.2 Long working hours and shift working

The RCN guidance on shift working (RCN, 2012a) noted that there has been much debate over the benefits and risks of eight-hour shifts versus 12-hour shifts, yet explains that evidence on the impacts on patient outcomes and staff safety are often conflicting. Previous RCN member surveys show that some prefer 12-hour shifts as they need to do fewer shifts and have more days off. However, long hours, fatigue and lack of rest breaks or time to recuperate between shifts are associated with an increased risk of errors.

"My team have been put on 12 hour days and I have noticed a deterioration in my health, both physical and mental."
NHS community psychiatric nurse

"Feeling tired due working lots of time over my contracted hours just to get the job done. Going in when absolutely tired, washed out, stressed out, but needing to because if I go off sick the pressures are even greater upon my return to work."
NHS community mental health nurse

"I took time off with stress-related symptoms...the shift patterns and lack of knowing where I was working from one week to the next affected my ability to plan a social life. Limited social life and not seeing my family equals no life for me."
NHS staff nurse, hospital ward

7.3 Burnout

Burnout is often described as the extreme experience of stress due to physical, emotional and mental exhaustion. Research at King's College London found that nurses in the UK demonstrate the highest rates of work-induced stress in Europe, with 42 per cent describing themselves as burnt out. In 2012 Dr Jocelyn Cornwell of the King's Fund commented in the *Nursing Standard* that: "Many nurses feel under enormous work pressure, but also feel they are not delivering the care they would like and are letting people down. If that goes on for an extended period, and there is no way of thinking or talking about it, it can be destructive. It leads to people shutting off and depersonalising patients."

We spoke to one nurse who has recently left the NHS after more than 20 years. She left on grounds of ill-health and capability. By the time she left she had anxiety performance, loss of confidence and a phobia of nursing. She described how, over time, she had increasingly found herself in conflict between what she was being asked to do and her values as a nurse. She explained that she had tried to bring things up in meetings, but nothing was done and subsequently she felt undermined. Facing other pressures due to high workloads she became increasingly ambivalent, lost confidence and had communication problems. She finally told her manager at her appraisal that she was burnt out and was then redeployed to another job. She feels let down that the symptoms were not spotted and she was not sufficiently supported.

7.4 Emotional support

Several respondents highlighted the need for emotional support in their job, particularly the need to offload to a manager or colleagues. This might be done through clinical supervision or regular meetings. One respondent working as a specialist nurse expressed how grateful she is to have regular access to a clinical psychologist to be able to talk through what are often traumatic aspects of her work. A community nurse told us: *"I would like to feel that I could take the liberty to go off sick for emotional stress, though this doesn't seem allowable, even in a mental health trust."*

7.5 Needlestick injuries

A small number of respondents (4.4 per cent) reported that they had received a needlestick injury in the previous 12 months. NHS Employers confirms that 40,000 incidents are reported each year in England, and that a similar number go unreported. While the majority of needlestick injuries are not life threatening, the possibility of developing infectious diseases such as hepatitis B, hepatitis C or HIV can cause immense distress, anxiety and anguish for nursing and other health care workers.

Research published in *Occupational Medicine* journal (Green and Griffiths, 2013) demonstrates how the psychiatric impact of needlestick and sharps injuries are often overlooked; these injuries can result in nursing staff experiencing sustained psychiatric trauma of a similar severity as being involved in a road accident. The research reveals the main health implications are psychiatric injury caused by fear and worry, often exacerbated by a long waits for blood test results.

7.6 Working with long-term conditions or disabilities

Nursing staff spend their working lives helping people experiencing ill health and injury and preventing ill health. But nurses can also become patients. It is vital then, that where necessary, nurses get the help they need to return to work and are supported well in work.

A large proportion of nurses with a health problem or disability are injured or made ill through their work and they should be fully supported by their employer through rehabilitation and return to work procedures. However, too often we heard from nursing staff who feel unsupported at work and in many cases pressured to return to work following absence due to their condition.

"If I don't go into work, I will end up being in trouble and find myself on an absence caution and threats of dismissal. I am disabled with multiple sclerosis."
E-health adviser

"I am currently off work following breast cancer. A senior manager called three weeks after my surgery and asked if I was coming back as people with cancer often don't return and they wanted to fill my post. There is no support and little if any contact, they rarely reply to correspondence."
Senior nurse, independent or private sector care home

"It is a vicious circle that we are always under staffed, and become run down through overwork and become susceptible to illness, and when we ended up going off with illness, this puts more pressure on those remaining at work, making them more susceptible to illness."
Staff nurse, NHS outpatients

"I have suffered depression/stress with leave, and feel like a 'freak' or 'weak' on return."
Health care assistant, GP practice

"I have depression, long-term and occasionally debilitating. The lack of insight and appreciation of my health problems from management is a big stress for me."
Staff nurse, independent or private sector hospital

"I have a couple of chronic health conditions and have asked for reduced hours to improve my sickness and am not being allowed to do this. I have been harassed into going back to work when still unwell and ended up collapsing and being admitted to hospital. My blood pressure is persistently raised probably made worse by work-related stress."
Clinical nurse specialist, NHS community care

7.7 Recommendations

7.7.1 Managing sickness absence

The Boorman report clearly showed that effective management practices can reduce both sickness and absence; these practices should include the consistent use of appraisals, a supportive approach to staff and fast access to care and support.

This survey, however, has identified that staff with long-term health conditions encounter a number of difficulties in managing their working life. Some of these problems are associated with punitive approaches to sickness absence management, and it is therefore important that organisations are mindful of the Equality Act 2010 in relation to disabled employees and make appropriate adjustments to support employment.

The Equality Act states that is against the law for employers to discriminate against anyone because of a disability. It also states that an employer has to make reasonable adjustments to avoid employees being put at a disadvantage compared to other people in the workplace; this could include adjusting working hours or providing a special piece of equipment to help people undertake their job. Guidance for workers and employers on the Equality Act and disability can be found at the Equality and Human Rights Commission website www.equalityhumanrights.com

NHS organisations need to ensure they are implementing *Annex Z: Managing sickness absences – developing local policy and procedures* of the Agenda for Change agreement. This sets out arrangements which are intended to support employers and staff in the management of sickness absence and in managing the risk of premature and unnecessary ill health retirements (NHS Staff Council, 2013).

The RCN also recommends that NICE guidelines (NICE, 2009a) on the management of long-term sickness absence are followed. These provide an evidence based framework to support staff with long-term conditions and aim to help employers and employees work together to ensure the right support is available to help someone on sickness absence return to work as soon as they are able.

7.7.2 Mental health

A growing proportion of the working population has mental health conditions, highlighting the need for support and appropriate adjustments within the workplace. Yet all too often mental health issues are taboo in the workplace and many people find it difficult to talk to colleagues and managers. Health care organisations should be exemplar employers in this area; by demonstrating healthy work environments and successful employment policies they can then convince others to do the same.

There are a number of national initiatives which have been developed to promote and support the employment of staff with mental health conditions. These include NICE guidelines on promoting mental wellbeing at work (NICE, 2009b) together with guidance from Mind (2011) and Acas (2012). Guidance is also available from such organisations as Mind and Acas.

7.7.3 Older workers

Older workers form a large part of the nursing workforce and they are more likely to be living with one or more long-term conditions. Since the normal retirement age for all workers is set to increase and may be extended even further, it is vital that age-appropriate plans are put in place now in order to avoid difficulties in the future. In jobs with a high physical workload, such as nursing, reduced physical capacity can also be a problem. However, given the right conditions and environment, most older workers are able to stay healthy and physically able to do their jobs. The European Agency for Health and Safety at Work (EU-OSHA, 2012) makes the following recommendations:

- age-related factors are taken into account in assigning particular tasks to individuals to find the right balance between the work and the people who carry it out
- health promotion takes place to help workers adopt a healthy lifestyle
- proper risk assessments are carried out which take into consideration individual differences between workers in terms of their capacities and health
- individual work tasks are redesigned to suit older workers; for example, through the reduction of physical workloads, or regular short breaks through the working day.

The CIPD and TUC have published joint guidance (CIPD, 2007) on good age management practices and managing without a retirement age, reflecting the business case for extending working life and employing people of all ages.

RCN guidance (RCN, 2011c) on the employment of older nurses provides information for RCN representatives and officers to help them influence health and social care employers to apply good practice in the effective management of the older nursing workforce. There are mutual benefits for all: health and social care employers will improve retention of older, experienced nurses; patients will receive quality care from nurses who understand and can empathise with their needs; and nurses will feel valued at work and therefore more willing to consider working beyond retirement age.

7.7.4 Physical hazards

It is important that physical hazards are not overlooked. Significant numbers of the nursing workforce continue to be exposed to risks from moving and handling activities, needlestick/sharps injuries, slips, trips and falls and exposure to harmful substances which could lead to dermatitis or asthma. There is a robust legal framework that employers must follow to ensure risks are managed.

In May 2103 new regulation on the prevention of sharps injuries came into force in the UK; the Health and Safety (Sharps Injuries in Healthcare) Regulations 2013 require employers to take specific steps to reduce the risk of sharps injuries. The RCN has produced guidance to support implementation of the EU Directive (RCN, 2011a) which is of particular use to health and safety representatives and members of the workforce with responsibility for infection control and occupational health.

The guidance states that 'everyone has a role to play in the prevention of sharps injuries to health care workers. From the chief executive and board directors, who have overall legal responsibility for the health and safety of their staff, to the individual nurse or health care worker – all have a duty to ensure that they protect themselves and others around them by safely using and disposing of sharp equipment.'

The NHS Staff Council Occupational health and safety standards (NHS Staff Council, 2010) provides guidance for health care organisations on managing workplace health and safety and are designed to help trusts meet their legal obligations and protect both staff and patients.

7.7.5 Managing health at work in the NHS

NHS Scotland has developed 10 guidelines around the protection and promotion of the health, safety and wellbeing of its staff. These range from stress at work to glove selection. The guidelines can be accessed at www.staffgovernance.scot.nhs.uk/partnership

NHS Employers in England provides guidance on developing and implementing a health and wellbeing strategy, more information is available at www.nhsemployers.org/HealthyWorkplaces

RCN support for injured, ill and disabled members

The RCN runs a Peer Support service for injured, ill and disabled RCN members to share experiences and knowledge. It is a membership group for any member affected by physical or psychological injury, ill health or disability - whether work-related or not. The group exists to assist members in making connections with peers to give and receive support, and information on the group and its services can be found on the RCN website at www.rcn.org.uk

8

Bullying, harassment and violence

We asked respondents about their experiences of verbal or physical violence and about workplace bullying. We found that well over half (56 per cent) have experienced verbal or physical violence from patients or service users and almost half (48 per cent) have done so from relatives of patients/service users.

The 2012 NHS Staff Survey for England found that a quarter (24 per cent) of registered nurses/midwives had experienced physical violence from patients, relatives or other members of the public and two-fifths (42 per cent) had experienced bullying, harassment or abuse. Among nursing and health care assistants, a third (35 per cent) had experienced physical violence from patients, relatives or other members of the public and 38 per cent had experienced bullying, harassment or abuse. The 2013 NHS Staff Survey for Wales found that 18 per cent of employees have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public. One in ten (11 per cent) have personally experienced physical violence at work from patients/service users or other members of the public.

The RCN 2011 employment survey asked respondents similar questions about violence and harassment; almost a third stated (30 per cent) stated that they had experienced violence or harassment from a patient/client or a member of their family. This more recent survey has captured a worryingly high level of verbal aggression perpetrated by patients or service users and their family members.

Around a fifth of respondents stated that they had experienced bullying from either a manager (23 per cent) or colleague (21 per cent). This is a similar finding to the RCN 2011 employment survey in which a quarter of respondents (27 per cent) stated that they had experienced bullying or harassment from a team member or manager. The 2012 NHS Staff Survey for England reported that similar numbers of registered nurses and midwives (27 per cent) and nursing/health care assistants (22 per cent) had experienced bullying, harassment and abuse from managers, team leaders or colleagues. The 2013 NHS Wales Staff Survey showed that and 18 per cent have personally experienced harassment, bullying or abuse at work from a manager/team leader or other colleagues.

Table 17: Have you had personal experience of any of the following?

	%
Verbal or physical violence	
Patients/service users	56.3
Relatives of patients/service users	47.6
Colleagues	20.7
Other members of the public	14.8
Manager/team leader	14.7
Workplace bullying	
Manager	22.6
Colleague	21.0

8.1 Physical and verbal violence from patients, service users or their relatives

A large number of respondents reported that some form of verbal or physical violence or abuse from patients, service users or their relatives was expected to some degree within their area of practice.

Physical and verbal violence as 'the norm'

"Abuse largely comes from confused patients to which there are limits to their management."
Sister, NHS hospital ward

"Because of the type of patients I care for, I experience verbal violence frequently and physical violence at least once on a monthly basis."
Staff nurse acute/urgent hospital ward

"I have received verbal violence probably on a weekly basis, mainly from irate relatives and 'confused' patients. I feel my employer's response is that of a 'it's part of the job' type."
Sister, NHS acute/urgent hospital ward

While many members expect some degree of abuse or violence, a significant proportion also stated that they received good support from their managers.

Good management support

"I felt very well supported by my line manager and by senior management after suffering from extreme verbal abuse in an incident this year."
NHS community mental health nurse

"The nature of my job leaves me and my colleagues open to a lot of verbal harassment – we are supported by our managers, the PCT and the prison."
Practice nurse in prison health care department

"Increase in patients with dementia, staff often abused verbally or physically. Trust now providing breakaway training and conflict resolution training."
Staff nurse, NHS hospital ward

However, a similar number also stated that they did not feel well supported by colleagues or managers, when having to deal with aggressive patients or members of their family.

Lack of management support

"I was once punched in the face by a patient with dementia. I told the sister on duty who laughed and made no attempt to ask after my welfare. There is no point reporting these incidents formally as managers do not demonstrate any genuine concern for the physical safety and wellbeing of staff."
Staff nurse, NHS hospital ward

"Often when patients and or relatives are angry, staff are encouraged to let it go or be sympathetic. It can be quite tiring or hurtful to staff leaving them feeling inadequate."
Staff nurse, NHS adult intensive care

"I don't always feel safe on the ward or supported with aggressive patients as we are short staffed or have too many special patients on the ward stretching the staffing levels."
Staff nurse, NHS hospital ward

8.2 Workplace bullying and harassment

Bullying can be overt and involve arguments and rudeness, but it can also be more subtle. Bullying can involve excluding and ignoring people and their contribution, unacceptable criticisms and overloading people with work.
We asked respondents to elaborate on their experiences of bullying and harassment in the workplace and nursing staff described both covert and overt bullying, for example one respondent stated: "Bullying and harassment is not easy to prove." Another stated that: "Bullying is sometimes too subtle for the victim to articulate fully what is actually happening. And as such, is incredibly difficult to deal with," while another respondent explained that "bullying is subtle, chipping away to wear you down".

The range of responses shows that bullying and harassment can involve a wide spectrum of behaviours. For example, several members stated that bullying occurred through the allocation of duties or shifts while others described how workplace cliques cause disquiet and concern. The quotes below provide a small sample of the issues being raised around bullying and harassment in the workplace from managers, colleagues and from the organisation as a whole.

Descriptions of bullying

"Our manager does the e-roster and gives no consideration to the outside lives of staff or the impact of poor shift patterns eg night shifts finishing on a Saturday morning with a day off on Sunday and back to work long days from the Monday. We are not allowed to have any sort of pattern to our duties; they have to be completely random or managers ask why we are working similar shifts most weeks – so no-one can book weekly educational or exercise classes without having to use up all of their requests. We are only allowed four requests in a four-week period. This is very restricting considering that we could be rostered to work any hour of any day throughout the whole year. If you want a long weekend off to visit family, you cannot make any other requests for four weeks. Caring profession? I think not!"
Staff nurse, NHS hospital ward

"Some senior managers bully covertly by keeping on saying about job losses. Our CEO said that any conduct that deviates from trust expectations, the person will be 'dealt with'. Staff are 'disappearing' after being off sick with stress or investigations, there is a culture of fear and mistakes will be punished with no second chances given. Staff are being rebanded but still expected to do the same or more work. If anything is said by staff, they are spoken to for their attitude."
NHS senior community nurse, learning disabilities

"I would class it more as harassment and disrespect for my role. I think responses are reactive, not proactive with the attitude that heads will roll if targets are not met or practice is not improved."
Senior nurse, NHS hospital unit

"Bank staff are bullied and harassed by permanent members of some units. The idea of team work is far fetched."
Health care assistant, NHS Bank

8.3 Bullying: firm management or unpleasant behaviour?

Bullying can be difficult to pin down; respondents pointed to instances of bullying in their workplace ranging from outright aggression to something far more subtle, while the comments of others raise questions as to whether what is perceived as bullying is in fact something else – firm management or just unpleasant behaviour. For example, one NHS sister said: *"Staff use the term bully very easily when they interpret this from just being managed."* One of our telephone interviewees even referred to the *"right kind of bullying"* being used to get *"people to do things"*. Another nurse stated: *"There is a member staff who likes to talk loudly and have a go at you, but I don't think this is bullying."*

The following extract taken from Acas guidance (Acas, 2010) gives a helpful description of bullying and harassment at work.

Acas guidance on bullying and harassment at work

Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual.

Examples of bullying/harassing behaviour include:

- spreading malicious rumours, or insulting someone by word or behaviour
- copying memos that are critical about someone to others who do not need to know
- ridiculing or demeaning someone – picking on them or setting them up to fail
- exclusion or victimisation
- unfair treatment
- overbearing supervision or other misuse of power or position
- unwelcome sexual advances
- making threats or comments about job security without foundation
- deliberately undermining a competent worker by overloading and constant criticism
- preventing individuals progressing by intentionally blocking promotion or training opportunities.

Bullying and harassment are not necessarily face to face. They may also occur in written communications, email, phone, and automatic supervision methods such as computer recording of downtime from work or the number of calls handled if these are not applied to all workers.

Further information is available from: www.acas.org.uk

8.4 Management support

Bullying and harassment takes place in all sectors of the economy and nursing is no exception, yet all employers have a duty of care to provide a safe working environment. When asked to provide further information about workplace bullying or harassment, many members described how they are well supported by their manager. However, many more said they felt let down by managers.

Positive feedback

"One consultant has bullying behaviour but we have been supported wholly by our manager."
NHS district nurse

"My workplace is very supportive and relationships between staff members are excellent. No bullying/harassment would be tolerated by anyone."
GP practice nurse

"One of my colleagues was verbally abusive but this has been resolved by management and we now have a good working relationship."
NHS staff nurse

Negative feedback

"I was bullied by a consultant that I work for. My manager told me the consultant 'wasn't that bad' after witnessing verbal abuse by the consultant towards me in a meeting. I therefore felt it was useless to put in a complaint as I would not be supported."
Sister, NHS mental health ward

"I have experienced verbal aggression and intimidation from a colleague. I was not supported by my immediate manager or matron and subsequently experienced stress-related ill health."
Clinical nurse specialist , NHS hospital unit

"No support from other senior staff or managers, when bullying or harassment is from another senior member of the nursing team."
NHS staff nurse, acute/urgent care

8.5 Corporate culture, bullying and organisational change

Many respondents referred to corporate bullying within their organisation, where bullying has become entrenched in the culture. This is often described as being linked to organisational change, as well as an increased emphasis on performance within tight budgetary constraints.

Looking at this issue in relation to the HSE management standards, organisational change can impact on all six factors. An increase in workplace ***demands*** may place pressure on individuals to work longer, faster or more intensively and result in undue stress. In turn, this impacts on the factor of ***'control'*** and ability to be self determining. ***Support***, in terms of management help and feedback, may be lacking during times of rapid change while clarity of ***role*** and quality of ***relationships*** may be undermined. ***Change*** is often imposed with a lack of, or perceived lack of consultation and communication.

"I believe that corporate bullying is occurring in my organisation as it is impossible to achieve what is expected of us with the resources we are given. Staff have expressed concerns about standards and safety of patients and staff in writing without any response from any level of management."
NHS district nurse

"The entire culture of the organisation is shifting, becoming hard line and unforgiving. As pressure builds up on individuals, some respond by exhibiting bullying behaviour to others."
Manager, NHS

"Low morale and workload demand due to practices brought in by management have an impact on inter-department relations."
Sister, NHS hospital ward

8.6 Concerns about safety and quality of care

Several respondents described their inability to perform their job to the standard they would wish to achieve and their frustrations in a perceived lack of support from their managers. In many cases nursing staff equated this to a form of bullying.

"I felt that I am bullied when I object to certain duties that I consider unsafe."
School nurse

"Under ongoing pressure to provide beds on an acute ward through inappropriate outlying of patients and early discharges due to bed crises and lack of staffing."
Staff nurse, NHS acute/urgent care hospital unit

"Bullying is a difficult concept to define – unrealistic deadlines and pressure to complete tasks are more common. Unrealistic workload and areas of responsibility with constant expectations to 'work smarter' without additional resource to undertake a high quality approach to role."
NHS senior infection prevention nurse

"Difficulties experienced in rotating to other clinical areas to update. Had to threaten those responsible for allocations with outside intervention unless they helped me to fulfil my competences."
NHS midwife

8.7 The middle management squeeze

Responses from senior nurses, matrons and sisters reveal the extent of pressure they feel from all sides – from members of their team as well as senior managers. Some comments highlight respondent concerns about the impact of pressure they receive from senior managers which, in turn, is felt by their team. In other cases respondents share anxieties about managing bullying by colleagues within the team they lead or even feeling bullied by their team.

"Low morale and workload demand due to practices brought in by management have an impact on inter-department relations."
Sister, NHS hospital ward

"When I emailed incident forms reporting risks to patients, I was made to feel the problem was with me and my team. Senior managers wanted to performance manage me."
Sister, NHS hospital unit

"Some staff are aggressive verbally if they feel wronged and can be nasty towards me."
Sister, independent sector care home

"Some of my staff have felt harassed from their colleagues. This makes me stressed as I feel I am not managing them well if they are making people feel like this."
Senior nurse, charity

Increasing numbers of her team, tell her they are worried about fulfilling the NMC codes of conduct. Meanwhile she feels under pressure from managers for her team members to undertake training but says *"we don't have time for training and taking people out would mean dangerous staff levels, so as a team leader I'm caught in the middle."*
Extract from interview with 'Lucy', NHS clinical team leader

8.8 Black and minority ethnic nurses

Concerns about the position and experiences of black and minority ethnic (BME) nursing staff in health care have been well highlighted by research which is often followed by policy statements and employment initiatives. Despite this, BME staff continue to be significantly underrepresented in more senior positions of the workforce and continue to report experiences of marginalisation.

The RCN survey found that a higher proportion of BME respondents, compared to white respondents, reported having experienced bullying from managers; a quarter (24 per cent) of white and Asian respondents, a fifth (20 per cent) of mixed race respondents and a third (36 per cent) of Black respondents reported they had been bullied by a manager.

A higher proportion of BME respondents also reported bullying from colleagues. Just over one fifth (22 per cent) of white and 11 per cent of mixed race respondents reported having experienced bullying from colleagues, compared to 31 per cent of black and 38 per cent of Asian respondents.

The following comments from the survey and telephone interviews highlight the scale of the problem among the nursing workforce. The research reveals how some BME nurses feel that they are not given support in career progression, and in some cases feel marginalised among their own teams. Among overseas nurses, we found exasperation that skills, qualifications and experience gained abroad are not sufficiently recognized; in one case a care home nurse described her frustrations at being tied to one employer as a condition of her work permit.

"Being on a work permit and tied to one employer, it gives room for a lot of abuse and bullying. You're afraid you might get sacked and having another permit will be a problem, so it goes unreported. There is a lot of abuse, bullying and intimidation in private sector where most workers are on sponsorship. I have been a victim and will continue to suffer until I'm a permanent resident."
Staff nurse, care home

"As junior sister I am often ignored by my manager. Information is given to ward staff before me, I am undermined and ignored, the only real contact is via email to pass on management duties. I find it hard to talk to her as although not expressed I feel there is an underlying racial element and am aware the 'non-white' staff feel this. I tried to report this to matron two years ago but she said there was no evidence and things have been more difficult since."
Sister, NHS hospital ward

"There is indirect racial abuse and blame culture, stopping people going on courses and work promotions even you have enough experience, qualifications and good skills. Because you do not belong to my colour skin and do not speak Queen's English."
Staff nurse, NHS hospital ward

'Rahma' reported feeling embittered that her extensive qualifications and experience gained abroad are not fully recognised in the UK and that her skills have been underused. She feels that this is part of the culture, rather than specific to any particular organisation or sector.
Extract from telephone interview with 'Rahma' NHS staff nurse.

8.9 Illness or injury and return to work

Several members described how they have felt under pressure to return to work after an illness or injury and how their treatment had felt like bullying or harassment.

"I felt bullied into returning to work and having the threat of formal warnings for sickness hanging over me."
Staff nurse, NHS outpatients

"Not bullying but made to feel time off sick may not be genuine – although I 100 per cent was. I was signed off with moderate depression."
Staff nurse, NHS hospital ward

8.10 Members accused of bullying and harassment

We also heard from several members who have themselves been accused of bullying and harassment by a member of their team; while some felt well supported, more felt aggrieved by how the situation was handled.

"When I was accused of B&H and disciplined I was totally unsupported, nobody listened to me or looked at the causes and why things happened when I had become very stressed due to my work."
NHS community nurse

"I have experienced a malicious bullying and harassment grievance by a junior member of staff who would not tolerate being managed by me. A full investigation occurred in which I was exonerated; however I do not feel I have been supported by my organisation during a very lengthy and stressful process. Managers should be supported throughout such processes and not be left to their own devices."
NHS social care manager

8.11 Taking a stand against bullying, harassment or violence

Some respondents have taken a stand against bullying, harassment or violence by directly confronting the bully, making a complaint or taking collective action. In other cases a more extreme position was taken; leaving the organisation or even the profession completely.

"Have had to take time off with work-related stress and leave employment because of bullying and intimidation from manager and colleague."
Staff nurse, independent sector care home

"No one would believe that I was being bullied for 7.5 years and only when I got to rock bottom and brought in the union was anything done about it. I now have it in writing that I was bullied and harassed by several staff, management and upper management. I was ready to leave nursing as I was made to think I was rubbish at my senior role. I now have my confidence and career back."
NHS community nursing sister

"I left one job as there was continued and systematic abuse by a few band sixes/seven, thankfully not often directed towards myself but it was difficult to work in that atmosphere. It was reported by the junior staff member but nothing was done."
NHS community nurse

8.12 Recommendations

8.12.1 Violence and aggression

All too often violence and aggression are seen as part of the job for health and social care workers, but physical assaults can have an instant impact and result in absence from work and even long-term psychological trauma. Constant verbal abuse and dealing with challenging behaviour such as hair pulling or pinching on a daily basis are also damaging to health, wellbeing and morale.

The RCN regularly works with employers to ensure that they have robust risk assessments in place to address the underlying causes of violence and aggression in health care environments. The RCN tool (RCN, 2008) on work-related violence provides a framework to address risks and identify

necessary changes to the physical environment, safe staffing levels and training, provides practical support, in completing assessments of work-related violence, and allows employees and organisations to gain more knowledge of the risks involved, and subsequently more control over reducing work-related violence.

In cases where staff have been assaulted at work we call on employers to fully support staff; this support should include effective liaison with the police. In turn, staff must be encouraged to report all instances of physical and verbal abuse, even where it is not appropriate to prosecute an individual with limited or no capacity. Employers need to assess the risks and take action to reduce the likelihood of assault, and staff must be provided with feedback on what actions have been taken as a result of an assault.

Violence should never be seen as part of the job and all nursing staff have a right to work in a safe and secure environment. Governments, health departments and enforcement bodies must send out this clear message to health care staff, patients, clients and their families.

8.12.2 Bullying and harassment

The survey has identified that bullying and harassment are an ongoing concern for members. Sadly this is a recurrent theme of numerous surveys and high profile inquiries into systematic failures in health care provision. While the majority of organisations have programmes and policies in place to cover dignity at work and bullying and harassment – the reality for many is a far cry from such policies.

The RCN calls on all health care organisations to ensure they regularly carry out suitable and sufficient risk assessments on workplace stress, as directed by the Management of Health and Safety at Work Regulations 1999. The HSE's stress management standards provide a framework for health care organisations can use to prevent and reduce the risks of work-related causes of stress. In relation to bullying and relationships at work, the HSE expects organisations to:

- promote positive behaviours at work to avoid conflict and ensure fairness
- ensure employees share information relevant to their work
- have agreed policies and procedures to prevent or resolve unacceptable behaviour
- have systems in place to enable and encourage managers to deal with unacceptable behaviour
- ensure systems are in place to enable and encourage employees to report unacceptable behaviour.

The RCN and other trade unions regularly work with organisations to identify bullying hot spots using staff survey results and other sources of data to take measures to tackle the underlying causes of bullying behaviour.

The RCN is clear that bullying is best dealt with when staff, their representatives and managers work in partnership, and endorses an active approach to reducing bullying and harassment and encouraging "a workplace culture in which everybody treats their colleagues with dignity and respect, and where all steps are taken to minimise the occurrence of bullying and harassment". Achieving this culture depends on effective management practices that promote fairness and addressing concerns promptly; from the board down, line managers play a key role in setting a culture of respect that does not tolerate bullying behaviour.

The RCN's Working with care toolkit (RCN, 2005) provides a framework for promoting positive working relationships in health care environments and supplies self-assessment toolkits to help organisations support and nurture relationships within health care teams.

National partnership initiatives such as NHS Scotland's *Dignity at work toolkit* (available online at www.staffgovernance.scot.nhs.uk) provide effective frameworks for local implementation, while the Welsh Partnership Forum's dignity at work guidance *Working in partnership: bringing respect to work* (2007) sets out core standards that are expected of all NHS staff.

8.12.3 Challenging racism and discrimination in the workplace

Nurses from black and minority ethnic backgrounds are often significantly under-represented in senior nursing posts and a disproportionate number are represented in disciplinary cases (Nursing Standard, 2012); in addition a disproportionate number of BME registrants are referred to the Nursing and Midwifery Council.

BME staff are more likely to be involved in disciplinary proceedings and to experience bullying and harassment than their white counterparts, and are under-represented in senior posts. This underlines the need for improved data collection on the employment experience of BME nursing staff so that effective action can be taken to provide support.

The RCN has implemented a three-year programme – *Is that discrimination?* – to tackle such systemic issues in the workplace and provide a coherent response to the issues of discrimination faced by BME nurses and health care support workers because of their age, disability, sexual orientation or religion, faith and belief for example. The project itself has three phases:

- raising member awareness of different forms of discrimination and the importance of exercising their employment rights
- enhancing the learning and development support available to accredited RCN representatives and caseworkers to improve their skills in identifying and challenging discrimination in the workplace
- working in partnership with employers to improve their employment practices and deliver more equitable outcomes for their employees; the RCN will employ a range of new techniques and skills to help organisations in tackling discriminatory workplace cultures.

8.12.4 NHS career pathways

The RCN has been concerned at the loss of investment in programmes such as the NHS *Breaking Through Programme* which, as a result, will further constrict developmental and career progression for BME nurses. We are also concerned that a reduction in posts held by senior BME nurses appears to be exacerbated throughout successive NHS reorganisations. We therefore urge employers to invest in the development and training of all nursing staff and ask them to pay particular consideration to the needs of BME staff.

In September 2012 the RCN, in partnership with the NHS Leadership Academy, agreed to sponsor a joint project aimed at supporting BME nurses leaders in response to growing concern about the sharply declining numbers of senior BME nurses. As a result of this work the RCN has committed to establishing a BME group within the Executive Nurse Network to address a range of issues, including career progression. Details of the BME Leadership Forum, which is hosted by the NHS Confederation in partnership with the RCN, can be found at www.nhsconfed.org

8.12.5 Nurses trained outside the UK and the European Economic Area (EEA)

This research highlighted ongoing confusion surrounding the rights and status of overseas nursing staff. Anyone wanting to work in the UK as a nurse must register with the Nursing and Midwifery Council (NMC), however this does not provide the right to work in the UK. Nurses can apply to be on the NMC Register; if they meet NMC standards their training will be compared with that required in the UK.

The only route to NMC registration for nurses trained outside the UK and EEA is through the Overseas Nurses Programme (ONP). The scheme provides a compulsory period of protected learning and, where appropriate, supervised practice; individuals must have a sponsor (the employer) in order to enter the UK to complete an ONP.

An overseas nurse who has a work permit and wishes to take work additional to that for which the permit was issued, may do so provided the work is:

- outside of their normal working hours
- no more than 20 hours per week
- in the same profession and at the same professional level for which the permit was issued
- not employment by a recruitment agency or employment agency.

Additional work can bring significant benefits in terms of professional experience and development as well as personal finances.

For overseas nurses who cannot register to work as a registered nurse or midwife and are currently living in the UK, the only method of upgrading overseas nursing qualifications is by undertaking a pre-registration nursing or midwifery programme at a university.

Many RCN members have concerns about working under a permit, or the points based system for managing student and employment migration to the UK; RCN Member Support Services can provide free confidential advice, guidance, representation and support.

9

Occupational health

While the promotion of good health and wellbeing is everyone's responsibility, occupational health services play a vital role and perform a wide range of functions; these include pre-employment health screening, implementing strategies to prevent illness and injury; helping get people back to work after illness or injury, and health promotion.

The Boorman Review (DH, 2009) stated that reducing working-age ill health has the potential to save the UK up to £100 billion a year. The RCN has consistently argued this can only be achieved through the adequate resourcing of occupational health services to support the implementation of proactive measures and not to simply engage in attendance management and reactive services.

We asked nursing staff to describe their level of access to occupational health services. The majority (86 per cent) stated they have access to these services at work, yet just over half (54 per cent) felt confident these would be helpful. In addition, just under two-thirds (61 per cent) said that they could access occupational health services without a referral.

Table 18: Access to occupational health services

	Yes %	No %	Don't know %
I have access to occupational health services at work	86	9	5
I feel confident that occupational health services would be helpful if I contact them	54	17	29
I can access occupational health services without a referral	61	10	26

An examination of these findings in more depth reveals that nursing staff working in the NHS, for social enterprises and universities were more likely to report having access to occupational health services than staff in other sectors. The majority of NHS nursing staff (98 per cent) stated they have access to services compared to just 54 per cent of those working in GP practices, 45 per cent in the independent sector and 66 per cent in the charity/voluntary sector.

However, confidence in the helpfulness of the services offered is consistently much lower across all sectors, particularly for those working in the charity/voluntary sector where just 31 per cent stated they felt confident that occupational health services would be helpful if contacted.

The group of nursing staff least likely to state they can access OH services without a referral are those working in universities and the independent sector, while respondents working in the NHS or for social enterprises are most confident of being able to refer themselves.

Table 19: Access to occupational health services – by sector

	NHS %	GP practice %	Independent sector %	Charity/ voluntary sector %	Social enterprise %	University %
I have access to occupational health services at work	98	54	44	66	93	93
I feel confident that occupational health services would be helpful if I contact them	54	50	55	31	56	54
I can access occupational health services without a referral	67	52	43	50	72	15

We gave members the opportunity to share their experiences of occupational health services. Responses are divided into different themes below.

9.1 Positive feedback

Positive comments were made about quality of or access to services provided. A staff nurse working in the independent sector stated: *"occupational health is routinely done and I believe if I have the need for help it will be easily accessible to me"*, while a GP practice nurse told us that: *"I recently had a needlestick injury from an unknown source and the occ health department have been really helpful and supportive."*

An NHS staff nurse also said: *"I work in a busy emergency department which can have traumatic events; we regularly are debriefed and also given further opportunity to talk if needed. I have access to counselling services for both work and personal problems and this is easily accessed and extremely helpful."* Positive feedback was also made about the ability to self refer to occupational health services.

9.2 Negative feedback

9.2.1 Difficulties in accessing services

Respondents stated that they have had difficulties in accessing OH services. Problems relate to long waiting lists, services located too far away or in an inconvenient location and lack of information on services provided. In some cases respondents stated that their employer offered no occupational health services at all.

One nurse working in the NHS stated: *"I recently had to make a 60 mile round trip to see an OH doctor"* while another stated *"I heard our OHS has moved to another area and merged with another organisation. I have not received any communication regarding this. So I do not know how to contact OH. Also it is an hour's drive away from where I work."* We were also told by an NHS staff nurse that: *"As I work night duty occupational health is unavailable during my working hours."*

9.2.2 Line management referral

Several members described how they were unable to self refer, but had to go through their line manager. In some cases members were put off approaching their manager, while in others they were actively blocked from accessing services by the manager. A typical response from one member was the following: *"If I need to go to occupational health my Clinical Lead has to refer me first so I have to explain why to them. It is not confidential."*

9.2.3 Negative perceptions of occupational health

Negative views mostly relate to a perception that the services are not confidential and in some cases that using occupational health would be used against them. One nurse working in the independent sector stated that *"occupational health was used as a threat and not as a positive thing"* and another working in the NHS stated that *"records held by occupational health can affect employment opportunities."*

Other typical statements were that occupational health services are *"not really open to staff in the way they would want, many staff are fearful of this dept and the support is not constructive. It is seen as a management tactic without solving the issues"*.

An occupational nurse saw the problem as lying with line managers, stating: *"I see the results of extensive harassment and bullying on staff. I have even faced attempted bullying from executives to produce a report in their favour instead protecting a deserving staff member."*

9.2.4 Health and wellbeing issues not properly addressed

Respondents also expressed frustration or dissatisfaction with the service received from occupational health, either because their specific needs were not fully addressed or not enough time was invested in tackling their problems.

We were told by a nurse practitioner working in the NHS that they had accessed OH services for a psychological problem, reporting that: *"The clinician did not have any skills in mental health issues. The appointment left me feeling worse."* Meanwhile, a district nurse working at a GP practice stated that *"they cannot offer any practical solution apart from telling me to take my breaks that is not possible all the time"*.

9.2.5 Problems with OH recommendations being implemented

Problems were also highlighted with OH recommendations being implemented in the workplace. Typical responses included *"whilst they can speak with you about health problems and so forth they can only make suggestions to the manager, not tell them what should happen"* and that *"when occupational health have given their instruction on matters, my line manager has baulked at it and said that she has no intention of being told what to do by them"*.

9.3 Recommendations

Occupational health services play an important role in promoting the health and wellbeing of staff. The RCN supports the implementation of Safe Effective Quality Occupational Health Service (SEQOHS) standards and the process of voluntary accreditation (www.seqohs.org). A number of NHS organisations have already achieved SEQOHS accreditation, and all providers of occupational health services to health care organisations should meet these standards. Investment in good OH support, which is valued by staff, will contribute to patient outcomes through its role in supporting the health of staff.

In addition to the SEQOHS standard around accessible OH services, the RCN believes that health care staff should be able to self refer to OH services. Self-referral provides an opportunity for staff to commence early interventions, as well as protecting confidentiality and promoting trust in occupational health services. Above all, it sends a clear message that staff are valued.

A number of reviews and audits into sickness absence in health care, including the Boorman review (DH, 2009), have recommended the implementation of early intervention programmes which allow prompt access to treatment and rehabilitation services for health care staff. Such programmes have been found to be cost-effective, ensure that staff absence (and time away from patient care) is minimised, and reduce the risk of conditions such as musculoskeletal disorders developing into long-term conditions. The RCN calls for the universal implementation of early intervention programmes for the nursing workforce.

NHS Employers (NHS Employers, 2012) has published guidance for NHS organisations on how to manage rapid access services for staff in their organisation. The rapid access system is designed to secure rehabilitation and OH treatment for NHS employees with a view to facilitating a return to work which is, as fast as practical, and reasonable.

10

Pre-registration students

This section reviews results for the 56 respondents who indicated they were pre-registration students.

Student retention has been an issue for concern for many years, with various factors associated either with the students themselves or the university or practice environment contributing to students' decisions to leave.

Research carried out by *Nursing Standard* shows that across 30 universities across the UK, 21 per cent of those who embarked on the three-year degree in 2008 did not complete it in 2011. This is a long-standing issue that has implications for NHS finances and for the future supply of nurses.

Gaining the student viewpoint of their placements can provide an insight into the student experience as they make the transition from the academic setting to the practice setting. Placements represent around 50 per cent of the course programme and are often singled out as a primary reason for student attrition.

While this is a small group of survey respondents, their feedback provides an interesting perspective on health, wellbeing and stress among those students who have recently undertaken placements.

Placements are a vital part of nursing degrees, allowing students to develop clinical and inter-personal skills. However, organisational cultures within the workplace can also be highly influential in affecting both the quality of the placement, and learned behaviours of the students. It is important therefore that these cultures do not undermine efforts to provide high-quality learning experiences for the next generation of nurses.

10.1 Profile of student respondents

- The majority of the student respondents are aged 44 or under and are white.
- When asked about their current or latest placement, the majority worked in either acute/urgent care or on an adult/general/medical/surgical ward or a hospital unit.

Table 20: Age

	n	%
25 or under	27	48.2
26-34	9	16.1
35-44	16	28.6
45-54	4	7.1
Total	**56**	**100**

Table 21: Ethnicity

	n	%
White	49	87.5
Black/African/Caribbean	2	3.6
Mixed/multiple ethnic groups	2	3.6
Prefer not to say	1	1.8
Other – not specified	2	3.6
Total	**56**	**100**

Table 22: Area of practice for current or latest placement

	n	%
Acute/urgent care	16	29.1
Adult/general/medical/surgical	13	23.6
Children and young people	6	10.9
Learning disabilities	6	10.9
Mental health	5	9.1
Primary/community care	3	5.5
Surgery	2	3.6
Long-term conditions	2	3.6
Older people	1	1.8
School nursing	1	1.8
Total	**55**	**100**

10.2 HSE management standards

This section looks at the findings from the HSE management standards indicator tool, comparing results for students to the whole group.

Table 23: HSE management standards – average scores

	All	Students
	1=low wellbeing 5=high wellbeing	
Demands	2.50	2.86
Control	3.08	2.79
Managerial support	3.08	2.79
Peer support	3.56	3.69
Role	4.20	4.01
Change	2.78	2.75

Overall, pre-registration students on placement indicated a marginally higher level of wellbeing than nursing staff in general in relation to the demands made on them and peer support. However, levels of wellbeing relating to control over work, job role and change at work are all lower, suggesting dissatisfaction at how placements are designed and managed.

Chart 7 indicates that a slightly higher proportion of pre-registration students stated that their levels of stress had increased over the previous year than the whole group (78 per cent compared to 73 per cent).

Chart 7: Over the last 12 months, my personal level of stress has... (All n=1,926, Students n=54)

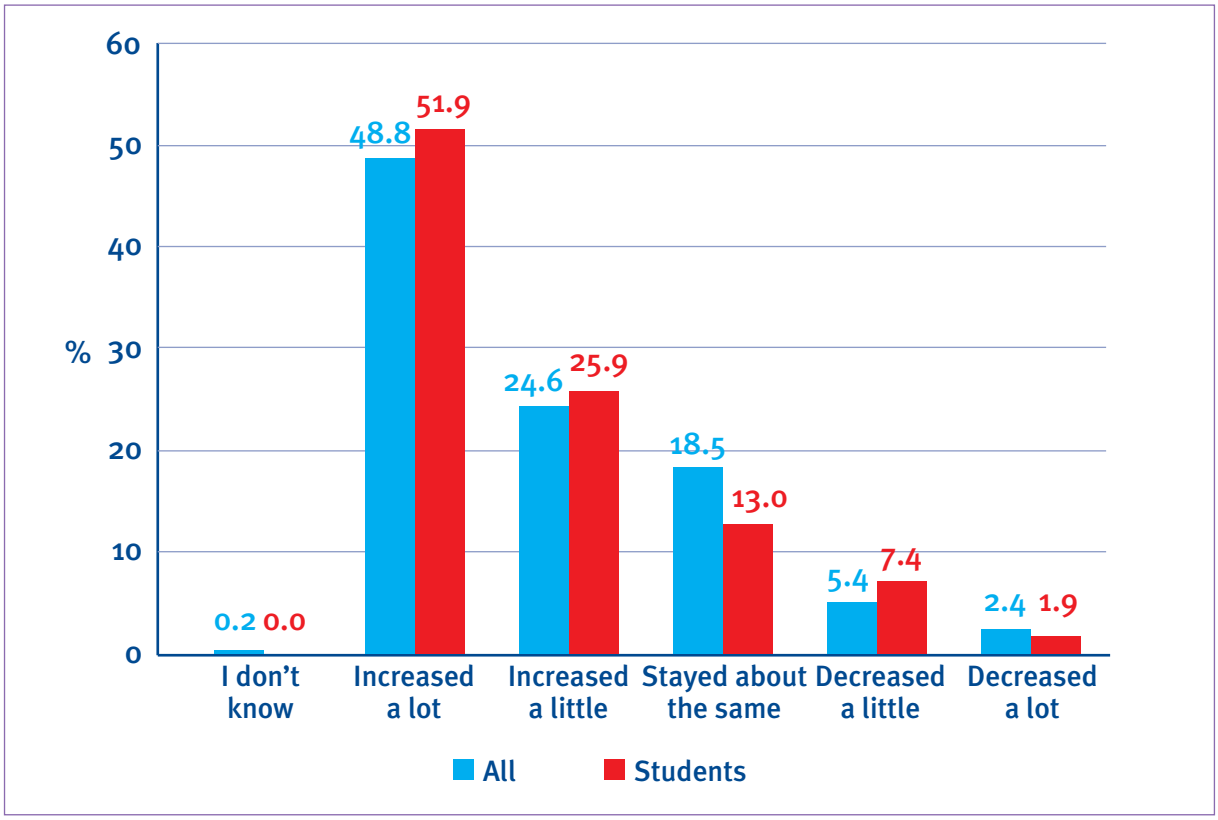
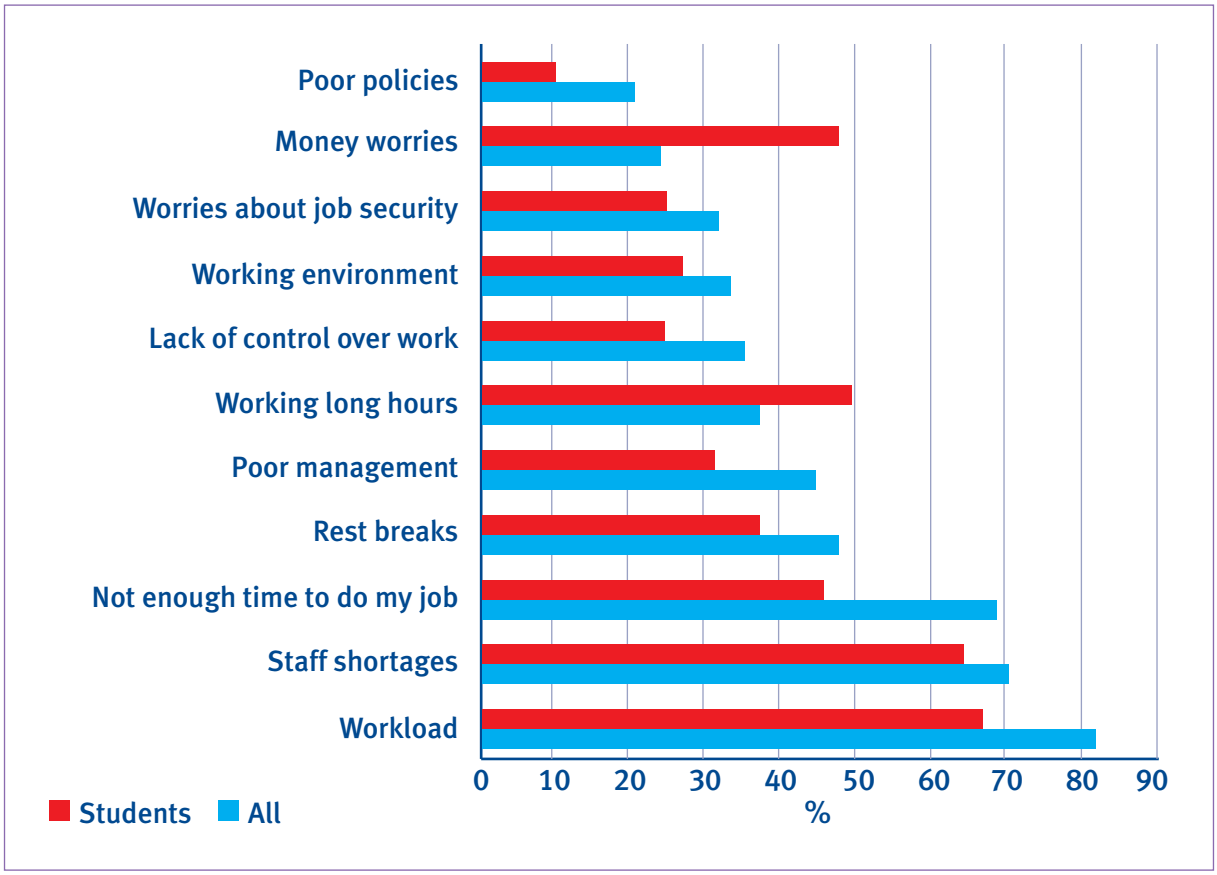


Chart 8: Reasons for high and/or increased levels of stress (All n=1,588, Students n = 48)

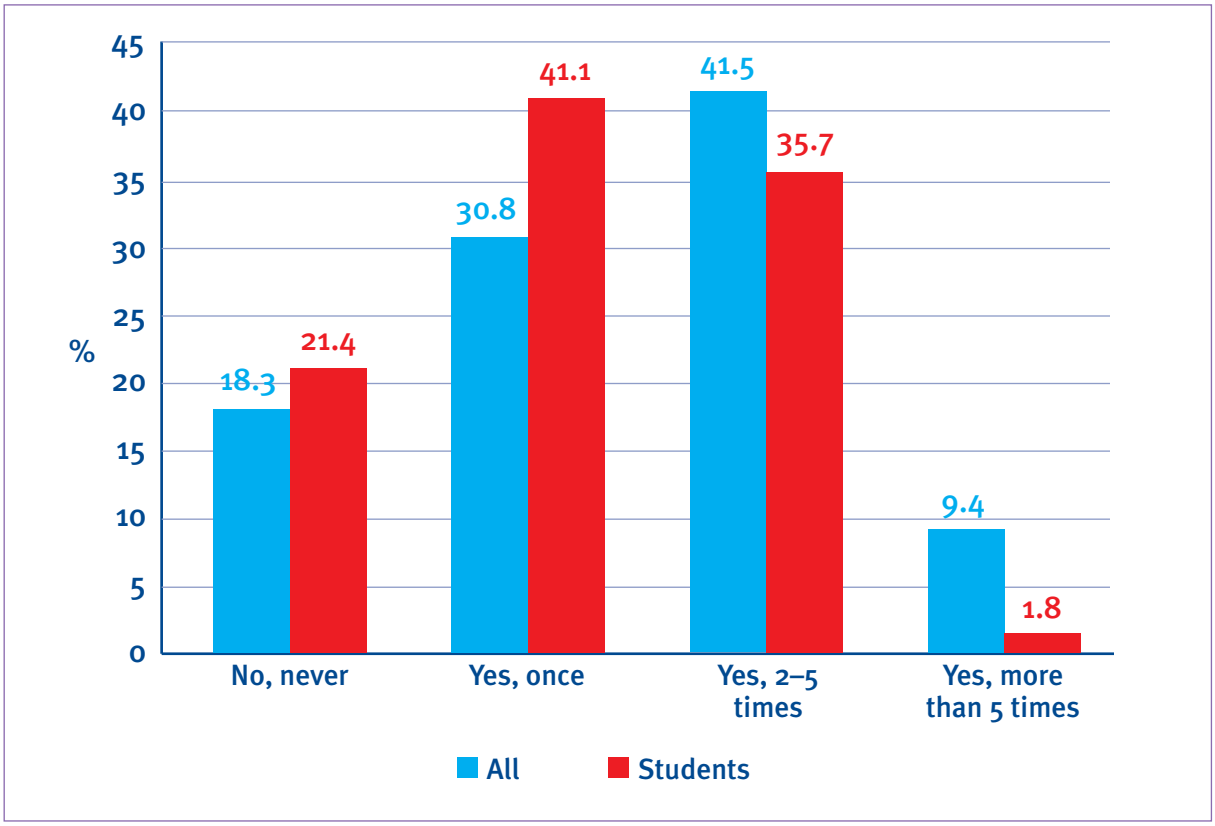


In common with respondents in employment, students expressed high levels of concern about staff shortages and workload. A higher proportion of students cited money worries and working long hours as a source of stress. In the comments given by students, many said they were anxious about fitting in training with university work, and felt unsupported during placements. One respondent said they felt under pressure because of "*not being able to do things as a student and not having a mentor around. Being treated as health care assistant and not being taught skills I need to learn*".

10.3 Presenteeism

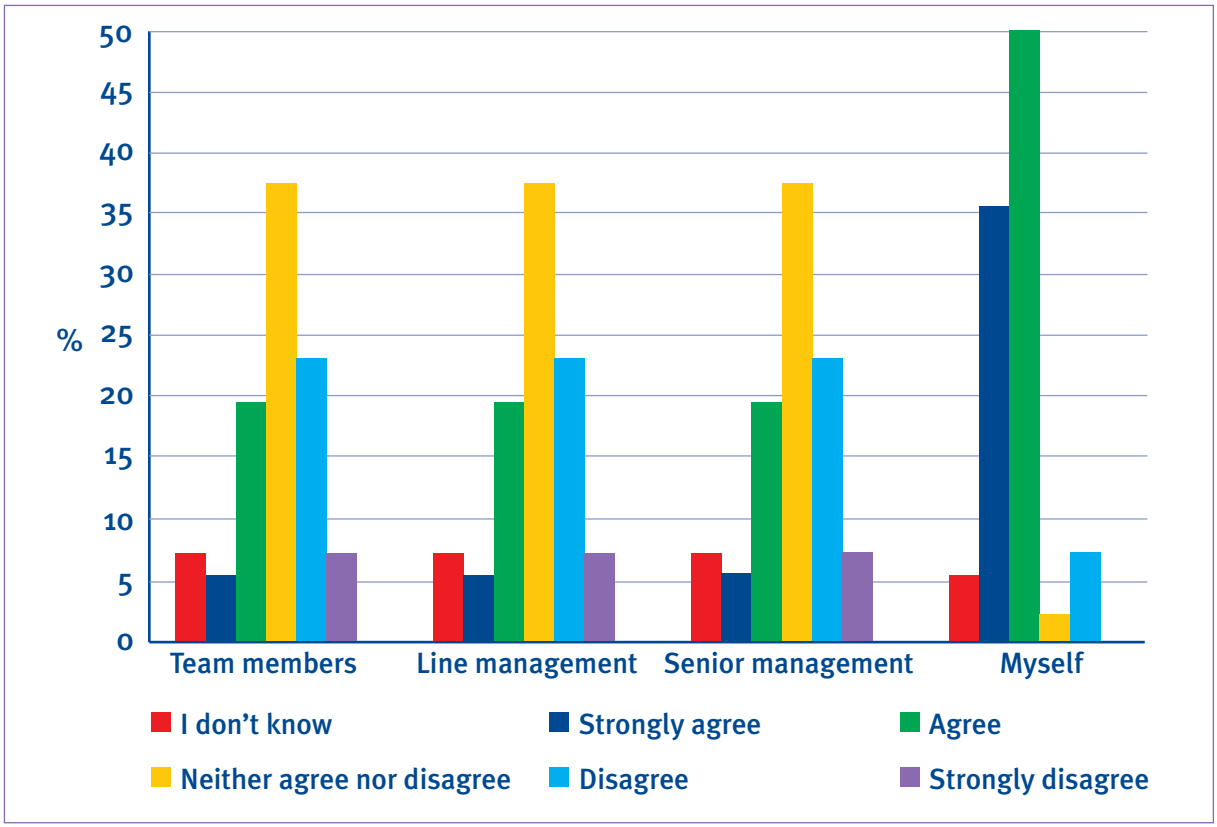
When asked about their current or latest placement, the majority of students (79 per cent) stated that they have gone into work despite feeling unwell or unfit at least once over the previous 12 months.

Chart 9: Over the previous 12 months, have you gone to work despite feeling that you really should have taken sick leave due to your state of health? (All n=1,926, Students n = 56)



Much like all nursing respondents, the pressure for students to go to work despite feeling unfit or unwell comes mostly from themselves. More than eight-in-ten (86 per cent) agreed or strongly agreed they feel under pressure from themselves, a third (30 per cent) said they feel under pressure from line managers, a quarter (25 per cent) said pressure comes from team members and 18 per cent said that pressure is felt from senior management.

Chart 10: Do you feel under pressure (from other team members/line manager/senior managers/myself) to go into work when you feel unwell? (n=56)



The comments below give sample of students' experiences of their placements. Universities require students to attend 100 per cent of their placements, and students are usually required report any periods of sickness or absence to their allocated practice placement and the university.

"In my current placement I feel run down, psychologically exhausted. There is no one to turn to as there is nobody around. I feel helpless and guilty as I don't manage to fulfil demands of patients. It is hard to learn anything under stress like this. Most of the staff are extremely busy so I cannot say they are not supporting me, but I am endangering my health and the wellbeing of patients. I have never been off sick on placement but lately I've started feeling like I am giving up. Instead of learning clinical skills I perform basic and manual handling on my own."
Pre-registration student on adult general/medical/surgical placement (aged 26-34)

"I have repeatedly been told the serious consequences of being ill and missing placement."
Pre-registration student on learning disabilities placement (aged 35-44)

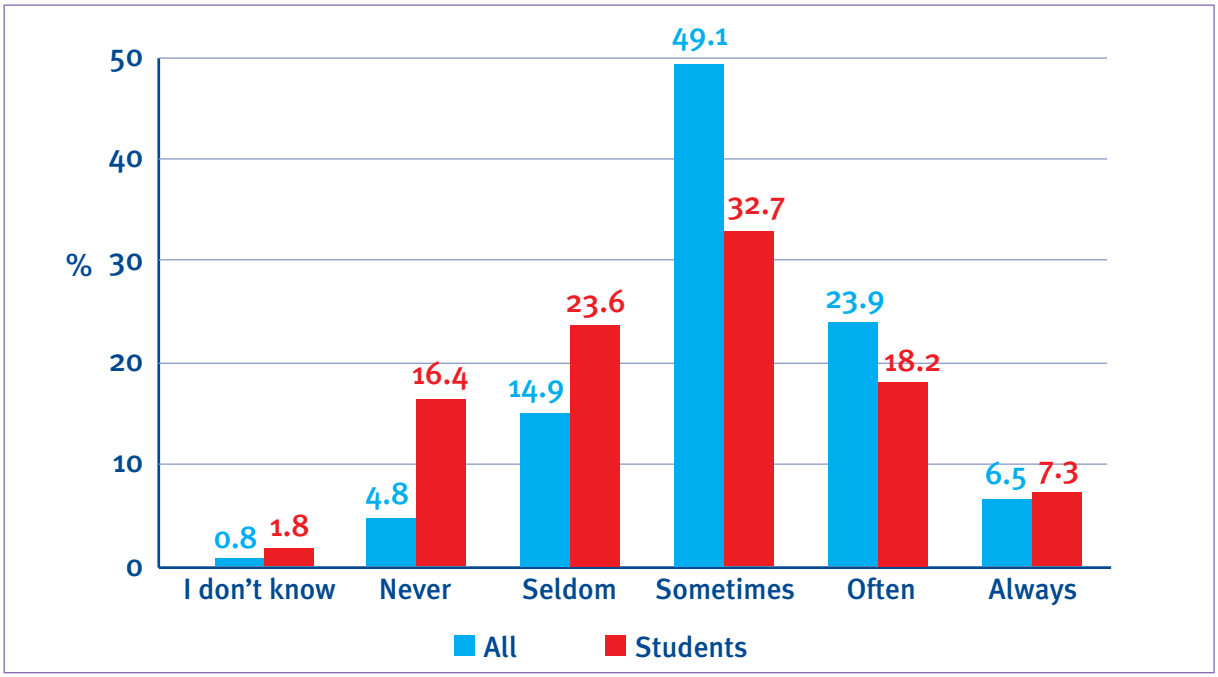
"I don't like to take time off as I feel it looks bad on my references and I have to make up the hours another time."
Pre-registration student on mental health placement (aged 25 under)

"I am expected to ring in and give details on a daily basis of my progress through recovery, which I found intrusive rather than supportive. I was not advised that if I was ill for such a period of time that I would fail the placement."
Pre-registration student on acute/urgent care placement (aged 35-44)

10.4 Health and wellbeing

Students are less likely than respondents in employment to state that their working life has a negative impact on their health and wellbeing, with around 40 per cent stating it seldom or never has an impact, compared to just 20 per cent of the larger group of respondents.

Chart 11: My working life has a negative impact on my health and wellbeing (All n=1,594, Students n=55)



When probed further about the causes of ill health or injury at work, it is somewhat alarming to note that students are more likely to cite moving and handling and needlestick/sharps injuries than those respondents in employment.

Table 24: During the last 12 months have you felt unwell or been injured as a result of any of the following at work?

	All %	Students %
Stress at work	54.8	42.9
Workload	45.9	32.1
Relationships with managers/ colleagues	32.0	23.2
Moving and handling	11.5	25.0
Needlesticks/sharps injuries	4.4	8.9
Slip, trip or fall at work	3.4	3.6
Exposure to harmful substances	0.9	5.4

A higher proportion of students stated that they had personal experience of verbal or physical violence from patients or service users than respondents in employment, but a lower proportion said they had experienced violence from relatives of patients or users.

Table 25: Have you had personal experience of any of the following?

	All %	Students %
Verbal or physical violence		
Patients/service users	56.3	60.7
Relatives of patients/service users	47.6	26.8
Colleagues	20.7	14.3
Other members of the public	14.8	16.1
Manager/team leader	14.7	7.1
Workplace bullying		
Manager	22.6	12.5
Colleague	21.0	33.9

10.5 Newly-qualified nurses

Responses from relatively newly-qualified nurses provide an interesting perspective on the early stages of the nursing career, looking back at placements and preceptorships.

One staff nurse, currently working in a private clinic told us that: *"I did not have preceptorship after qualifying, I had a large preceptorship folder and a first meeting and never did anything after that. I was thrown in the deep end and although I had some great training opportunities and support from managers, other staff nurses were very unsupportive and expected far too much from me as a newly qualified nurse. Some colleagues are very intimidating at times and often try to blame you for their mistakes using the fact that I only qualified a year ago as an excuse. They use their age and years of experience to make me feel like I don't know what I am doing."*

Telephone interviews with two other newly-qualified nurses revealed similar experiences. For example 'Richard' described his preceptorship and whole first year of nursing as *"terrible"*, due mostly he says to the level of bullying towards new and inexperienced nurses and that *"often people don't even know they're doing it"*.

Richard believes that newly-qualified nurses need a great deal of guidance and help from other nurses and line managers as decision making and clinical skills are still developing. He points particularly to situations where he and fellow newly-qualified nurses have made mistakes and have got in trouble rather than the situation being treated as a learning opportunity.

10.6 Willis Commission

The Willis Commission on Nursing Education produced a report in autumn 2012 examining which features of pre-registration nursing education in the UK and what types of support for newly registered practitioners are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services (Willis Commission, 2012). The Commission found that high quality mentorship, preceptorship and continuing professional development are crucial to improving patient outcomes and made the following recommendations, with regard to practice placements:

- **the quality of many practice learning experiences urgently needs improvement**. Learning to care in real-life settings lies at the heart of patient-centred education and learning to be a nurse
- **employers and universities must together identify positive practice environments in a wide range of settings**. Many more placements must be made available in community settings, including medical general practice. The absence of funding to HEIs to support nursing students' practical learning experiences must be addressed
- **employers must ensure mentors have dedicated time for mentorship, while universities should play their full part in training and updating mentors**. Mentors must be selected for their knowledge, skills and motivation; adequately prepared; well supported; and valued, with a recognised status.

10.7 Recommendations

The RCN toolkit *Helping students get the best from their practice placements* (RCN, 2006) makes it clear that practice placements are a vital component of the student experience. As well as setting out students' responsibility while on placement, it also sets out responsibilities for providers, higher education institutions, personal tutors and mentors.

Providers have a responsibility to:

- recognise a student's supernumerary status, so the student has the opportunity of learning in the practice placement
- ensure that the environment has a philosophy of care, and appropriate policies and guidelines for care
- ensure a meaningful mentoring relationship that enables a student's development and promotes increasing confidence in professional practice
- provide students with an effective orientation and induction to the practice area, including policies on sickness, uniform and so forth
- allocate a named mentor within the first week
- provide opportunities for students to experience the 24-hour, seven-days a week pattern of care where appropriate.

Higher education institutions (HEIs) have a responsibility to:

- monitor both the capacity and quality of all practice placements to meet statutory and professional body requirements
- ensure that practice placements meet all standards for the specific programme validated by the HEI
- provide sufficient numbers of link lecturers and practitioners to support students and staff in placements
- ensure students can readily access support structures while in their placement.

11

Conclusions

The findings of this survey highlight the high levels of stress among the nursing workforce. Stress can cause health problems, physical injuries, psychological effects and burnout. In addition to the high personal toll, stress is a major cause of both sickness absence and presenteeism and affects workers' ability to be effective.

The research reveals that the main causes of stress are high workloads, long hours, unrealistic expectations, lack of job control, conflicting roles, bullying and violence, poor working relationships and a lack of engagement in workplace change. Addressing these problems is an obvious way to improve nurses' working experience, while also improving the safety and quality of care for patients.

Issues of workload, stress and working life are often symptoms of systemic organisational problems. Poor work environments and working relationships damage the ability of nursing staff to provide safe care – there is a direct correlation between job satisfaction and patient satisfaction.

Nursing staff concerned about their inability to meet their professional standards of care must be able to raise their concerns in a safe and protected way.

The Francis Inquiry final report (2013) reinforced the importance of an open culture which enables concerns to be raised and disclosed freely without fear, and for questions to be answered. While this inquiry raises acute questions about whistleblowing and the importance of preventing and eliminating wrongdoing at work, the RCN believes that nursing staff should also be able to raise concerns about the issues raised in this survey – workload, staffing levels, bullying and working relationships. A *Nursing Times* survey (*Nursing Times*, March 2013) also found that a third of respondents felt they were likely to face negative consequences or be ignored as a result of raising concerns.

12

Raising concerns

RCN guidance

The RCN has produced a series of resources to provide guidance to members and RCN representatives on raising concerns, highlighting the responsibilities of all in respect of the importance of preventing and eliminating wrongdoing at work. The RCN recommends that members and representatives should be watchful for unsafe, illegal or unethical conduct and report anything of this nature to employers, who have a duty to respond; if they do not then the RCN can help escalate concerns.

One respondent to the RCN survey shared their experiences of raising concerns about demands and workloads:

"Demands and workloads are completely unachievable, we are continuously threatened with disciplinary action if [data inputting] isn't done within three days of patient visits despite having lists day in day out, [and the fact that] we are over capacity, working 62 hour weeks. When brought to managers' attention they say it's our fault saying 'if you choose to work over your time that's your choice', 'poor time management', 'driving like a snail' or 'being too thorough.' It's totally unachievable every single day and worst of all it is affecting patient safety and care. Currently commencing a procedure of 'Raising Concerns' with the RCN."
Community nurse, social enterprise

It is essential that health and social care organisations put in place effective mechanisms to enable staff to raise concerns on such issues as staffing levels and pressure of work, particularly when these get in the way of delivering patient care. Organisations should have policies in place outlining the processes to follow when raising concerns.

RCN members can draw on member resources and local RCN representatives for support on how to raise concerns; RCN workplace representatives can play an important role in supporting members in raising concerns and highlighting issues to management.

The RCN guidance encourages members to raise a matter or issue and ask the RCN to discuss and decide if it can be considered as a concern and, if so, respond collectively. It gives the following examples of issues or concerns:

- changes to the staffing or skill mix in an area will result/is resulting in staff not having sufficient time to answer call bells promptly or monitor patients effectively
- changing mandatory training to an e-learning format that may not be fit for purpose or providing staff with the necessary skills to deliver high quality care
- changing shift patterns that may have an effect on the health and wellbeing of staff or effect their ability to deliver appropriate levels of care
- a lack of moving and handling equipment on the ward or poorly maintained equipment.

The guidance states that in matters such as these, representatives can work in partnership to raise these concerns in the appropriate forum (staff side, health and safety committee, training and education committee) and prevent a problem emerging in the first place.

By raising concerns early, before any impact on patient care, unions can offer support in finding pragmatic and workable solutions.

Appendix 1: Pen pictures from telephone interviews

'Ann' is a full-time site leader in a private hospital in England. She is aged between 55 and 64 and is black.

Ann's working day is very busy and she works long days (usually 3 x 12 hour shifts). She says her job is very results driven, and that she derives satisfaction out of feeling able to get to the end of a shift having supported staff and patients. Her main worry is not having her and her team's achievements fully recognised from senior managers. She says it would nice to feel appreciated once in a while.

When asked about her company's policies on health and wellbeing, Ann feels it's 'talk-talk' at the moment, but hopes this 'talk-talk' will translate into something positive with clinics for staff and improved occupational health services.

She acknowledges that presenteeism is an issue in the hospital and said: "You always think you're going to let people down if you're off sick. I feel under pressure from my manager but she's under pressure from the top." She links this pressure to feelings of stress among the whole workforce: "You have your manager breathing down your neck to cut costs and boost profits and on the other side you have patients who are paying for their care and their expectations are high. And there are rumours of redundancies, so we are under extreme pressure in the private sector."

Her responses also highlight the sensitive and subjective nature of organisational culture and bullying, stating that there is a degree of bullying in the hospital and that "in one sense, it's the right kind of bullying and trying to get people to do things. Sometimes, it's the wrong kind because you don't like the person because of her race or gender or whatever."

'Joanne' is a full-time urgent care practitioner in Scotland. She is aged 55-64 and white.

Joanne explains that her job can be very stressful, having to deal with an unpredictable flow of patients, with varying level of acuity. "It is highly challenging but I love it!"

Having a well-functioning service depends on having the appropriate level of staff and Joanne worries that staffing shortages are compromising safety. She told us that "the manager is doing what she can, but budgets are tight." She also said that problems caused by shortages are only aggravated by staff sickness absence.

Stress levels are also heightened by the nature of the job, dealing with a constant flow of patients who can be anxious and in acute need of help. She explained that "nurses can be open to complaints and that can be very unpleasant and stressful - and this is getting worse". She described instances of where patients had made complaints about the care she had given, but fortunately these had been handled well by her manager and she had felt well supported.

'Barbara' is a part-time occupational health nurse for a private company in England. She is aged between 55 and 64 is white.

Barbara says the best thing about her job is helping people feel better about themselves, particularly when they are going through difficult periods in their lives, often compounded by the fear of redundancy. Frustrations with her job lie mostly with her inability to make positive changes to her clients' workplaces, ranging from employers' delays in putting in place appropriate changes in the work setting, to dealing with clients she believes are 'bullied out' of the workplace.

She describes having a good relationship with her team and managers, feeling that her work is valued and says that being able to offload to colleagues makes the biggest difference in being able to cope with the work.

Speaking as a nurse, rather than as an occupational health adviser, Barbara says she's amazed about at the extent of mental health issues among fellow nurses, particularly low mood. She says: "There's an expectation that as a nurse you can't just leave if there's work to be done. I believe consultants and doctors have no regard for nurses and undermine nurses. It needs to be a collaborative workplace."

'Sian' is a full-time senior specialist nurse in the NHS in England. She is aged between 26 and 34 and is white.

Sian enjoys supporting her patients and their relatives in what she says is a highly emotionally stressful job, but gets frustrated by staff shortages in her department. While she describes having a supportive relationship with her line manager, she recognises that managers are under pressure to reach targets and this causes tensions. She cites problems caused by the sickness absence policy in place at her trust, which is causing anxiety among staff. Sian says that: "They say you need to improve sickness absence levels, but do nothing to support staff." She also described feeling that she was letting colleagues down if she is off sick.

Sian is highly appreciative of having access to a clinical psychologist who works closely with staff, patients and their families. Apart from this resource, however, she says that health and wellbeing provision is poor. She advocates better guidance for employers and managers to support health and wellbeing, and in particular improved awareness of mental health issues. Nursing is an emotionally draining profession and staff need appropriate support.

She would also like to see major improvements in the trust's treatment of complaints, feeling that instead of addressing a particular issue or problem, managers merely follow up complaints with emails to all nurses reminding them of trust policies. She says this only serves to upset the balance within the department.

'Helen' is a full-time clinical nurse specialist in the NHS in England. She is aged between 45 and 54 and is white.

Helen says every day is stressful and that this is mostly due to staff shortages and heavy workloads. Despite asking for over two years for at least two more part-time members of staff, this has been refused and recruitment freezes have been put in place. "You push yourself to the limit to make sure that no harm occurs," she says, but feels strongly that staff do not feel cared for or supported by managers.

Helen considers that nurses can be their own worst enemy, saying "the more you deal with what you've got the more they [managers] will let you get on dealing with it... we've made a rod for our own back". She says that problems caused by staff shortages and workloads are made even more serious if she or her colleagues are unfit or unwell. She says that there are only two in her team and "we only phone in sick if we're practically dead and that leaves the other with everything. And that's not safe."

Helen feels let down by the lack of support from managers and feels that she and her colleagues are never praised for their work and do not receive sufficient training and development. At the time of the interview, Helen's trust had an emergency escalation situation over winter beds and staffing levels. She feels aggrieved about how this situation was dealt with, stating that she felt "emotionally blackmailed" to work overtime to cover extra shifts and while overtime pay was given, she would have preferred time off in lieu.

'Tamsin' is a nurse adviser working for a private company in England. She is aged between 35 and 44 and is white.

Tamsin works part-time 'office hours' and has worked for the company for about a year. She says that her job fits well with home life and caring responsibilities for children. Her previous job was in a nursing home, but left due to illness and sought alternative employment that was less physically demanding. She is pleased that the illness has not forced her out of nursing altogether and likes being able to continue using her skills.

Although she is still relatively new to the job she is highly appreciative of the supportive she has received so far from her manager and particularly showing understanding about needing time off for surgery.

When she started at the company she received relevant training, feels confident to be able to update her skills if necessary and that she can consult other colleagues on clinical issues. She is also satisfied with pay, terms and conditions and pensions.

'Sue' is a full-time district nurse in Scotland. She is aged between 45 and 54 and is white.

Sue says that contracted hours are 8.30am-5pm, but she usually starts work earlier and rarely gets home before 7pm most nights.

She describes a heavy workload, having to catch up with admin after seeing patients as she has no administrative support, and often drives around 70 miles a day to visit

patients. She also describes a high level of stress due to taking on a new role of triaging: assessing whether patients should be referred to a doctor. She says that this is on top of her own caseload and in any case does not feel sufficiently trained to carry out the role. She says: "I don't have a problem with doing the job I'm trained for and the admin. I just have a problem with being a doctor."

"GPs should be triaging their own calls, and if they want us to see somebody – it should be that way round. GPs are not really concerned about the impact of the workload on us. I'm worried that something will go drastically wrong and it's my neck on the line."

On top of this heavy and increasing workload, Sue has recently been diagnosed with a chronic illness and had to pull out of a clinical skills course. She feels that her employer has been supportive around her illness so far, but does not feel confident that they would be flexible with her hours or workload if her condition deteriorated. She says "I'm looking after everybody else. But who's looking after me? Certainly not me. You just give them more and more, but I don't want to be seen to be failing at my job because I'll be shown the door."

'Gill' is a full-time health visitor in Scotland. She is aged between 55 and 64 and is white.

Gill works office hours, but states she regularly works additional hours to keep on top of her workload, describing the paperwork as 'horrendous.' She says she feels stressed by having to keep up with new policies and guidance and record keeping, all on top of running clinics and conducting clinical supervision. Gill travels a lot with her job and states that problems related to parking, rather than travel itself, cause a great deal of stress. She also feels under pressure due to the sheer volume of change, with the introduction of new initiatives and ways of working, but says she has a good team leader who is looking at ways to give the team more support.

She also appreciates the good working relationships among her team members and points to the necessity of clinical supervision. She says it is vital that nurses are given the opportunity to talk things through at work, with emotional support. However, this confidence in her team is not matched by confidence is senior management. She says: "We all feel very frightened. There are so many nurses and they don't want to pay us. So they're trying downband our jobs and people feel very helpless and very demotivated. That's how my colleagues feel and not valued at all and frightened for the future."

She says these feelings of anxiety are made worse by sickness absence policies. "A lot of staff have said they're frightened to take time off because they'll get an interview. There are people coming in with heavy colds or coming back early. They're either scared of racking up sick leave, or very, very aware of the pressure the rest of team is under and that their work will have to be divided among the team."

Gill also points to the support available for lone workers, stating that while some structures are in place, there is no lone working system in place, despite working in environments that can be unsafe. She says: "We've waited months for the new system to be put in place. This just reinforces the feeling that we're not cared for."

She says she recognises that the NHS has tried to introduce initiatives to improve staff health and wellbeing such as healthy eating and exercise. Her response to this is: "It would be nice to have the time... These things aren't helping us – we know we're stressed out. We can see the need, but just don't have the time."

She ends the interview by stating: "I've always loved nursing but we always seem to be undergoing change and never settling."

'Amy' is a full-time staff nurse in an independent sector care home in England. She is aged between 35 and 44 and is white.

Amy has recently started working in her current job after having poor previous working experiences at two different nursing homes, where she says there was no respect from the owners for either staff or patients.

In her previous role, she says her manager would not accommodate her requests on working hours and tried to force her to work a 60 hour week. She got a sick note for work-related stress, but her manager refused to accept it. She returned to work on reduced hours despite being signed off work, but when ready to go back to her usual hours she was told that those hours had been filled. Amy describes her treatment as 'psychological abuse.' In the job prior to this, she says that staff turnover was high in the home and that other members of staff had reported the owner for being disrespectful to nurses and other staff. Amy herself reported

a lack of equipment to the CQC feeling that problems there put her in a vulnerable position.

While she admits having reservations about moving to another nursing home after these two bad experiences, Amy says that her current post is a completely different environment: "It seems a lot better here and they are always asking if everything is ok. I feel like I'm respected. It's early days, but so far so good."

'Jan' is a full-time senior nurse in a social enterprise in England. She is aged between 55 and 64 and is white. She is due to retire next year.

Jan works for a community interest company treating NHS patients. She is a staff member on the board; she was involved in the transfer and continues to be involved in much of the decision making.

She enjoys working at the unit stating that there is a great team in place and everybody is very supportive. As a team leader she says that her main complaint is what she describes as the lack of flexibility with the Agenda for Change framework to be able to better reward health care assistants. Jan says she has tried to get the HCAs in her team upgraded, but cannot within the current system. She also says that the sickness absence payments are too generous and that she would like the flexibility to put in place different arrangements.

'Carrie' works as a support worker in the NHS in England. She is aged between 35 and 44 and is white.

Carrie works with children with severe learning disabilities and their families. She works condensed hours to fit with caring responsibilities.

She enjoys her job and likes being busy, and feeling she has good supervision and support, so if anything has gone wrong she feels able to pick up the phone to the lead clinician. She appreciates the opportunity to have time to reflect under supervision and said that: "If I'm not able to offload, that can be quite stressful."

Carrie says she works in a small team, with most of her support coming from her supervisor than the team, but that she has good relationships with her colleagues. She says that apart from support from her supervisor, she does not feel well supported in terms of support for own health and wellbeing. She adds that she has used occupational health services previously which she found useful, but found it frustrating having to chase everything up herself.

'Lucy' is a full-time clinical team leader in England. She is aged between 55 and 64 and is white.

Lucy is a team leader responsible for a large team of nurses and points to two main barriers to doing her job to the standard she would like. The first barrier is related to unclear lines of responsibility, with Lucy explaining that her work is governed by different managers, each responsible for different, and overlapping, aspects of performance.

She says that the result is feeling pulled in different directions at once, with lack of clarity or focus over decision making. The consequence of this can be poor policies or procedures, citing the example of meetings being arranged at inconvenient times. She also links this to lack of progress on health and wellbeing issues, with nobody taking direct responsibility.

The second major barrier Lucy identified is staff shortages, stating that her team is understaffed by almost half, leading to heavy workloads. She says that increasing numbers of her team tell her they are worried about fulfilling the NMC codes of conduct. Meanwhile she feels under pressure from her managers for her team members to undertake training, but says "we don't have time for training and taking people out would mean dangerous staffing levels, so as a team leader, I'm caught in the middle".

'Jenny' is a clinical nurse specialist, working for a private hospital in England. She is aged between 45 and 54 and is white.

Working as a specialist nurse is evidently a great source of pride and enjoyment for Jenny, having spent years developing both her own skills and the specialist service with the private hospital where she works.

Management decisions that challenge Jenny's ability to deliver care in the way she aspires to are therefore personally disappointing and frustrating. For example, she described a recent decision to reduce both the number of clinics she runs and the length of appointments, stating "I just can't deliver a good service in these circumstances. They didn't consult me about any of the changes. I just run late all the time."

Jenny understands the pressures facing managers in the private healthcare sector, but says that the combination of making profits and providing a high standard of care is difficult for nurses: "You're trained to provide the best care you possibly can and go the extra mile for patients and the cost isn't something you think about, but you have to in the private sector. Management say they want us to deliver high standard care and the patient is the most important but sometimes that doesn't feel the case and making money is the priority."

Nevertheless, she feels well paid for the private sector and points to good occupational health services and private medical insurance provided by the company. She feels it is overall a good place to work and would recommend the hospital to patients.

'Rahma' is a staff nurse in the NHS in England. She is aged between 45 and 54 and is black.

Rahma has recently moved to a specialist hospital after having worked in a general hospital in a different city, desperately frustrated at the lack of career progression opportunities.

She says: "Usually in the trust, you go for a Band 6 job and they train you on those skills. But they said they can't offer me a Band 6 position because I don't have those skills. People who had only been qualified for a few years were given opportunities, but not me."

In her new job as a Band 5 staff nurse, Rahma's manager has promised her the appropriate training to become a Band 6 nurse and feels confident that her manager is committed to help her progress. Rahma is determined to get on and become a nurse practitioner but cannot understand why she received so little support in her previous job, stating "If a person has been in a job for seven years and you haven't developed them, you're just using them and not seeing their potential."

Rahma also feels bitter that her extensive qualifications and experience gained abroad are not fully recognised in the UK and that her skills have been underused. She feels that this is part of the culture, rather than specific to any particular organisation or sector.

'Liz' is a clinical nurse specialist for a charity in England. She is aged between 55 and 64 and is white.

Liz works with young people and derives a great deal of job satisfaction from engaging with her clients. Her main frustration and source of stress lies with feeling unsupported by senior management. She explains that: "Their understanding of clinicians' roles is quite poor. You can tell them you have a problem, but often nothing is done to support you."

Liz also feels frustration at the lack of time she is given to accomplish her job, particularly time for training and for regular team meetings. She says that the lack of regular meetings means there is no facility for people to 'iron out problems' before they get bigger. However, she appreciates the good working relationships developed with colleagues, particularly centred around clinical supervision.

She says that financial restraints mean that her team is understaffed and it is often difficult to get cover, stating: "We really have to fight for support if one of us is on annual leave. We carry each other and we know we're going to be working long hours to keep the service going, basically doing two people's work."

Liz described wider issues in nursing beyond her own job and stated that there is a "misconception that you can train people to do tasks and pay them less". In reality, "you need well trained staff, able to understand and interpret" as well as valuing 'basic' nursing care.

'Kathy' is an emergency nurse practitioner (ENP) in the NHS in Wales working part-time hours. She is aged between 45 and 54 and is white.

Kathy's job has undergone enormous change in the last year due to widespread changes in the configuration of services in Wales. Having worked for many years in a nurse-led minor injury unit, the unit was recently moved to the A&E department of the local district general hospital as a temporary measure.

Kathy explains that the move was well supported by management and that her team were offered group therapy sessions which alleviated stress among her team to a large degree. However, a further change came after the unit was reopened with the team redeployed to rotate between the minor injuries unit and the A&E department.

She explains that this development has been extremely stressful for her and her colleagues, feeling forced to work at a level beyond their scope. She says that ENPs are being "used in a medical role, but we should be supplementary to medical staff not a replacement".

Kathy feels that her unit has become the "victim of our own success". She and her colleagues have undertaken extensive training, successfully completing a wide range of academic and practical qualifications, helping to develop and shape the service they provide. She acknowledges that some of her colleagues do wish to take on extended and advanced roles and to work as consultant nurses, but others prefer to work at their current levels. She states: "We provide a good service and have a high educational standard to support that service. Some nurses are keen to work at an advanced level, but the majority are 50 plus and we have reached an advanced point in our career that we're happy with and don't want to be pushed into anything. We're more expensive than an A&E staff nurse but cheaper than a doctor. Doctors can't mop floors and toilet patients, but nurses can't order and interpret an x-ray. We can cover all bases for one wage so we can see how we're being used financially. We feel like pawns in a game, with no one thinking we have opinions and ambitions."

Further stress has been caused by having a split role between the minor injuries unit and A&E, meaning that she and colleagues work at different levels of competence depending on where they work. Being embedded in A&E also causes problems, with difficulties experienced by both nurse practitioners and A&E nurses in working alongside each other. Kathy says that this has been a source of stress for colleagues, with some having been referred to occupational health. Yet she is amazed at the low level of sickness absence through this period of change, which she attributes entirely to loyalty to the service they provide and colleagues.

Kathy is determined to make the new arrangements successful but has recently heard that the minor injuries unit will imminently be closed for good, and that redundancies are expected.

'Katie' is a full-time staff nurse working for the NHS in England. She 25 years old or younger and is white.

Katie has been a qualified nurse for around five years and currently works in an emergency assessment unit. She recently started this role after becoming dissatisfied with her previous role. She explains that her frustration lay with her feeling that her line manager showed favouritism to certain nurses, by being less strict with one group and allowing them to take advantage of training courses. Katie says she is at the end of a long line of nurses who have left due to frustration with the management style. She says: "There wasn't a week that would go past without someone being upset."

Katie describes the environment as very cliquey and was frustrated that she felt unable to talk to some of the more senior nurses about the situation, while others outside the clique had no power to challenge the line manager.

She states that an unprofessional attitude had taken hold in the ward due to the favouritism shown by the line manager, meaning that she felt pressured to complete her workload without the support of colleagues. At the time of the interview, Katie was due to start a new job in the same type of ward but a different trust and seemed optimistic and excited about the new post stating, "I'm looking forward to the fresh start, there is better equipment and a better feel."

'Will' is a community nurse in the NHS in England, working full-time hours. He is 25 years old or younger and is white.

Will qualified as a nurse in 2010 and has worked as a community nurse for around several months, having decided early on in his nursing career that he wanted to work to specialise in his area of interest. He explains that he didn't have quite the right experience at the time he applied for the post, but his supervisor helped by organising the appropriate training and support to help him adapt. He says: "I feel grateful that I've been able to get where I want to be so quickly."

It is obvious that Will is enjoying his new job and appreciates the opportunities it is giving him. He enjoys the multi-disciplinary nature of the job and the training offered. He recognises that the job is stressful and that the burnout rate could be high, but states that colleagues look after each other work and give each other a helping hand. He says that he benefits from clinical supervision and while he recognises that it doesn't occur as often as planned, there are other opportunities to 'offload'.

The main stress factors in his job relate to heavy workloads and bureaucracy, stating that everything has to be diarised

and that "you constantly feel you're chasing paperwork." However, after having unsatisfactory experiences in his preceptorship and previous job, the positive factors of his current job outweigh these problems.

Will states that he was bullied in his first job and was on sick leave for a long period because of it. This was obviously a distressing time for Will, but is now able to reflect on the experience, stating that "it makes you realise how it important it is to find a good job with a good team and luckily at the start of your career you can slot into different areas".

Will says he is very happy in his job, but feels frustrated that the job is on a six month contract. He is confident that his employers want to keep him on permanently, but acknowledges that the decision is due to financial pressures. He explains that most jobs currently advertised are short-term contracts and this situation is not good for nurses' security or peace of mind.

'Richard' is a full-time staff nurse in the NHS in England. He is 25 years old or younger and is white.

Richard works as an intensive care nurse, working what he describes as 'changeable, erratic shifts.' This in itself, is not a problem, but explains that there is little consultation over rota scheduling.

As a relatively newly-qualified nurse, Richard's experience of the preceptorship training and first years of nursing are significant to his outlook on nursing. Unfortunately he describes his preceptorship and whole first year of nursing as "terrible", due mostly he says to the level of bullying towards new and inexperienced nurses and that "often people don't even know they're doing it". He wonders how nurses can be "so horrible to each other, but so nice to patients and relatives," but feels that this experience toughened him up, and now feels more confident.

He says that newly qualified nurses need a great deal of guidance and help from other nurses and line managers as their decision making skills and clinical skills are still developing. He points particularly to situations where he and fellow newly qualified nurses have made mistakes and have got in trouble rather than the situation being treated as a learning opportunity.

Richard describes two situations where he was told off by his manager, explaining that one instance occurred because there was nobody to ask for help. He says that in both cases he felt like he was being performance managed rather than supported by his line manager. He left this job stating that he "couldn't cope with those kinds of working conditions".

Richard says he recognises that managers are under pressure and that this can result in bullying behaviour, "because I can't think of any other reason that people act that way". He is aware that managers are under pressures from senior levels, and this has put him off being a manager in the NHS. Yet he also feels that career prospects for band 5 nurses are being limited, with opportunities for progression slowing down and so leading to resentment among the biggest group of nurses in the NHS.

Richard goes on to reflect on the impact of the recent criticism of nursing care on morale among the nursing workforce, stating that he feels like nurses are being victimised. He says that "I have never personally seen poor care, but I know that there are staffing shortages and that will affect care in some way". He goes on to say that: "It's not nurses' inherent care or skill levels that causes problems, it's staffing levels. If these were appropriate – care would fine and it's insulting to say otherwise." He finishes by saying: "I look after my patients and that is why you're stressed. You wouldn't be stressed if you didn't care."

'Martina' is a full-time clinical nurse specialist in the NHS in England. She is aged between 35 and 44 and is white.

Martina has worked as a nurse for around 20 years and is currently a nurse specialist. She trained abroad in Europe and has worked in the UK since 2006.

Martina explains that she used to work five days a week, and increasingly found herself working far longer than contracted hours. Without being able to get the time back, she moved to a compressed four day week with longer days. She states that she likes having the day off and feels more in control of her workload.

She enjoys her job and says getting acknowledgement or thanks from patients or their families makes all the difference. The negative aspects of her job she says come from strained relationships between teams: blaming each other when something goes wrong. She explains that the

biggest tensions exist between different disciplines, due to a lack of understanding of what other people do. However, she describes a good relationship between her and her line manager and clinical director and says they make her and her colleagues feel valued and supported. She also says her colleagues are very supportive of each other.

Martina also says that working with very sick children is highly emotionally stressful, yet feels that there is not enough support. She says that she would like more opportunity to reflect on the care she gives, but says "it's hard to go home and not think about things, it is so emotional draining". Martina also says that training has been limited only to mandatory study days, but would appreciate more opportunities for reflection or counselling.

She goes on to describe the tension between working with immune compromised children and looking after her own health and wellbeing. She says it is particularly important not to be working when unwell so as not to put patients at danger, but "you know that colleagues will suffer and you don't want to let them down. We are very protective of each other".

She also describes pressure from HR policies, stating that "you feel you have to justify yourself if you're off work and you feel under pressure. Managers support us, but there is pressure from HR."

'Fiona' is an advanced nurse practitioner in the NHS in Scotland. She is aged between 35 and 44 and is white.

Fiona enjoys the autonomous aspect of her job; she has her own caseload and generally manages her own hours and commitments. She enjoys the opportunity to both run clinics and work in the community, with flexibility around managing her time. She says she has good support from colleagues and enjoys working part-time hours, stating that this allows a good work-life balance. She recognises that colleagues working full-time are often more stressed.

Fiona says that both patients and consultants value her work and contribution to patient care. She says she particularly values the "huge change" she has experienced in working relationships with medical staff over her career in that there is more respect, with doctors actively asking for her opinion. However, she feels less valued by her line manager who only expresses appreciation when pressed to do so, with no "general culture of telling us we've done a good job".

The biggest sources of stress for Fiona come she says from the negative impact of a 'box ticking' approach to management, and the need for more staff and resources. She makes reference to her team's involvement in a range of pilots. She says that they are very interesting and valuable to the service, but team members don't get enough time or support for them, as managers' interest in them has waned over time.

Fiona also refers to lack of time and support for training and development, explaining that she and her team members are expected to attend courses in their own time. She states "I work at a senior level, but everything is constantly changing and we need to keep our knowledge and skills updated."

'Daniel' is a full-time NHS staff nurse in England. He is aged between 44 and 54 and is mixed race.

Daniel is a highly experienced staff nurse, qualified for over twenty years. He regrets some of the changes he's seen in the NHS over this time, particularly the speed that the system now works at, having to cope with ever increasing numbers of people. He says that this relentless pace means that "it's become more possible over the years either to make a mistake, to forget something or not fully act to your potential as part of your duty". Allied to that, he sees that the focus on nurses has changed from a professional to a more legal one, and this gets translated into ever more paperwork.

Daniel also believes that the pressure of high workloads means that staff don't spend enough time with each other, reflecting on patient care and that they need more time for debriefing during the shift.

As an example, Daniel cites the example of hourly check rounds introduced as a pilot. He believes that the initiative felt for the most part like "lip service" stating that it is very difficult to go around a group of patients and make sure the boxes are ticked and do it contemporaneously rather than two to three hours after. "You just worry about missing a tick and somebody coming along later and asking why you haven't ticked the box and you have to argue your decision."

He states that while hourly check rounds "can mean that if everything has been done properly and people have made the right judgement, there are records," but on reflection they also "take away the intention to think for yourself and use your skills."

Daniel relates that there has been an increase in sickness absence due to stress in his department, and says that this is managed quite differently by different managers. Acknowledging that sickness absence causes increased workloads for everybody else, Daniel states that the better managers in his department try to make sure that nurses take proper breaks, "but on some wards, you're not far the end of your shift before you get the chance to have a drink and that can often be people working long days as well."

Daniel goes on state that many staff in his department are working long days. He states that long days are supposed to improve continuity of care, but doubts that they do, given the impact on staff wellbeing. He states "if you add in travel times it's not good for staff, you don't get chance to rest enough. It also impacts on staff numbers and training opportunities especially if you have even one person off sick."

Daniel makes the link between national targets and corporate bullying, stating that it is a "significant part of what we go through every day". He adds that on a one-to-one basis "the way managers sometimes approach staff is dismissive and in the worst cases pre-judgmental, taking the word of some above others, but it's a very insidious thing and difficult to prove".

As a Band 5 nurse, Daniel believes that his career prospects are somewhat limited, citing the example of being told by a matron that "if I wanted a Band 6 post, one of the requirements is to put up and shut up, and not make suggestions". He says that "it's difficult to look ahead, thinking I'll be able to be independent and proactive, but I also see the downsides of being a manager and all the hassle that entails".

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NHS Contracts Tendered : £16.6bn NHS Tendered

	Area	TYPE OF SERVICE	Maximum Value	Date	Evidence
1	Dorset	Pathology	£60,000,000.00	Dec-13	https://t.co/cFvjWi5KEq
2	Midlands	Nursing Home	£50,000,000.00	Dec-13	https://www.supply2health.nhs.uk/0AD/Lists/Advertisements/DispForm.aspx?ID=8
3	South Downs	Out of Hours	£14,000,000.00	Dec-13	https://www.supply2health.nhs.uk/0AX/Lists/Advertisements/DispForm.aspx?ID=9
4	London	Immigration Removal	£37,000,000.00	Dec-13	https://www.supply2health.nhs.uk/X24/Lists/Advertisements/DispForm.aspx?ID=7
5	Kent	Out of Hours	£12,000,000.00	Dec-13	https://www.supply2health.nhs.uk/0AX/Lists/Advertisements/DispForm.aspx?ID=9
6	Nationwide	Digital Records	£450,000,000.00	Dec-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=30
7	Yorkshire	Screening	£8,500,000.00	Nov-13	https://www.supply2health.nhs.uk/0AR/Lists/Advertisements/DispForm.aspx?ID=10
8	Bradford	Treatment Centre	£16,000,000.00	Nov-13	https://www.supply2health.nhs.uk/0CF/Lists/Advertisements/DispForm.aspx?ID=20
9	Bexley	Nursing	£7,000,000.00	Nov-13	https://www.supply2health.nhs.uk/07N/Lists/Advertisements/DispForm.aspx?ID=8
10	Luton	Mental Health	£230,000,000.00	Nov-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=30
11	London	Screening	£5,700,000.00	Oct-13	https://www.supply2health.nhs.uk/5K8/Lists/Advertisements/DispForm.aspx?ID=13
12	Kent	Mental Health (Prisons)	£5,000,000.00	Oct-13	https://www.supply2health.nhs.uk/0AM/Lists/Advertisements/DispForm.aspx?ID=14
13	Nationwide	Transport	£515,000,000.00	Oct-13	https://www.supply2health.nhs.uk/CP4/Lists/Advertisements/DispForm.aspx?ID=87
14	Sussex	MSK	£250,000,000.00	Oct-13	https://www.supply2health.nhs.uk/09X/Lists/Advertisements/DispForm.aspx?ID=1
15	North West	Care Homes	£240,000,000.00	Oct-13	https://www.supply2health.nhs.uk/CP4/Lists/Advertisements/DispForm.aspx?ID=88
16	Hampshire - Young Peoples Se	Young Peoples Services	£13,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0AW/Lists/Advertisements/DispForm.aspx?ID=9
17	Lincoln - MSK	MSK	£4,400,000.00	Sep-13	https://www.supply2health.nhs.uk/0AK/Lists/Advertisements/DispForm.aspx?ID=29
18	Tyneside (Talking Therapies)	Talking Therapies	£2,500,000.00	Sep-13	https://www.supply2health.nhs.uk/0AR/Lists/Advertisements/DispForm.aspx?ID=6
19	Warrington - Children's Servic	Children's Services	£12,000,000.00	Sep-13	https://www.supply2health.nhs.uk/X24/Lists/Advertisements/DispForm.aspx?ID=2
20	Knowsley - Cardiovascular	Cardiovascular	£10,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0CE/Lists/Advertisements/DispForm.aspx?ID=6
21	Manchester - MSK	MSK	£1,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0AJ/Lists/Advertisements/DispForm.aspx?ID=10
22	Southport - Hospice	Hospice	£1,200,000.00	Sep-13	https://www.supply2health.nhs.uk/0CE/Lists/Advertisements/DispForm.aspx?ID=5
23	Kent - Integrated Wellness	Integrated Wellness	£3,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=25
24	Midlands Ophthamology	Opthamology	£3,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0AD/Lists/Advertisements/DispForm.aspx?ID=5
25	Bedfordshire Opthalmic	Opthalmic	£22,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=22
26	Warrington	Children's Services	£12,000,000.00	Sep-13	https://t.co/xFocx7xTxb
27	Coventry	Hospital	£1,210,000,000.00	Sep-13	http://www.bbc.co.uk/news/uk-england-26953455
28	Kent	MSK	£140,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0AM/Lists/Advertisements/DispForm.aspx?ID=8
29	East Midlands	Community Health	£107,000,000.00	Sep-13	https://www.supply2health.nhs.uk/Q35/Lists/Advertisements/DispForm.aspx?ID=13
30	Hampshire	Patient Transport	£75,000,000.00	Sep-13	https://www.supply2health.nhs.uk/0AW/Lists/Advertisements/DispForm.aspx?ID=7
31	Nationwide	450 AQP Community Health	£500,000,000.00	Sep-13	http://www.theguardian.com/society/2011/jul/19/nhs-services-open-to-competition
32	Kent - Radiology	Radiology	£2,000,000.00	Aug-13	https://www.supply2health.nhs.uk/RVV/Lists/Advertisements/DispForm.aspx?ID=5
33	King's Lynn - Histology	Histology	£15,000,000.00	Aug-13	https://www.supply2health.nhs.uk/RGD/Lists/Advertisements/DispForm.aspx?ID=1
34	Oxfordshire - School Nursing	School Nursing	£9,500,000.00	Aug-13	https://www.supply2health.nhs.uk/0AE/Lists/Advertisements/DispForm.aspx?ID=12
35	Manchester - Palliative Care	Palliative Care	£3,000,000.00	Aug-13	https://www.supply2health.nhs.uk/0AJ/Lists/Advertisements/DispForm.aspx?ID=7
36	Bexley - Integrated Cardiac	Integrated Cardiac	£27,000,000.00	Aug-13	https://www.supply2health.nhs.uk/0AX/Lists/Advertisements/DispForm.aspx?ID=3
37	Bedfordshire - Dermatology	Dermatology	£2,300,000.00	Aug-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=18
38	Bristol - Assertive Engagemen	Assertive Engagement	£5,000,000.00	Aug-13	https://www.supply2health.nhs.uk/0AC/Lists/Advertisements/DispForm.aspx?ID=4
39	NW London - Teledermatolog	Teledermatology	£3,000,000.00	Aug-13	https://www.supply2health.nhs.uk/0AT/Lists/Advertisements/DispForm.aspx?ID=3
40	South Manchester - Endoscopy	Endescopy	£1,500,000.00	Aug-13	https://www.supply2health.nhs.uk/0AJ/Lists/Advertisements/DispForm.aspx?ID=6
41	Hampshire - Wheelchair Servic	Wheelchair Services	£20,000,000.00	Aug-13	https://www.supply2health.nhs.uk/0AW/Lists/Advertisements/DispForm.aspx?ID=5
42	North East - Paedeatric Speech	Paedeatric Speech	£6,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0AR/Lists/Advertisements/DispForm.aspx?ID=3
43	North East - Paedeatric OTS	Paedeatric OTS	£6,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0AR/Lists/Advertisements/DispForm.aspx?ID=4
44	Essex - Phlebotomy	Phlebotomy	£2,400,000.00	Jul-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=12
45	York - Dermatology	Dermatology	£6,500,000.00	Jul-13	https://www.supply2health.nhs.uk/0AR/Lists/Advertisements/DispForm.aspx?ID=2
46	Bexley - MSK	MSK	£15,000,000.00	Jul-13	https://www.supply2health.nhs.uk/07N/Lists/Advertisements/DispForm.aspx?ID=4
47	Oxfordshire - Patient Transpor	Patient Transport	£12,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0AE/Lists/Advertisements/DispForm.aspx?ID=8
48	Essex - Mental Health	Mental Health	£10,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=9
49	Cambridgeshire	Elderly Services	£800,000,000.00	Jul-13	http://www.cambridge-news.co.uk/Cambridge/1-billion-sell-off-of-NHS-services-in-Cambridgeshire-20130729060002.htm
50	Bristol	Mental Health	£210,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0AC/Lists/Advertisements/DispForm.aspx?ID=1
51	London	Prison Services	£100,000,000.00	Jul-13	https://www.supply2health.nhs.uk/X24/Lists/Advertisements/DispForm.aspx?ID=1
52	Basildon	MSK	£81,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=16
53	Oldham	Community Health	£69,000,000.00	Jul-13	https://www.supply2health.nhs.uk/0AJ/Lists/Advertisements/DispForm.aspx?ID=4
54	Essex - Elderly Services	Elderly Services	£10,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=8
55	Chesire - Anti-Cogulation	Anti-Cogulation	£6,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0CE/Lists/Advertisements/DispForm.aspx?ID=4
56	South Yorkshire - Sexual Assu	Sexual Assualt Referral	£20,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0CF/Lists/Advertisements/DispForm.aspx?ID=3
57	Tameside - Disabetes	Diabetes	£3,000,000.00	Jun-13	https://www.supply2health.nhs.uk/CP4/Lists/Advertisements/DispForm.aspx?ID=82
58	Medway - Prison Services	Prison Services	£2,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0AM/Lists/Advertisements/DispForm.aspx?ID=1
59	Bracknell - Urgent Care	Urgent Care	£5,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0AE/Lists/Advertisements/DispForm.aspx?ID=1
60	Nationwide	Blood Plasma	£230,000,000.00	Jun-13	http://www.theguardian.com/business/2013/jul/18/bain-capital-plasma-resources-uk
61	Wiltshire	Maternity	£63,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0AE/Lists/Advertisements/DispForm.aspx?ID=5
62	Surrey	Out of Houra	£35,000,000.00	Jun-13	https://www.supply2health.nhs.uk/0CC/Lists/Advertisements/DispForm.aspx?ID=1
63	Bath - Urgent Care	Urgent Care	£12,500,000.00	May-13	https://www.supply2health.nhs.uk/0AE/Lists/Advertisements/DispForm.aspx?ID=3
64	Berkshire - Physiotherapy	Physiotherapy	£3,200,000.00	May-13	https://www.supply2health.nhs.uk/0AE/Lists/Advertisements/DispForm.aspx?ID=2
65	Thurrock - Nursing Care	Nursing Care	£5,000,000.00	May-13	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=2
66	Barnet - Psychological Therapi	Psychological Therapies	£6,000,000.00	Apr-13	https://www.supply2health.nhs.uk/5A9/Lists/Advertisements/DispForm.aspx?ID=23
67	Bexley - Neurological Rehab	Neurological Rehab	£6,000,000.00	Apr-13	https://www.supply2health.nhs.uk/TAK/Lists/Advertisements/DispForm.aspx?ID=12
68	Surrey - Prison Services	Prison Services	£10,000,000.00	Apr-13	https://www.supply2health.nhs.uk/5P5/Lists/Advertisements/DispForm.aspx?ID=31
69	Bromley - Community Rehab	Community Rehab	£10,000,000.00	Apr-13	https://www.supply2health.nhs.uk/5A7/Lists/Advertisements/DispForm.aspx?ID=18
70	Barnet - Speech & Therapy	Speech & Therapy	£6,000,000.00	Apr-13	https://www.supply2health.nhs.uk/5A9/Lists/Advertisements/DispForm.aspx?ID=22
71	Bournemouth Continuing Heal	Continuing Healthcare	£5,000,000.00	Apr-13	https://www.supply2health.nhs.uk/5QN/Lists/Advertisements/DispForm.aspx?ID=19
72	West Hertfordshire	Digital Records	£50,000,000.00	Apr-13	http://www.computerworlduk.com/news/it-business/3442070/west-herts-nhs-trust-tenders-50m-ict-contract/
73	West Middlesex - Urgent Care	Urgent Care	£25,000,000.00	Mar-13	https://www.supply2health.nhs.uk/5HY/Lists/Advertisements/DispForm.aspx?ID=12
74	Waltham Forest - Rehab Servc	Rehab Services	£12,500,000.00	Mar-13	https://www.supply2health.nhs.uk/5NC/Lists/Advertisements/DispForm.aspx?ID=4
75	Wirral - Primary Medical Serv	Primary Medical Services	£3,000,000.00	Mar-13	https://www.supply2health.nhs.uk/5NK/Lists/Advertisements/DispForm.aspx?ID=55
76	Birmingham	Elderly Care Homes& Home	£830,000,000.00	Mar-13	http://www.ft.com/cms/s/0/6424b29e-f60a-11e2-a55d-00144feabdc0.html
77	Hillingdon - Urgent Care	Urgent Care	£29,000,000.00	Feb-13	https://www.supply2health.nhs.uk/5AT/Lists/Advertisements/DispForm.aspx?ID=6
78	Mid Yorks - Acute Services	Acute Services	£2,000,000.00	Feb-13	https://www.supply2health.nhs.uk/RXF/Lists/Advertisements/DispForm.aspx?ID=3
79	Nottingham	Treatment Centre	£208,000,000.00	Feb-13	http://www.healthinvestor.co.uk/(A(ehHcOi9BzgEkAAAAYWRlYzk2NTItM2E0Ny00NTExLWE2MjctYzdjNTZjZWU3YTQxsxLMs1X4b3DRhXcwjesrppsq-OY1)S(lvp2ev55dnob13vwjm4or455))/ShowArticleNews.aspx?ID=2675&AspxAutoDetectCookieSupport=
80	Leicestershire	Estate Services	£700,000,000.00	Jan-13	http://www.cnplus.co.uk/news/sectors/health/interserve-wins-landmark-700m-nhs-shared-services-deal/8640652.article
81	Bedforshire	MSK	£125,000,000.00	Jan-13	https://www.supply2health.nhs.uk/5P2/Lists/Advertisements/DispForm.aspx?ID=17
82	Kent - Prison Services	Prison Services	£12,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5QA/Lists/Advertisements/DispForm.aspx?ID=27
83	Leicester GP	GP	£3,800,000.00	Dec-12	https://www.supply2health.nhs.uk/5PC/Lists/Advertisements/DispForm.aspx?ID=21
84	Hounslow - Dermatology	Dermatology	£3,800,000.00	Dec-12	https://www.supply2health.nhs.uk/5HY/Lists/Advertisements/DispForm.aspx?ID=11
85	Southwark - Dermatology	Dermatology	£2,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5LE/Lists/Advertisements/DispForm.aspx?ID=7
86	Gloucs. Out of Hours	Out of Hours	£21,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5QH/Lists/Advertisements/DispForm.aspx?ID=16
87	Manchester - Community Nurs	Community Nursing	£10,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5LH/Lists/Advertisements/DispForm.aspx?ID=35
88	Gloucs. - Learning Difficulties	Learning Difficulties	£10,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5QJ/Lists/Advertisements/DispForm.aspx?ID=40
89	Sheffield - Patient Transport	Patient Transport	£3,600,000.00	Dec-12	https://www.supply2health.nhs.uk/5H8/Lists/Advertisements/DispForm.aspx?ID=14
90	HMP East Mids - Substance A	Substance Abuse	£4,500,000.00	Dec-12	https://www.supply2health.nhs.uk/5ET/Lists/Advertisements/DispForm.aspx?ID=3
91	HMP Cheshire - Addiction	Addiction	£4,800,000.00	Dec-12	https://www.supply2health.nhs.uk/5NK/Lists/Advertisements/DispForm.aspx?ID=52
92	HMP Leicester	Prison Services	£5,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5PC/Lists/Advertisements/DispForm.aspx?ID=18
93	Ealing Nursing Home	Nursing Care	£2,300,000.00	Dec-12	https://www.supply2health.nhs.uk/5HX/Lists/Advertisements/DispForm.aspx?ID=12

94	Midlands	Pathology	£770,000,000.00	Dec-12	https://www.supply2health.nhs.uk/Q35/Lists/Advertisements/DispForm.aspx?ID=24
95	Gloucs.	Out of Houra	£35,000,000.00	Dec-12	https://www.supply2health.nhs.uk/5QH/Lists/Advertisements/DispForm.aspx?ID=17
96	South West	Hospital Services	£75,000,000.00	Nov-12	http://www.berkeley-scott.co.uk/hospitality-matters/contract-catering/sodexo-wins-contract-at-sussex-nhs-trust
97	Camden - Child Weight	Child Weight	£3,300,000.00	Sep-12	https://www.supply2health.nhs.uk/5K7/Lists/Advertisements/DispForm.aspx?ID=26
98	Bedfordshire - Sexual Health	Sexual Health	£2,000,000.00	Sep-12	https://www.supply2health.nhs.uk/5P2/Lists/Advertisements/DispForm.aspx?ID=15
99	Derby - Lifestyle Change	Lifestyle Change	£4,500,000.00	Sep-12	https://www.supply2health.nhs.uk/5N7/Lists/Advertisements/DispForm.aspx?ID=10
100	Kent - Special Behaviour	Special Behaviour	£7,500,000.00	Sep-12	https://www.supply2health.nhs.uk/5QA/Lists/Advertisements/DispForm.aspx?ID=24
101	East Mids - Continuing Health	Continuing HEalthcare	£2,900,000.00	Sep-12	https://www.supply2health.nhs.uk/5NW/Lists/Advertisements/DispForm.aspx?ID=7
102	South Gloucs.	Community Health	£75,000,000.00	Sep-12	https://www.supply2health.nhs.uk/5QJ/Lists/Advertisements/DispForm.aspx?ID=41
103	Nationwide	450 AQP Community Health	£500,000,000.00	Sep-12	http://www.theguardian.com/society/2011/jul/19/nhs-services-open-to-competition
104	Watford	Watford Health Campus	£240,000,000.00	Aug-12	http://www.constructionenquirer.com/2012/08/30/kier-wins-550m-watford-health-campus/
105	Suffolk	Suffolk Community Health	£140,000,000.00	Jul-12	http://www.healthinvestor.co.uk/ShowArticleNews.aspx?ID=3046
106	Devon	Devon Children's Services	£132,000,000.00	Jul-12	http://www.theguardian.com/society/2012/jul/12/virgin-care-children-nhs-devon
107	Suffolk	Suffolk Elderly Care Homes	£60,000,000.00	Jun-12	http://www.careuk.com/suffolk-care-homes
108	East Anglia	East Anglia Partnership	£400,000,000.00	May-12	http://www.information-age.com/it-management/outsourcing-and-supplier-management/1681073/serco-is-last-supplier-left-in-nhs-shared-services-bid
109	North West	NHS NW Personal Social Ca	£300,000,000.00	Apr-12	
110	Hillingdon	NHS Hillingdon MSK/ MRI/	£200,000,000.00	Apr-12	
111	Yorkshire	NHS Yorkshire (Urgent Care	£150,000,000.00	Apr-12	
112	Essex	NHS South West Essex (Elec	£150,000,000.00	Apr-12	
113	Surrey	Surrey Community Health	£468,000,000.00	Mar-12	http://www.bbc.co.uk/news/uk-england-surrey-17567842
114	Cambridgeshire	Hinchingbrooke Hospital	£1,000,000,000.00	Feb-12	http://www.hsj.co.uk/news/acute-care/circle-to-run-hinchingbrooke-hospital/5037742.article
115	Kent	NHS Residential Continual H	£135,000,000.00	Feb-12	https://www.supply2health.nhs.uk/Results.aspx?k=111
116	Bath	NHS 111 (Bath)	£100,000,000.00	Feb-12	https://www.supply2health.nhs.uk/Results.aspx?k=111
117	South Gloucs.	NHS Community Health in S	£90,000,000.00	Feb-12	
118	Walton, Colchester & Devon	New Hospital Construction	£68,000,000.00	Feb-12	
	Nottingham	Weight Management	£200,000,000.00	Feb-14	https://www.supply2health.nhs.uk/04E/Lists/Advertisements/DispForm.aspx?ID=2
	Midlands	Nursing	£50,000,000.00	Feb-14	https://www.supply2health.nhs.uk/0AD/Lists/Advertisements/DispForm.aspx?ID=8
	Kent		£45,000,000.00	Mar-14	https://www.supply2health.nhs.uk/RVV/Lists/Advertisements/DispForm.aspx?ID=10
	Merton		£56,000,000.00	Mar-14	https://www.supply2health.nhs.uk/0AX/Lists/Advertisements/DispForm.aspx?ID=22
	Bedfordshire	Mental Life	£290,000,000.00	Mar-14	https://www.supply2health.nhs.uk/0CG/Lists/Advertisements/DispForm.aspx?ID=43
	Cannock	End of Life	£535,000,000.00	Mar-14	https://www.supply2health.nhs.uk/0AK/Lists/Advertisements/DispForm.aspx?ID=59
	East/West Midlands	Cancer Services	£687,000,000.00	Mar-14	https://www.supply2health.nhs.uk/0AK/Lists/Advertisements/DispForm.aspx?ID=60
	East Midlands	Diagnostics	£300,000,000.00	Mar-14	https://www.supply2health.nhs.uk/0AK/Lists/Advertisements/DispForm.aspx?ID=61
	Normanton	Imaging/Screening	£760,000,000.00	Apr-14	http://ted.europa.eu/udl?uri=TED:NOTICE:115058-2014:TEXT:EN:HTML&tabId=1
	Gloucestershire	Out of Hours	£21,000,000.00	Apr-14	https://online.contractsfinder.businesslink.gov.uk/Common/View%20Notice.aspx?site=1000&lang=en&noticeid=1335312&fs=true
	Essex	Community dental Services	£17,500,000.00	Apr-14	https://online.contractsfinder.businesslink.gov.uk/Common/View%20Notice.aspx?site=1000&lang=en&noticeid=1360712&fs=true
	England	PET Services	£320,000,000.00	May-14	https://online.contractsfinder.businesslink.gov.uk/Common/View%20Notice.aspx?site=1000&lang=en&noticeid=1372262&fs=true
	Essex	Urgent Care	£350,000,000.00	May-14	https://t.co/FUzbVqtYOc
	Doncaster	Unplanned Care Services	£13,000,000.00	May-14	https://online.contractsfinder.businesslink.gov.uk/Common/View%20Notice.aspx?site=1000&lang=en&noticeid=1385339&fs=true

9 April 2014 Last updated at 11:36

Peterborough and Stamford NHS services tender plan to stem defc it

Peterborough City Hospital opened in 2010 and cost £298m to build

Services offered by a cash-strapped NHS trust could be privately managed under rescue proposals from the UK's heath watchdog, Monitor.

Peterborough and Stamford NHS Foundation Trust has an annual deficit of £40m and was described by Monitor as "not financially sustainable".

A competitive tendering process to manage services at its two hospitals could begin in the summer.

A spokesman said "whatever the outcome" services would remain within the NHS.

The newest of the trust's two hospitals, Peterborough City Hospital, was opened in November 2010 at a cost of £298m.

'Maximise value'

But a 33-year private finance initiative (PFI) contract to fund its construction is costing more than £40m a year to repay, prompting concerns from the regulator, Monitor.

It appointed a Contingency Planning Team (CPT) which concluded in September that the trust was "clinically and operationally sustainable, but not financially sustainable in its current form".

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The trust also runs Stamford and Rutland Hospital in Lincolnshire

The CPT made a number of recommendations including whether its assets could be better managed to "maximise the value for patients and taxpayers from the use of trust's assets".

A competitive tender plan for running the trust's services has now been submitted to Monitor.

Potentially this could involve a private company taking over management of the NHS services in a similar way to Hinchingbrooke Hospital in Cambridgeshire, or a merger with other hospitals.

Dr Peter Reading, the trust's interim chief executive, said: " At this stage we would not discount any option presented, however the tender process is designed to identify those options which would maximise the use of the hospitals."

"Whatever the outcome, services would continue to be run from Peterborough City Hospital and Stamford Hospital sites," he added.

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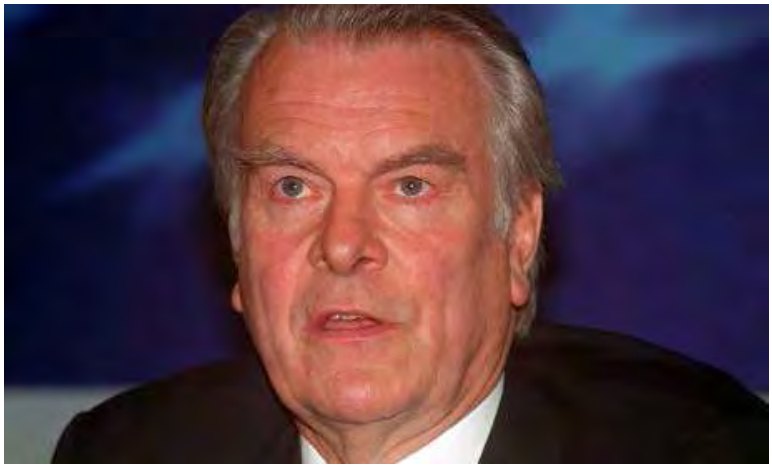
Bain Capital buys majority stake in Plasma Resources UK

Private equity firm buys 80% share in blood products company for £200m, with Department of Health retaining the remainder

Jennifer Rankin

The Guardian, Thursday 18 July 2013 20.03 BST



Former Labour health minister Lord Owen said it was 'hard to conceive of a worse outcome' for Plasma Resources UK. Photograph: Michael Stephens/PA

Bain Capital, the private equity firm branded a "job destroyer" in the US presidential elections, has bought a majority stake in the state-owned blood products firm Plasma Resources UK.

Lord Owen, a former Labour health minister in the 1970s, who created a service to make the UK self-sufficient in blood supplies, said it was "hard to conceive of a worse outcome" than the £200m sale of an 80% stake in the Hertfordshire-based company to private equity. The Department of Health will retain a 20% share in the business.

Plasma Resources UK turns plasma - the watery fluid in blood that carries the white and red cells - into life-saving treatments for immune deficiencies, neurological diseases and haemophilia.

Since the firm was created by the Labour government in 2002 to maintain a steady supply of blood products, all plasma has been collected from US donors because of the theoretical risk of contamination with variant Creutzfeldt-Jakob disease, the human form of BSE, which cannot be reliably tested for.

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Under the deal announced on Thursday, Bain Capital has agreed to pay £90m upfront, with a deferred payment "expected to be worth £110m" due in five years' time.

The US private equity firm, which was founded in 1984 by former Republican presidential candidate Mitt Romney, has promised to invest £50m in PRUK to increase production, refurbish facilities and develop new products. It has also pledged to keep the company's headquarters in the UK.

Bain Capital shot to notoriety in the US presidential elections, when Barack Obama's team made Mitt Romney's tenure at Bain a centrepiece of its campaign against the Republican candidate, accusing him and the company of shredding jobs in the American heartland. Romney made his fortune at Bain but left the company at least a decade before the presidential election.

The sale of the 80% stake adds to the growing list of privatisations now underway, including the Royal Mail, Search and Rescue, which will be taken over in 2015, and a tranche of the student loans book.

Health Minister Dan Poulter said the deal, which values PRUK at £230m, will "ensure that patients will have access to high quality plasma products for years to come".

"Bain Capital was chosen following a fair and open competitive process which looked at who offered the best deal for patients and to ensure future employment at the company."

But Lord Owen, the crossbench peer, blasted the deal. "It's hard to conceive of a worse outcome for a sale of this particularly sensitive national health asset than a private equity company with none of the safeguards in terms of governance of a publicly quoted company and being answerable to shareholders. Private equity has a useful function, as I saw in years past on the advisory board of Terra Firma, but Bain Capital should not have been chosen for this sale."

"Is there no limit to what and how this coalition government will privatise?"

In March the peer warned prime minister David Cameron that he would be foolish to allow the sale of PRUK, which he described as "an excellent insurance policy for the NHS" that ensures the integrity of plasma supplies. A privatised company posed risks of contaminated plasma, he suggested. "The worldwide plasma supply line has in the past been contaminated ... We in this country should do everything in our power to avoid being reliant on open market tendering processes for NHS patients." Professor Allyson Pollock, professor of public health research and policy at Queen Mary University London, said there was "not a shred of evidence" to support government claims that private firms would boost innovation in plasma treatments.

"Where is the evidence that when you use venture capital such as Bain Capital that they invest and they don't asset strip?" she said. Innovation in the NHS and its blood supply services was at risk as a result of the deal, she said.

The sale illustrated "why we are concerned at the way that NHS and NHS associated products are being denationalised and privatised and put out to the market place as a source of profit rather than responding to patient needs."

Devin O'Reilly, managing director of Bain Capital in London and leader of the firm's healthcare team in Europe, said: "We are excited about the prospects of PRUK in the growing plasma products industry and are

Vince Cable warns Tory leaders against stoking anti-immigration panic

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committed to investing in the company to help it reach its full potential in this global market."

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West Hertfordshire Hospitals NHS Trust has put out an ICT contract for tender worth up to £50 million over five years.

The ICT infrastructure improvement programme contract will support the work of almost 4,000 staff across three main sites and one satellite site.

Services required include the provision of a service desk; service management including disaster recovery, business continuity and security; data management including storage, back-up and archiving; and information management covering desktops, laptops and other devices.

NHS Trust uses in-memory analytics to deliver better patient care | Jeremy Hunt hopes to make UK the 'global hub of health technology' | Cambridge NHS Trust awards HP £130 million contract to lead digital strategy

The contract also covers unified communications across LANs, WANs and mobile networks; and videoconferencing, fixed and mobile telephony, printing services, and application hosting.

The trust said: "Bidders will be aware of the continuing changes that are occurring both in technology, and within the NHS at large.

Bidders must be able to flex their service arrangements to take into account these changes in technology and organisational structure that will inevitably occur during the five-year life of the contract."

The trust said it may want to extend the contract to cover clinical or information systems, business applications, portals and digital service user engagement, such as tele-health.

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"The services may be extended under this contract either during the procurement process itself, or during the term of the contract under change control procedures," said the trust.

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The estimated contract value is between £30 million and £50 million. There is also the possibility that the five year deal could be extended by a further two years at the trust's discretion.

Bids of interest have to be in by 22 May, with full invitations to tender sent to suppliers on 6 June.

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Interserve wins landmark £700m NHS shared services deal

3 January, 2013 | By Luke Cross

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Sodexo wins contract at Sussex NHS Trust

November 28, 2012

-

Sodexo is to provide catering services at two hospitals in Sussex after securing a new contract with the local NHS trust.

The facilities management giant has won a five-year deal with Brighton and Sussex University Hospitals NHS Trust, worth more than £15 million a year in turnover.

It will see the firm supply patient and staff catering services across two sites managed by the trust – the Royal Sussex County Hospital in Brighton and the

Princess Royal Hospital in Haywards Heath – alongside a host of other services including housekeeping and cleaning, grounds maintenance, waste management and linen supply.

Sodexo, a major source of catering recruitment in the hospitality industry, has already provided facilities management services to the Princess Royal Hospital since 1996.

Simon Scrivens, the group's managing director, said: "We are delighted to have won this contract and are especially pleased to be building on our existing relationship with the trust.

"Today's announcement is testament to Sodexo's commitment to supporting the NHS with its twin challenges of improving quality and at the same time delivering operational efficiencies."

A number of the services being supplied by Sodexo had previously been outsourced to a number of different companies.

Bringing them all together under a single contract will allow the trust to attain better value for money on behalf of the tax payer as well improve the quality the services, said Chris Adcock, chief executive of Brighton and Sussex University Hospitals NHS Trust.

He added: "Sodexo has a proven track record in providing the services included in this contract to a very high standard including at the Princess Royal Hospital in Haywards Heath."

The new contract, one of the largest of its kind that the NHS has awarded this year, will come into effect in December this year and will include an option to extend by two years at the end of the initial five-year agreement.

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NHS services to be opened up to competition

More than £1bn of NHS services are to be opened to competition from private companies and charities, including wheelchair services for children

Randeep Ramesh

The Guardian, Tuesday 19 July 2011 21.52 BST

Jump to comments (398)

Wheelchair services for children are one of the first NHS areas open for competition from private providers from next April. Photograph: Christopher Thomond for the Guardian

The government will open up more than £1bn of NHS services to competition from private companies and charities, the health secretary announced on Tuesday, raising fears it will lead to the privatisation of the health service.

In the first wave, beginning in April, eight NHS areas – including musculoskeletal services for back pain, adult hearing services in the community, wheelchair services for children, and primary care psychological therapies for adults – will be open for "competition on quality not price". If successful, the "any qualified provider" policy would from 2013 see non-NHS bodies allowed to deliver more complicated clinical services in maternity and "home chemotherapy".

Andrew Lansley – admitting that the government's initial plans for competition in the NHS were too ambitious, and stung by criticism from Steve Field, the senior doctor called in by David Cameron to review the reforms, that the proposals were "unworkable" – has slowed down the

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rollout of competition. The health secretary said his plans would now "enable patients to choose [providers] … where this will lead to better care".

Labour questioned the policy, which the shadow health secretary, John Healey, said was "not about giving more control to patients, but setting up a full-scale market".

His colleague Emily Thornberry, the party's health spokeswoman, added that "today is a good day to announce the policy because everyone is preoccupied with telephone hacking. [They] hope no one will notice it."

This theme was picked up on Twitter with a stream of comments about it "being a good day to bury bad news".

Critics warned of "huge dangers lurking in the plans".

The trade union Unison said: "Patients will be little more than consumers, as the NHS becomes a market-driven service, with profits first and patients second. And they could be left without the services they need as forward planning in the NHS becomes impossible."

A spokesman for the British Medical Association questioned "the assumption that increasing competition will always mean improving choice.

"The ultimate consequence of market failure in the NHS is the closure of services, restricting the choice of patients who would have wished to use them." The Department of Health dismissed these charges and argued the policy would benefit patients by bringing many services out of hospitals, which would make it easier to access healthcare.

As an example, the policy could lead to patients being able to walk into a retailer on the high street or a local GP's surgery for a blood test rather than being forced to go to hospital.

One of the new policy's aims is to promote innovation, highlighting the "Tony Blair example". Abnormal heart rhythms, such as those suffered by Tony Blair, no longer need the immediate attention of a cardiologist.

Instead, a concerned patient could be treated by using the telephone to measure the heart beats and give an instant diagnosis, followed by a call from a nurse advising on whether the patient needed to go to hospital or not.

There were also major savings that could be made, the department said. It cited the example of chronic leg wounds, where the NHS pays out £18,000 per patient over four years, often without curing them. One not-for-profit company – Wound Healing Centre in Sussex – treats patients successfully for £720.

Lansley's commissioning tsar, Dame Barbara Hakin, said the NHS must push ahead with the agenda to offer patients more choice despite financial challenges and a period of "significant transition".

The NHS must save £20bn over the next four years in efficiencies.

Labour disputed the gains, saying the policy was just a step towards privatisation.

Healey said: "The Tory-led government is pushing ahead with its wasteful and unnecessary NHS reorganisation, rather than focusing on improving patient care."

Care options

From April 2012 patients receiving one of eight types of community and mental health services in England will be able to be choose to access their care or support from a private health provider or voluntary or charitable organisation, not just the NHS.

• Services for back and neck pain.

• Adult hearing services in the community.

• Continence services (adults and children).

• Diagnostic tests closer to home.

• Wheelchair services (children).

• Podiatry (feet) services.

• Leg ulcer and wound healing.

• Talking Therapies (primary care psychological therapies, adults).

These represent about £1bn of the NHS's £110bn a year activity.

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Virgin Care to take over children's health services in Devon

Sir Richard Branson's company named preferred bidder in £130m deal that will see core NHS services farmed out

Randeep Ramesh and **Felicity Lawrence**

The Guardian, Thursday 12 July 2012 16.30 BST

Jump to comments (479)

Sir Richard Branson's Virgin Care already has a £500m contract with NHS Surrey to run community health services. Photograph: Danny Moloshok/Reuters

Sir Richard Branson's Virgin Care has been named preferred bidder for a £130m contract to run core NHS and social care services for children and young people in Devon, it has been announced.

The company will take over integrated children's services in the south-west in March 2013 and will run frontline services for three years. Critics have warned that such deals herald the breakup of the NHS, with private firms cherrypicking services.

Virgin, which earlier signed a £500m contract with NHS Surrey to run community health services, beat competition from two rival bidders: a consortium of Devon Partnership NHS Trust with charities Barnado's, Young Devon and Interserve; and Serco with Cornwall Partnership NHS Trust.

The deal will see Virgin take over about 1,100 staff employed by NHS Devon and Devon county council, which currently oversees about 2,400 children with disabilities, children's mental health services and school nurses and health visitors.

While the most sensitive parts of children's services – such as child

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protection – will remain in local government hands, concerns were expressed during the bidding process about whether private companies would be able to deal with safeguarding cases in which health visitors liaise with GPs and teachers to ensure children are protected from maltreatment and there is adequate care in the home.

Virgin says it has increased its experience in children's services since it began working more than a year ago with the charity Kids Company, focusing on teenagers and sexual health issues. Branson bought 75% of Assura Medical with a £4m loan in 2010. The company, rebranded Virgin Care this year, has expanded and now runs 120 NHS services, most notably GP practices. An investigation last year showed Virgin had links with 50% or more of the board members at three of the 52 first-wave GP commissioning groups that will purchase care on behalf of patients from next year.

Virgin Care has pointed out that the "privatisation" was not a consequence of the coalition's health and social care bill; it was the Labour government under Gordon Brown that separated the NHS's £10bn of community services from the bodies that commissioned care. Most were absorbed by hospitals or mental health trusts.

Although the coalition inherited the programme, there have been suspicions that the pace of contracting has increased. Until 2011 only about £400m of services had been put out to tender.

In Devon's case, since the local authority had integrated services with the NHS these were put out to tender as a single contract. Rebecca Harriott, director of commissioning development at NHS Devon, said there were "many benefits" to the deal. "We know that these are important and sensitive services and it is vital to ensure that everyone can be confident that a winning bidder is able to deliver the best possible outcomes for children and young people across Devon.

"That is why we have been so careful to involve as many stakeholders as possible in the evaluation process including young people, parents and carers and professionals such as GPs and head teachers.

"Bringing together community-based health and social care staff has brought many benefits for children, young people, parents and carers. Keeping these services together and developing them further means finding the right provider with the right vision and commitment. Today's announcement is just one step towards this."

A Virgin Care spokesman said: "We have a strong track record of delivering investment and complex care for children and young people as well as a wider range of NHS services across the country. Since 2006 we have treated over 2 million people delivering services that offer improved accessibility, convenience, satisfaction and most importantly, that deliver improved health outcomes while at the same time providing improved value for money."

Care UK residential services in Suffolk

At Care UK we offer a range of care services for older people in Suffolk, including residential, respite, rehabilitation and specialist dementia care. And for people living in their own home, there's our Wellbeing Centres providing personalised daytime care and activities.

Improving services in Suffolk

Care UK is investing £60 million in 10 new care homes and wellbeing centres, to help fulfil Suffolk County Council's vision for older people's care. Click here to get the latest update on the plan.

Find out more >

Eye, Paddock House

www.careuk.com/paddock-house

Paddock House is a relaxed and friendly care home where the emphasis is on enjoying time together. The regular coffee mornings, and in the warmer months cream teas in the garden, are always popular with residents and their families. Other social events include theatre trips, days at the seaside and the annual summer fair.

Paddock House
Wellington Road
Eye
Suffolk
IP23 7BE

0333 321 8604

- Day care
- Residential care
- Residential dementia care
- Respite care

Make an enquiry >

Haverhill, Place Court

www.careuk.com/place-court

Place Court is very much a part of the local community. The home is located next to Haverhill recreation ground where there's always plenty going on, from family fun days and boot fairs to live music at the bandstand. Every summer the team organise a 'holiday week' where residents

decide a programme of fun activities and outings such as visits to the Imperial War Museum in Duxford and pub lunches.

Place Court
Camps Road
Haverhill
Suffolk
CB9 8HF

0333 321 8607

- Day care
- Residential care
- Residential dementia care
- Respite care

Make an enquiry >

Ixworth, Ixworth Court

www.careuk.com/ixworth-court

Residents at Ixworth Court are very much hands-on. The thriving gardening club grow a variety of vegetables and herbs, which the kitchen team uses to prepare healthy and tasty meals for everyone to enjoy. And other residents help to bake and decorate the cakes for afternoon tea.

Ixworth Court
Peddars Close
Ixworth
Suffolk
IP31 2HD

0333 321 8596

- Residential care
- Residential dementia care
- Respite care

Make an enquiry >

Lowestoft, Blyford

www.careuk.com/blyford

Blyford is a care home where fun and entertainment are the focus. Singing, quizzes, bingo and film afternoons are just some of the many activities. Residents also enjoy regular outings to local attractions such as the Sea Life Centre in Great Yarmouth and the Africa Alive wildlife park in Lowestoft.

Blyford
61 Blyford Road
Lowestoft
Suffolk
NR32 4PZ

0333 321 8351

- Day care
- Residential care
- Residential dementia care
- Respite care

Make an enquiry >

Stowmarket, Wade House

www.careuk.com/wade-house

Keeping active and busy is central to life at Wade House. Suffolk Artlink provides arts and crafts workshops and professional performers and musicians regularly visit to entertain residents. There are regular trips out to Abbey Gardens, Bury St Edmunds Cathedral and the coast at Felixstowe.

Wade House
Violet Hill Road
Stowmarket
Suffolk
IP14 1NH

0333 321 8395

- Residential care
- Residential dementia care
- Respite care

Make an enquiry >

Wickham Market, Lehmann House

www.careuk.com/lehmann-house

Residents at Lehmann House love to get involved in the life of the home whether it's washing up, laying the table or fetching the papers. Every month residents get together to chat and make decisions about the home from what dishes they would like on the menu to what activities they would like to try.

Lehmann House
Church Terrace, Off Chapel Lane
Wickham Market
Suffolk
IP13 0SG

0333 321 8598

- Dementia care
- Residential care
- Residential dementia care
- Respite care

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Information Age
Insight and analysis for IT leaders

Serco is last supplier left in NHS shared services bid

UK services giant looks set to win outsourcing contract, worth up to £400 million, from East England NHS Trust partnership

Posted by Information Age on 22 December 2011

Business services conglomerate Serco is the only remaining supplier in the running for a contract to supply shared back-office functions to a group of NHS Trusts in the East of England.

In 2002, Cambridgeshire and Peterborough NHS Foundation Trust and five other NHS trusts founded the Anglia Support Partnership (ASP), which provides back-office functions, including HR, IT and procurement. ASP, which also supplies a further 50 other public and private organisations, has to date been managed by the NHS trusts themselves, with Cambridge and Peterborough as the lead trust.

In March 2011, the contract to operate ASP was offered up for tender. The contract was valued at between £75 million and £400 million. The tender document revealed that ASP turns over £34 million a year, and owns assets worth £3.8 million.

Out of 70 interested parties, Serco has been "taken forward as the remaining single bidder", with French facilities management company Sodexo as "reserve bidder", ASP's acting managing director Gus Williamson announced today.

Serco still has to supply a final proposal by 19 January 2012, which will need to be approved by Cambridgeshire and Peterborough NHS Foundation Trust.

Christopher Hyman, Serco's chief executive, said that the company will be seeking to "radically improve service quality" and provide "guaranteed

cost savings" to ASP's clients. "These middle and back office services can also be accessed by a wide number of organisations, further leveraging the growth potential," Hyman said.

Earlier this year, trade union UNISON expressed its opposition to ASP's outsourcing bid. "It's a scandal. There is no accountability at all," said UNISON's Eastern Region Head of Health Tracey Lambert. "The NHS is paying the salaries and running costs of bodies that appear dedicated to handing public services and assets over to private companies – and to ensuring that neither staff nor public have any chance to affect this one-way process."

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30 March 2012 Last updated at 18:31

Virgin Care to run Surrey community health services

Community health services in two areas of Surrey are to be run by a private company in a £500m deal.

Unison said it had concerns about privatisation of services accessed through GPs

NHS Surrey said the contract signed with Virgin Care also included some county-wide services such as prison healthcare and sexual health services.

Virgin is to manage community services in south west and north west Surrey.

Anne Walker, chief executive of NHS Surrey, said it was "excellent news" but Unison said it had concerns about NHS privatisation.

Virgin will manage services but lease premises from the NHS under the deal, which will run until 2017.

NHS Surrey said patients would continue to be cared for by existing staff, who had been fully involved throughout the procurement process.

'Proft over care'

Services involved include seven Surrey community hospitals, community nursing and dentistry, health visiting and physiotherapy, diabetes treatment and renal care.

"This is excellent news for patients, carers and staff in Surrey," said Ms Walker.

"This contract signed with Virgin Care will bring best quality, safety and value for Surrey's NHS patients, carers and taxpayers."

But public service union Unison said it had concerns over the privatisation of the NHS and fears of profit over care.

"The services that Surrey's million-plus population access through their GPs, including community nursing, therapies, end of life care and sexual health screening, will now be provided by a private company," it said.

Regional organiser Sarah Hayes said: "Both staff and the public do have fears over what this means for the future of the NHS.

"Unison is keen to now work with Virgin Care to ensure that quality health services for all are maintained across Surrey and to support staff in continuing to provide care and a vital service for all patients."

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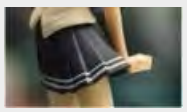

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Circle to run Hinchingbrooke hospital

10 November, 2011 | By The Press Association

A private company has been given the final go-ahead to take over the running of a debt-ridden NHS hospital.

Service contract - 115058-2014

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I.II.III.IV.VI.

United Kingdom-Normanton: Surgical hospital services

2014/S 067-115058

Contract notice

Services

Directive 2004/18/EC

Section I: Contracting authority

I.1) **Name, addresses and contact point(s)**
NHS Supply Chain acting as agent for NHS Business Services Authority
NHS Supply Chain, Foxbridge Way
For the attention of: Kayla Takvam
WF6 1TL Normanton
UNITED KINGDOM
Telephone: +44 1924328842
E-mail: kayla.takvam@supplychain.nhs.uk
Fax: +44 1924328744
Internet address(es):
General address of the contracting authority: www.supplychain.nhs.uk
Further information can be obtained from: NHS Supply Chain acting as agent for NHS Business Services Authority
Internet address: http://procurement.supplychain.nhs.uk/ISS/
Specifications and additional documents (including documents for competitive dialogue and a dynamic purchasing system) can be obtained from: NHS Supply Chain acting as agent for NHS Business Services Authority
Internet address: http://procurement.supplychain.nhs.uk/ISS/
Tenders or requests to participate must be sent to: NHS Supply Chain acting as agent for NHS Business Services Authority
Internet address: http://procurement.supplychain.nhs.uk/ISS/

I.2) **Type of the contracting authority**
National or federal agency/office

I.3) **Main activity**
Health

I.4) **Contract award on behalf of other contracting authorities**
The contracting authority is purchasing on behalf of other contracting authorities: yes

Section II: Object of the contract

II.1) **Description**

II.1.1) **Title attributed to the contract by the contracting authority:**
Mobile and Strategic clinical Solutions and Associated Goods.

II.1.2) **Type of contract and location of works, place of delivery or of performance**

Services
Service category No 25: Health and social services
Main site or location of works, place of delivery or of performance: Various locations across UK.
NUTS code UK

II.1.3) **Information about a public contract, a framework agreement or a dynamic purchasing system (DPS)**
The notice involves the establishment of a framework agreement

II.1.4) **Information on framework agreement**
Framework agreement with several operators
maximum number of participants to the framework agreement envisaged: 80
Duration of the framework agreement
Duration in years: 4
Estimated total value of purchases for the entire duration of the framework agreement
Estimated value excluding VAT:
Range: between 260 000 000 and 760 000 000 GBP

II.1.5) **Short description of the contract or purchase(s)**
To provide Mobile and Strategic clinical Solutions and Associated Goods to NHS providers within various environments to cover a range of clinical and imaging applications as listed below but not limited to:
Imaging- Bone Densitometry Cardiac Angiography CT Mammography MRI PET CT X-ray Ultrasound
Theatres- Cardiology Dental Endoscopy ENT General Surgery Gynaecology.
Ward/ Clinic/ Consultation Room- including the options for booking reporting and staffing where required and relevant.
It is anticipated that the awarded Framework Agreement will enable customers to have the ability to supplement their existing Imaging; Theatre or Ultrasound with solutions (provided from Mobile or Static Sites) by third party providers. Further details are set out in the relevant Annexes to this notice and the Invitation to Tender (ITT). Applicants are requested to read these in order to understand the Lotting structure which will be applied to this Framework Agreement.
The length of service required will be determined by the customers' local Clinical requirements and may exceed the length of the awarded Framework Agreement. . However Applicants should note that there is potential for a wide range of configurations of the service which may include the provision of further services (such as booking reporting and additional staffing) and associated equipment and consumables depending on the customers' requirements. Please note that specific requirements as to the configuration of this service will be determined by customers over the life time of the Framework Agreement and for the purpose of appointment to the Framework Agreement the evaluation will take place against a representative scenario. Applicants must be able to provide the service in the scenario as a minimum requirement.

II.1.6) **Common procurement vocabulary (CPV)**
85111100, 44211100, 34223330, 85150000, 33100000, 85121200, 75200000, 33124120

II.1.7) **Information about Government Procurement Agreement (GPA)**
The contract is covered by the Government Procurement Agreement (GPA): yes

II.1.8) **Lots**
This contract is divided into lots: yes
Tenders may be submitted for one or more lots

II.1.9) **Information about variants**
Variants will be accepted: yes

II.2) **Quantity or scope of the contract**

II.2.1) **Total quantity or scope:**
This is an estimate only as precise quantities of likely purchases are unknown. It is anticipated that in the first year of the Framework Agreement the value of purchases will be in the region of GBP 65 000 000 to GBP 195 000 000 however this is approximate only. The figures below for the total estimated value are based on that initial expenditure.
In addition to including the first year values above the estimated value/range over the total Framework Agreement term is expected to be between GBP 260 000 000 to GBP 780 000 000
Estimated value excluding VAT:
Range: between 260 000 000 and 780 000 000 GBP

II.2.2) **Information about options**

II.2.3) **Information about renewals**

II.3) **Duration of the contract or time limit for completion**
Duration in months: 48 (from the award of the contract)

Information about lots

Lot No: 1 Lot title: Mobile Services- Imaging

1) **Short description**
The purpose of this Lot is to facilitate the capture of diagnostic images along with patient care within a mobile unit at a location as chosen by the customer organisation which may or may not be on the customer's site. The results of this image capture will be used to make clinical patient diagnosis. This service must consist of the supply of at least one member of staff (who must be of skilled experience to operate the equipment included in this service). However, the customer may also request booking and reporting services, together with provision of Radiographers and other clinical support staff.

2) **Common procurement vocabulary (CPV)**
34223330, 44211100, 85150000, 85111100, 33100000, 85121200, 75200000

3) **Quantity or scope**
This is an estimate only as precise quantities of likely purchases are unknown. It is anticipated that in the first

year of the Framework Agreement the value of purchases will be in the region of GBP 20 000 000 to GBP 60 000 000 however this is approximate only. The figures below for the total estimated value are based on that initial expenditure.
NHS Supply Chain anticipates appointing a minimum of 3 successful Applicants to this Lot should there be 3 or more suitable successful Applicants for this Lot.
Estimated value excluding VAT:
Range: between 80 000 000 and 240 000 000 GBP

4) **Indication about different date for duration of contract or starting/completion**

5) **Additional information about lots**

Lot No: 2 Lot title: Mobile Services - Operating Theatres

1) **Short description**
The purpose of this Lot is to enable the customer to carry out defined surgical procedures within a mobile sterile operating environment at a location as chosen by the customer's organisation which may or may not be on the customer's site. This service must consist of the supply of at least one member of staff (who must be of professional experience to operate equipment included in the service). This would not include the supply of any anaesthetist or surgeons to perform a procedure; these would be supplied by the customer procuring the service. However, Operating Department Practitioners, Operating Department Assistants and other clinical support staff may be provided by a successful Applicant where these are requested by the customer, together with the provision of a booking service.

2) **Common procurement vocabulary (CPV)**
85111100, 44211100, 34223330, 33100000, 85121200, 75200000

3) **Quantity or scope**
This is an estimate only as precise quantities of likely purchases are unknown. It is anticipated that in the first year of the Framework Agreement the value of purchases will be in the region of GBP 10 000 000 to GBP 40 000 000 however this is approximate only. The figures below for the total estimated value are based on that initial expenditure.
NHS Supply Chain anticipates appointing a minimum of 3 successful Applicants to this Lot should there be 3 or more suitable successful Applicants for this Lot.
Estimated value excluding VAT:
Range: between 40 000 000 and 160 000 000 GBP

4) **Indication about different date for duration of contract or starting/completion**

5) **Additional information about lots**

Lot No: 3 Lot title: Strategic Clinical Solutions - Imaging

1) **Short description**
The purpose of this Lot is to facilitate the capture of diagnostic images along with patient care at a location as chosen by the customer's organisation which will not be on the customer's site (and which does not include mobile units). The results of this image capture will be used to make clinical patient diagnosis and procedures (including (but not limited to) cathlab). The services under this lot must consist of the supply at least one member of staff (who must be of professional experience to perform the capture of diagnostic images such as CT/MRI examinations) together with the provision consumables (and other related equipment) and the recovery of the patient. Additional staff (such as Radiographers and other clinical support staff) who can meet the demand and requirements of the services being performed together with the provision of booking and reporting services may also be requested by the customer.

2) **Common procurement vocabulary (CPV)**
85150000, 85111100, 33100000, 85121200

3) **Quantity or scope**
This is an estimate only as precise quantities of likely purchases are unknown. It is anticipated that in the first year of the Framework Agreement the value of purchases will be in the region of GBP 20 000 000 to GBP 60 000 000 however this is approximate only. The figures below for the total estimated value are based on that initial expenditure.
NHS Supply Chain anticipates appointing a minimum of 3 successful Applicants to this Lot should there be 3 or more suitable successful Applicants for this Lot.
Estimated value excluding VAT:
Range: between 80 000 000 and 240 000 000 GBP

4) **Indication about different date for duration of contract or starting/completion**

5) **Additional information about lots**

Lot No: 4 Lot title: Strategic Clinical Solutions - Operating Theatres

1) **Short description**
The purpose of this Lot is to enable the customer's organisation to carry out defined surgical procedures within a permanent operating theatre environment at a permanent location as chosen by the customer's organisation which will be off a customer's site (and which does not include mobile units). This service must consist of the supply of the relevant staff (who must be qualified to perform/assist operations such as orthopaedic, general surgery) as determined by the customer. Together with the provision of consumables and other related equipment required to perform a procedure; and the admission, recovery of the patient together and reporting of the clinical outcome of the procedure. Booking services may also be required as an additional option.

2) **Common procurement vocabulary (CPV)**
85111100, 33100000, 85121200

3) **Quantity or scope**
This is an estimate only as precise quantities of likely purchases are unknown. It is anticipated that in the first year of the Framework Agreement the value of purchases will be in the region of GBP 10 000 000 to GBP 20

000 000 however this is approximate only. The figures below for the total estimated value are based on that initial expenditure.
NHS Supply Chain anticipates appointing a minimum of 3 successful Applicants to this Lot should there be 3 or more suitable successful Applicants for this Lot.
Estimated value excluding VAT:
Range: between 40 000 000 and 80 000 000 GBP

4) **Indication about different date for duration of contract or starting/completion**

5) **Additional information about lots**

Lot No: 5 Lot title: Ultrasound Services

1) **Short description**
The purpose of this Lot is to enable the customer's organisation to arrange a service based ultrasound scanning service to reflect their clinical speciality needs. This will include the provision of obtaining an ultrasound image for diagnosis purposes and reporting on the findings. This service may be mobile or delivered at static site as defined by the customer; a static location will be as chosen by the NHS organisation which may be on or off a customer's site. This service must consist of the supply at least one member of staff (who must be of professional experience to perform Ultrasound in this case a Sonographer) and the provision of an ultrasound scanner to perform the relevant procedure and the diagnostic report. Customers may also request additional numbers of staff to be provided meet the demand and requirements of the services being performed, together with the provision of booking services.

2) **Common procurement vocabulary (CPV)**
85150000, 85111100, 33100000, 85121200, 75200000, 33124120

3) **Quantity or scope**
This is an estimate only as precise quantities of likely purchases are unknown. It is anticipated that in the first year of the Framework Agreement the value of purchases will be in the region of GBP 5 000 000 to GBP 15 000 000 however this is approximate only. The figures below for the total estimated value are based on that initial expenditure.
NHS Supply Chain anticipates appointing a minimum of 3 successful Applicants to this Lot should there be 3 or more suitable successful Applicants for this Lot.

4) **Indication about different date for duration of contract or starting/completion**

5) **Additional information about lots**

Section III: Legal, economic, financial and technical information

III.1) **Conditions relating to the contract**

III.1.1) **Deposits and guarantees required:**
Parent company or other guarantees may be required in certain circumstances. Further details will be in the tender documents.

III.1.2) **Main financing conditions and payment arrangements and/or reference to the relevant provisions governing them:**
Please see tender documents.

III.1.3) **Legal form to be taken by the group of economic operators to whom the contract is to be awarded:**
The Contracting Authority reserves the right to require groupings of entities to take a particular form or to require one party to undertake primary legal liability or to require that each party undertakes joint and several liability.

III.1.4) **Other particular conditions**
The performance of the contract is subject to particular conditions: yes
Description of particular conditions: The Framework Agreement includes obligations with respect to environmental issues and a requirement for successful suppliers to comply with the NHS Supply Chain Code of Conduct.

III.2) **Conditions for participation**

III.2.1) **Personal situation of economic operators, including requirements relating to enrolment on professional or trade registers**
Information and formalities necessary for evaluating if the requirements are met: Submission of Expression of Interest and Procurement Specific Information:
This procurement exercise will be conducted on the NHS Supply Chain eTendering portal at http://procurement.supplychain.nhs.uk/ISS/
Candidates wishing to be considered for this contract must register their expression of interest and provide additional procurement-specific information (if required) through the NHS Supply Chain eTendering portal as follows:
Registration:
1. Use URL http://procurement.supplychain.nhs.uk/ISS/ to access the NHS Supply Chain Procurement portal.
2. If not yet registered:
— Click on the 'Not Registered Yet' link to access the registration page.
— Complete the registration pages as guided by the mini guide found on the landing page.
Portal Access:
If registration has been completed:
— Login with URL http://procurement.supplychain.nhs.uk/ISS/
— Click on the 'Supplier Dashboard' icon to open the list of new procurement events.
Expression of Interest:
— View Contract Notice content by clicking on the 'view Notice' button for the procurement event. This opens a PDF document.
— Express an interest by clicking on the 'express Interest' button.
— To start the response process after the expression of interest has been done select the 'My Active

Opportunities' option and click on the 'Apply' button.
— Select the procurement event from the list by clicking on the description.
— In the detail view click on the orange coloured 'Framework Agreement' button to start responding to the tender.
Tender Response
The system tasks required to complete the tender are:
Header Level
1. Read Framework header documents. These are the documents provided by NHS Supply Chain that must be read by all Applicants. Access these by clicking on the 'NHS SC Header Documents' button found in the 'Select Framework' tab.
2. Upload header documents. These are the documents the Applicant must provide as instructed by NHS Supply Chain. Access this area using the 'Supplier Header Documents' button.
3. Complete price offers per Lot Scenario. Complete the required fields for the lines the Applicant wants to include in the bid using the Lot Line Detail tab.
4. Accept the Terms and Conditions. Click on the 'Terms and Conditions' to view and accept the Terms and Conditions.
5. Submit Lot Response. Click on the 'Submit Response' button to submit your response for the Lot.
Notes:
a. No data is sent to NHS Supply Chain until the 'Submit Response' button is clicked on.
b. The detail will only become visible to NHS Supply Chain after the tender has closed.
Supplier Submission Report. Open and review the 'Supplier Submission Report' to ensure all entries are correct. If an error is found and the tender has not yet closed the Applicant can update the response and re-submit the response. Note: Only the latest submission will be available to NHS Supply Chain after the tender has closed.

III.2.2) **Economic and financial ability**

III.2.3) **Technical capacity**

III.2.4) **Information about reserved contracts**

III.3) **Conditions specific to services contracts**

III.3.1) **Information about a particular profession**

III.3.2) **Staff responsible for the execution of the service**

Section IV: Procedure

IV.1) **Type of procedure**

IV.1.1) **Type of procedure**
Open

IV.1.2) **Limitations on the number of operators who will be invited to tender or to participate**

IV.1.3) **Reduction of the number of operators during the negotiation or dialogue**

IV.2) **Award criteria**

IV.2.1) **Award criteria**
The most economically advantageous tender in terms of the criteria stated in the specifications, in the invitation to tender or to negotiate or in the descriptive document

IV.2.2) **Information about electronic auction**

IV.3) **Administrative information**

IV.3.1) **File reference number attributed by the contracting authority:**

IV.3.2) **Previous publication(s) concerning the same contract**
Prior information notice
Notice number in the OJEU: 2013/S 140-243847 of 20.7.2013

IV.3.3) **Conditions for obtaining specifications and additional documents or descriptive document**

IV.3.4) **Time limit for receipt of tenders or requests to participate**
15.5.2014 - 15:00

IV.3.5) **Date of dispatch of invitations to tender or to participate to selected candidates**

IV.3.6) **Language(s) in which tenders or requests to participate may be drawn up**
English.

IV.3.7) **Minimum time frame during which the tenderer must maintain the tender**
in days: 180 (from the date stated for receipt of tender)

IV.3.8) **Conditions for opening of tenders**
Date: 16.5.2014 - 09:00
Place:
As in above mentioned I.1.
Persons authorised to be present at the opening of tenders: yes
Additional information about authorised persons and opening procedure: Only the NHS Supply Chain contract owner or delegate.

Section VI: Complementary information

VI.1) **Information about recurrence**

VI.2) **Information about European Union funds**

VI.3) **Additional information**
The Framework Agreement will be between NHS Supply Chain and the Successful Applicant. Under the Framework Agreement there will be two different methods of supply - one for Non-Direct Contract Services and

one for Direct Contract Services.
NHS Supply Chain will be entitled to purchase the services identified in the tender document as Non-Direct Contract Services which it will then make available for purchase by:
1) any NHS Trust;
2) any other NHS entity;
3) any government department agency or other statutory body and/or
4) any private sector entity active in the UK healthcare sector.
For the services identified as Direct Contract Services below in the tender documents
1) NHS Supply Chain;
2) any NHS Trust;
3) any other NHS entity;
4) any government department agency or other statutory body and/or
5) any private sector entity active in the UK healthcare sector will be able to enter into a direct contract with the Successful Applicant for any of the services under the Framework.
For Direct Contract Services the Successful Applicant will be required to report to and pay a direct contract management fee to NHS Supply Chain as detailed in the tender documents.
Non-Direct Contract Services.
As set out in the tender documents.
Direct Contract Services.
As set out in the tender documents.
Tenders and all supporting documentation for the Framework Agreement must be priced in sterling and written in English. Any agreement entered into will be considered a contract made in England according to English law and will be subject to the exclusive jurisdiction of the English Courts. NHS Supply Chain is not liable for any costs incurred by those expressing an interest in tendering for this contract opportunity. NHS Supply Chain reserves the right to terminate the procurement process (or part of it) to change the basis of and the procedures for the procurement process at any time or to procure the subject matter of the contract by alternative means if it appears that it can be more advantageously procured by alternative means. The most economically advantageous or any tender will not automatically be accepted. All communications must be made through NHS Supply Chain's eTendering portal at http://procurement.supplychain.nhs.uk/ISS/ using the Message Centre facility.
Please note that the number of maximum Applicants as set out in II.1.4 is provided as an estimate only.
Applicants should refer to section 3.5 of the Invitation to Tender for details of the scores which tenderers will need to obtain in order to be appointed to the relevant Lot of the Framework Agreement. NHS Supply Chain reserves the right to appoint more Applicants to each Lot of the Framework Agreement in the event that more than 80 tenderers reach the minimum score for appointment which is set out in the ITT.
If Applicants are unable to comply with this requirement then NHS Supply Chain reserves the right to exclude them from the Tender process.
NHS Supply Chain believes that the services which are subject of this procurement are those which are classified as Part B Services under the Public Contracts Regulation 2006 (as amended) (the “Regulations”). By way of best practice NHS Supply Chain will be following one of the procedures set out in the Regulations on a voluntary basis only. It is not the intention of NHS Supply Chain to be bound by any the Regulation except for those which apply specifically to Part B service contracts.

VI.4) **Procedures for appeal**

VI.4.1) **Body responsible for appeal procedures**

Refer to point VI.4.2

Body responsible for mediation procedures

Not applicable

VI.4.2) **Lodging of appeals**

Precise information on deadline(s) for lodging appeals: "Precise information on deadline(s) for lodging appeals:
Any appeals under this process should be addressed to the contact in point I.1.
"

VI.4.3) **Service from which information about the lodging of appeals may be obtained**

VI.5) **Date of dispatch of this notice:**

31.3.2014

The buying process may or may not still be ongoing, and the buyer is publishing the tender documentation to meet the government transparency commitments.

Does this
any of m

Created on 09/05/2014

Unplanned Care Services (Prior information notice)

Reference number: WSYB/DONC/PT/14/07

Estimated duration 36 Months

Estimated value £0 - £13,000,000

Location where the contract is to be carried out:

Doncaster

Doncaster area specifically

Is this suitable for smaller suppliers? Yes

Is this contract suitable for a voluntary, community and social enterprise organisations?
Yes

Name of the buying organisation:

NHS Doncaster Clinical Commissioning Group

Description of the contract

NHS Doncaster Clinical Commissioning Group (CCG) is seeking to appoint providers for Unplanned Care Services covering the population of Doncaster. The commissioners are currently eager to engage with providers in the marketplace to develop our planning of the Unplanned Care system in Doncaster, by holding a

series of informal sessions. These sessions will take the form of 1:1 meetings to preview the service specifications and to focus on the development of an integrated care pathway across the borough. The CCG is looking to improve the Doncaster Unplanned Care System by commissioning redesigned Out of Hours, Walk-in Centre (For unregistered patients) and Emergency Care Practitioner Services. These services are currently commissioned by the CCG and have a collective contract value of circa £4,200,000 per annum. Each session will last for up to 2 hours and there are 8 slots available for providers on a first come basis. Any provider who doesn't secure a slot and who wishes to help develop the approach will have an opportunity to do so remotely. Draft specifications and an indicative agenda will be made available following receipt of expression of interest. The 1:1 sessions will take place at the following venue: Sovereign House, Ten Pound walk, Doncaster, South Yorkshire, DN4 5DJ, On 21st and 22nd May 2014. The meetings will not be for providers to present their delivery model for this service but for commissioners to understand how best to integrate these services and develop a robust performance management framework. The resulting procurement will be concluded by December 2014 with services to be mobilised by 1st April 2015. This will be a restricted OJEU compliant tender process for the provision of Part B services, as described under the Public Contract Regulations (2006). Providers should express their interest in attending a session by registering on the https://www.nhssourcing.co.uk website. Please send a message through the online messaging system confirming the attendees (max 3 per organisation), their job title and a contact telephone number. All subsequent documentation will also be published through this eTendering portal.

Tender documents

Classification of the contract

Additional information

Who to contact

500 Privately Run Hospitals in England : Sheet1		
Sussex Nuffield Hospital	BN2 6DX	Alliance Medical
Leeds PET/CT Centre, St James University Hospital	LS9 7TF	Alliance Medical
Clacton Hospital	CO15 1LH	Anglian Community Enterprise Community Interest Company (ACE CIC)
Fryatt Hospital, Harwich	CO12 4EX	Anglian Community Enterprise Community Interest Company (ACE CIC)
Baxter Healthcare (Kidderminster)	DY11 6RJ	Baxter Healthcare
benenden hospital	TN17 4AX	Benenden Hospital
BMI Southend Private Hospital	SS0 9AG	BMI Healthcare
BMI Woodlands Hospital	DL1 4PL	BMI Healthcare
BMI Gisburne Park Hospital	BB7 4HX	BMI Healthcare
BMI Fitzroy Square Hospital	W1T 6AH	BMI Healthcare
BMI Sefton Hospital	L9 7AL	BMI Healthcare
BMI - Sutton Medical Centre	B75 6DX	BMI Healthcare
BMI Gisburne Park Hospital	BB7 4HX	BMI Healthcare
BMI Southend Private Hospital	SS0 9AG	BMI Healthcare
Redhill (East Surrey Hospital)	RH1 5RH	BMI Healthcare
Pool General Hospital	BH15 2JB	BMI Healthcare
Ashford Hospital	TW15 3AA	BMI Healthcare
St Helens	WA9 3DA	BMI Healthcare
Royal Surrey County Hospital	GU2 7XX	BMI Healthcare
Cumberland Infimary - Carlisle	CA2 7HY	BMI Healthcare
Royal Lancaster Infirmary	LA1 4RP	BMI Healthcare
Halton District Hospital	WA7 2DA	BMI Healthcare
Bicester Community Hospital	OX26 6DU	BMI Healthcare
St Martin's Hospital	CT1 1TD	BMI Healthcare
Maidstone Hospital	ME16 9QQ	BMI Healthcare
St Mary's Hospital	PO30 5TG	BMI Healthcare
Eastbourne District General Hospital	BN21 2UD	BMI Healthcare
North Devon District Hospital	EX31 4JB	BMI Healthcare
Derriford Hospital	PL6 8DH	BMI Healthcare
St Michael's Hospital	TR27 4JA	BMI Healthcare
BMI Mount Alvernia Hospital	GU1 3LX	BMI Healthcare
BMI Gerrards Cross	SL3 6NH	BMI Healthcare
BMI Nottingham	NG5 3FZ	BMI Healthcare
BMI The Cavell Hospital	EN2 7PR	BMI Healthcare
BMI The Lincoln Hospital	LN2 1QU	BMI Healthcare
BMI The Lancaster Hospital	LA1 3RH	BMI Healthcare
BMI The Huddersfield Hospital	HD2 2BL	BMI Healthcare
BMI The Duchy Hospital	HG2 0HF	BMI Healthcare
BMI St Edmunds Hospital	IP33 2AA	BMI Healthcare
BMI The Edgbaston Hospital	B15 2QQ	BMI Healthcare
BMI The Winterbourne Hospital	DT1 2DR	BMI Healthcare
BMI Three Shires Hospital	NN1 5DR	BMI Healthcare
BMI Thornbury Hospital	S10 3BR	BMI Healthcare
BMI The South Cheshire Private Hospital	CW1 4QP	BMI Healthcare
BMI The Somerfield Hospital	ME16 0DU	BMI Healthcare
BMI The Sloane Hospital	BR3 5HS	BMI Healthcare
BMI Shirley Oaks Hospital	CR9 8AB	BMI Healthcare
BMI The Shelburne Hospital	HP11 2TR	BMI Healthcare
BMI The Saxon Clinic	MK6 5LR	BMI Healthcare
BMI Sarum Road Hospital	SO22 5HA	BMI Healthcare
BMI The Sandringham Hospital	PE30 4HJ	BMI Healthcare
BMI The Runnymede Hospital	KT16 0RQ	BMI Healthcare
BMI The Ridgeway Hospital	SN4 9DD	BMI Healthcare
BMI The Priory Hospital	B5 7UG	BMI Healthcare
BMI The Princess Margaret Hospital	SL4 3SJ	BMI Healthcare

BMI The Park Hospital	NG5 8RX	BMI Healthcare
BMI The Meriden Hospital	CV2 2LQ	BMI Healthcare
BMI The Manor Hospital	MK40 4AW	BMI Healthcare
BMI The London Independent Hospital	E1 4NL	BMI Healthcare
BMI The Kings Oak Hospital	EN2 8SD	BMI Healthcare
BMI The Highfield Hospital	OL11 4LZ	BMI Healthcare
BMI The Harbour Hospital	BH15 2BH	BMI Healthcare
BMI The Hampshire Clinic	RG24 7AL	BMI Healthcare
BMI Goring Hall Hospital	BN12 5AT	BMI Healthcare
BMI The Garden Hospital	NW4 1RP	BMI Healthcare
BMI The Foscote Hospital	OX16 9XP	BMI Healthcare
BMI Fawkham Manor Hospital	DA3 8ND	BMI Healthcare
BMI The Esperance Hospital	BN21 3BG	BMI Healthcare
BMI The Droitwich Spa Hospital	WR9 8DN	BMI Healthcare
BMI The Clementine Churchill Hospital	HA1 3RX	BMI Healthcare
BMI The Chiltern Hospital	HP16 0EN	BMI Healthcare
BMI Chelsfield Park Hospital	BR6 7RG	BMI Healthcare
BMI The Chaucer Hospital	CT4 7AR	BMI Healthcare
BMI - Chatsworth Suite	S44 5BL	BMI Healthcare
BMI The Blackheath Hospital	SE3 9UD	BMI Healthcare
BMI Bishops Wood Hospital	HA6 2JW	BMI Healthcare
BMI The Beaumont Hospital	BL6 4LA	BMI Healthcare
BMI The Beardwood Hospital	BB2 7AE	BMI Healthcare
BMI Bath Clinic	BA2 7BR	BMI Healthcare
BMI The Alexandra Hospital	SK8 2PX	BMI Healthcare
The Flying Scotsman Centre	DN1 3AP	Bridgegate Surgical Services
Bridgegate Surgical Services HQ	DN22 7XF	Bridgegate Surgical Services
Bridgewater Hospital	M15 5AT	Bridgewater Hospital (Manchester) Ltd
Bristol Community Health Site	BS1 3NX	Bristol Community Health
Bristol Hospital Education Service	BS6 5JL	Brook Advisory Centres
Milton Park Hospital	MK44 3AS	Brookdale Healthcare Ltd (T/A Brookdale Care)
Bupa Cromwell Hospital	SW5 0TU	Bupa Group
Burrswood Hospital	TN3 9PY	Burrswood Hospital
The Limes	NG20 9HD	Cambian Healthcare Limited
The Fountains	BB2 1TU	Cambian Healthcare Limited
Storthfield House	DE55 3AA	Cambian Healthcare Limited
Sedgley Lodge	WV14 9RT	Cambian Healthcare Limited
Sherwood House	NG21 0HR	Cambian Healthcare Limited
Sedgley House	WV14 9RT	Cambian Healthcare Limited
SEQOl Wheelchair Service	SN2 8UU	Care and Support Partnership
Wroughton Health Centre	SN4 9LW	Care and Support Partnership
Swindon Intermediate Care Centre	SN3 6BW	Care and Support Partnership
North Swindon District Centre	SN25 4AN	Care and Support Partnership
Swindon Health Centre	SN1 1ED	Care and Support Partnership
Care and Support Partnership Site	SN1 2JH	Care and Support Partnership
St Mary's NHS Treatment Centre	PO3 6DW	Care UK
Mid & South Buckinghamshire Diagnostic NHS Centre	HP12 3QL	Care UK
Eccleshill NHS Treatment Centre	BD10 0JE	Care UK
Will Adams NHS Treatment Centre	ME8 6AD	Care UK
North East London NHS Treatment Centre	IG3 8YB	Care UK
Barlborough NHS Treatment Centre	S43 4XE	Care UK
Peninsula NHS Treatment Centre	PL6 5XP	Care UK
Southampton NHS Treatment Centre	SO14 0YG	Care UK
NHS Rotherham Diagnostic Centre	S60 1RY	Care UK
Sussex Orthopaedic NHS Treatment Centre	RH16 4EX	Care UK Clinical Services Se
Mid and South Buckinghamshire Diagnostic NHS Cent	HP12 3QL	Care UK Clinical Services Se

Halstead Hospital	CO9 2DL	Central Essex Community Services
St Michaels Hospital	CM7 2QU	Central Essex Community Services
Sutherland Lodge Surgery	CM2 7PY	Central Essex Community Services
Tennyson House Surgery	CM1 4HW	Central Essex Community Services
Tom Davies House	CM7 1EP	Central Essex Community Services
Western House	CO5 9JQ	Central Essex Community Services
William Julien Courtauld Hospital	CM7 2LJ	Central Essex Community Services
Woodlands	CM7 3SX	Central Essex Community Services
Kestrel House	CM2 5PF	Central Essex Community Services
Central Essex Community Services HQ	CM9 6EG	Central Essex Community Services
Dorking Hospital	RH4 2AA	Central Surrey Health
New Epsom and Ewell Cottage Hospital	KT19 8PB	Central Surrey Health
Molesey Hospital	KT8 2LU	Central Surrey Health
Leatherhead Hospital	KT22 8SD	Central Surrey Health
Dorking Hospital	RH4 2AA	Central Surrey Health
Cobham Community Hospital	KT11 1HT	Central Surrey Health
Chime Social Enterprise - Seaton Hospital	EX12 2UU	Chime Social Enterprise
Chime Social Enterprise - Tiverton Hospital	EX16 6NT	Chime Social Enterprise
Chime Social Enterprise - Ottery St. Mary Hospital	EX11 1DN	Chime Social Enterprise
Chime Social Enterprise - Honiton Hospital	EX14 2DE	Chime Social Enterprise
Chime Social Enterprise - Crediton Hospital	EX17 3NH	Chime Social Enterprise
Chime Social Enterprise - Budleigh Salterton Hospital	EX9 6HF	Chime Social Enterprise
Chime Social Enterprise - Axminster Hospital	EX13 5DU	Chime Social Enterprise
Chime Social Enterprise - Sidmouth Hospital	EX10 8EW	Chime Social Enterprise
Chime Social Enterprise - Okehampton Hospital	EX20 1PN	Chime Social Enterprise
Circle Reading	RG2 0NE	Circle
Nottingham NHS Treatment Centre (Circle)	NG7 2FT	Circle
Centres Of Clinical Excellence At The Meavy Clinic, Ply	PL6 8DH	Circle
Circle Bath	BA2 8SF	Circle
East Riding Community Hospital	HU17 0FA	City Health Care Partnership Cic
City Health Care Partnership (Earls Court)	HU4 7DY	City Health Care Partnership Cic
Claremont Hospital	S10 5UB	Claremont & St Hugh's Hospitals (Hmt)
St Hugh's Hospital	DN32 9RP	Claremont & St Hugh's Hospitals (Hmt)
Lourdes Hospital	L18 1HQ	Classic Hospitals Ltd
Hollyhouse Hospital	IG9 5HX	Clinicenta Limited
St Johns Medical Practice	TN13 3NT	Concordia Community Outpatients Ltd
University Medical Centre	CT2 7PB	Concordia Community Outpatients Ltd
Sandgate Road Surgery	CT20 2HN	Concordia Community Outpatients Ltd
Cygnet Springside Exeter	EX1 1UG	Cygnet Health Care Limited
Cygnet Springside Stockport	SK4 4PE	Cygnet Health Care Limited
Tupwood Gate Nursing Home	CR3 6YE	Cygnet Health Care Limited
Tabley House Nursing Home	WA16 0HN	Cygnet Health Care Limited
The Springs Community	TN29 0HN	Cygnet Health Care Limited
Cygnet Lodge Westlands	HA3 8AE	Cygnet Health Care Limited
Cygnet Lodge Lewisham	SE13 6QZ	Cygnet Health Care Limited
Cygnet Hospital Wyke	BD12 8LR	Cygnet Health Care Limited
Cygnet Hospital Stevenage	SG1 4YS	Cygnet Health Care Limited
Cygnet Hospital Harrow	HA1 3JL	Cygnet Health Care Limited
Cygnet Hospital Harrogate	HG1 2JL	Cygnet Health Care Limited
Cygnet Hospital Ealing	W5 2HT	Cygnet Health Care Limited
Cygnet Hospital Derby	DE24 8WZ	Cygnet Health Care Limited
Cygnet Lodge Brighouse	HD6 3EL	Cygnet Health Care Limited
Cygnet Wing Blackheath	SE10 8AD	Cygnet Health Care Limited
Cygnet Hospital Beckton	E6 6ZB	Cygnet Health Care Limited
Cygnet Hospital Kewstoke	BS22 9UZ	Cygnet Health Care Limited
Cygnet Hospital Bierley	BD4 6AD	Cygnet Health Care Limited

Cygnet Health Care Limited (Godden Green)	TN15 0JR	Cygnet Health Care Limited
Crofton & Sharlston Medical Practice	WF4 1HJ	Diagnostic Health Systems Ltd
Cossington House Surgery	CT1 3HX	Diagnostic Health Systems Ltd
Oaklands Health Centre	CT21 6BD	Diagnostic Health Systems Ltd
Woodlands Health Centre	TN12 6AR	Diagnostic Health Systems Ltd
Warders Medical Centre	TN9 1LA	Diagnostic Health Systems Ltd
Pelham Medical Practice	DA11 0HN	Diagnostic Health Systems Ltd
The Cedars Surgery	CT14 7DN	Diagnostic Health Systems Ltd
Swanscombe Health Centre	DA10 0BF	Diagnostic Health Systems Ltd
Downs Way Medical Practice	DA13 9LB	Diagnostic Health Systems Ltd
The Market Place Surgery	CT13 9ET	Diagnostic Health Systems Ltd
Bridge Health Centre	CT4 5BL	Diagnostic Health Systems Ltd
George Street Primary Care Centre	SK13 8AY	Diagnostic Healthcare Ltd
Harwich Community Hospital	CO12 4EX	Dmc Healthcare
Ecch Lowestoft Hospital	NR32 1PT	East Coast Community Healthcare C.I.C
Ecch Southwold Hospital	IP18 6LD	East Coast Community Healthcare C.I.C
Ecch Patrick Stead Hospital	IP19 8HP	East Coast Community Healthcare C.I.C
Ecch Beccles Hospital	NR34 9NQ	East Coast Community Healthcare C.I.C
Eastbourne Healthcare Partnership HQ	BN22 7PF	Eastbourne Healthcare Partnership
St Catherine's Hospital	CH42 0LQ	E-Logica Ltd
Liskeard Community Hospital	PL14 3XD	Express Diagnostics
Fairfield Hospital	WA11 7RS	Fairfield Hospital
Caterham Dene Community Hospital	CR3 5RA	First Community Health and Care Cic
Freeman Clinics Limited HQ	NE25 9DX	Freeman Clinics Limited
Vale Community Hospital	GL11 4BA	Gloucestershire Gp Provider Company Ltd
Weston General Hospital	BS23 4TQ	Gryphon Health Llp
Gryphon Health LLP (Totton)	SO40 3WX	Gryphon Health Llp
Kirton Medical Centre	PE20 1DS	H S Physiotherapy Ltd
Parkside Surgery	PE21 7TT	H S Physiotherapy Ltd
Harmoni HQ	WD18 8YA	Harmoni
Wellington Hospital	NW9 9LE	Hca International
Soho Health Centre (Healthharmonie)	B21 9RY	Healthharmonie Limited
Healthharmonie Limited HQ	B15 3BU	Healthharmonie Limited
Hillingdon Health Limited HQ	SO40 3WX	Hillingdon Health Limited
Holywell Healthcare (Holywell House)	S41 7SH	Holywell Healthcare
Hms Ltd - BMI Hospital	HD2 2BL	Huddersfield Medical Services Ltd
Huddersfield Medical Services HQ	HD9 3TP	Huddersfield Medical Services Ltd
Vascular Studies Room (Macclesfield)	SK10 3BL	Independent Vascular Services Ltd
Vascular Ultrasound (Bolton)	BL4 0JR	Independent Vascular Services Ltd
Vascular Ultrasound (Wirral)	CH49 5PE	Independent Vascular Services Ltd
Vascular Services Department	FY3 8NR	Independent Vascular Services Ltd
Vascular Studies Room (Bury)	BL9 7TD	Independent Vascular Services Ltd
Vascular Studies Room (Manchester)	M8 5RB	Independent Vascular Services Ltd
Vascular Ultrasound (Oldham)	OL1 2JH	Independent Vascular Services Ltd
Vascular Studies Unit	M23 9LT	Independent Vascular Services Ltd
Beaconsfield Medical Practice	BN1 6AG	Inhealth Group Limited
Rivers Hospital	CM21 0HH	Inhealth Group Limited
University Hospital Lewisham	SE13 6LH	Inhealth Group Limited
The Sloane Hospital	BR3 5HS	Inhealth Group Limited
Shirley Oaks Hospital	CR9 8AB	Inhealth Group Limited
Kings Oak Hospital	EN2 8SD	Inhealth Group Limited
Barking Hospital	IG11 9LX	Inhealth Group Limited
iSIGHT	PR8 2AT	Isight
Kleyn Ultrasound Blackfriars Medical Practice	M3 6AF	Kleyn Healthcare
Lakeside Medical Diagnostics - Billericay Community H	CM12 9SA	Lakeside Medical Diagnostics
Whipps Cross University Hospital	E11 1NR	London Wound Healing Centres Ltd

Matrix Health Services UK Limited HQ	DH4 5QY	Matrix Health Services Uk Limited
Mediscan - St. Andrew's House	SK15 2AU	Mediscan - Diagnostics Services Limited
Milton Keynes Urgent Care Services Cic	MK6 5NG	Milton Keynes Urgent Care Services Cic HQ
BMI Woodlands Hospital	DL1 4PL	Minor Ops Ltd
Nottingham NHS Treatment Centre(Nations Healthcar	NG7 2FT	Nations Healthcare Ltd
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Navas [Mansfield Community Hospital]	NG18 5QJ	Navas
Navas [Treatment Centre]	PE29 6NT	Navas
Bicester Community Hospital - Cherwell Vale	OX26 6DU	Netcare Healthcare UK
St Catherine's General Hospital	CH42 0LQ	Netcare Healthcare UK
Cumberland Infirmary - Carlisle	CA2 7HY	Netcare Healthcare UK
Royal Lancaster Infirmary	LA1 4RP	Netcare Healthcare UK
Rossendale Hospital	BB4 6NE	Netcare Healthcare UK
Ashford Hospital	TW15 3AA	Netcare Healthcare UK
St Helens Hospital	WA9 3DA	Netcare Healthcare UK
North Devon District Hospital	EX31 4JB	Netcare Healthcare UK
St Michael's Hospital Site	TR27 4JA	Netcare Healthcare UK
Royal Hospital Haslar	PO12 2AA	Netcare Healthcare UK
Eastbourne District General Hospital	BN21 2UD	Netcare Healthcare UK
St Martin's Hospital	CT1 1TD	Netcare Healthcare UK
Maidstone Hospital	ME16 9QQ	Netcare Healthcare UK
The Marina Healthcare Centre	BS20 7BL	North Somerset Community Partnership Community Interest Company
Worle Health Centre	BS22 6HB	North Somerset Community Partnership Community Interest Company
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Congresbury Surgery	BS49 5DX	North Somerset Community Partnership Community Interest Company
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Long Ashton Surgery	BS41 9DY	North Somerset Community Partnership Community Interest Company
Tower House Medical Centre	BS48 2XX	North Somerset Community Partnership Community Interest Company
Winscombe Surgery	BS25 1AF	North Somerset Community Partnership Community Interest Company
Clevedon Community Hospital	BS21 6BS	North Somerset Community Partnership Community Interest Company
Nuffield Health, York Hospital	YO31 8TA	Nuffield Health
Nuffield Health, The Manor Hospital, Oxford	OX3 7RP	Nuffield Health
Nuffield Health, Wolverhampton Hospital	WV6 8LE	Nuffield Health
Nuffield Health, Woking Hospital	GU21 4BY	Nuffield Health
Nuffield Health, Tunbridge Wells Hospital	TN2 4UL	Nuffield Health
Nuffield Health, Taunton Hospital	TA2 6AN	Nuffield Health
Nuffield Health, Tees Hospital	TS20 1PX	Nuffield Health
Nuffield Health, Shrewsbury Hospital	SY3 9DP	Nuffield Health
Nuffield Health, Plymouth Hospital	PL6 8BG	Nuffield Health
Nuffield Health, North Staffordshire Hospital	ST5 4DB	Nuffield Health
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Helston Community Hospital	TR13 8DR	Peninsula Community Health C.I.C
Camborne Redruth Community Hospital	TR15 3ER	Peninsula Community Health C.I.C
Falmouth Hospital	TR11 2JA	Peninsula Community Health C.I.C
Newquay Hospital	TR7 1RQ	Peninsula Community Health C.I.C
Fowey Hospital	PL23 1EE	Peninsula Community Health C.I.C

St Austell Community Hospital	PL26 6AD	Peninsula Community Health C.I.C
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Cumberland Centre	PL1 4JZ	Plymouth Community Healthcare (Cic)
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Priory Hospital Roehampton	SW15 5JJ	Priory Group Limited
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Priory Grange St Neots	PE19 2JA	Priory Group Limited
Priory Grange Potters Bar	EN6 2SE	Priory Group Limited
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The Westbourne Centre	B15 3SJ	Ramsay Healthcare UK Operations Limited
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Spamedica (Citygate)	M15 4SQ	Spamedica
The Montefiore Hospital	BN3 1RD	Spire Healthcare
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Spire Harpenden Hospital	AL5 4BP	Spire Healthcare
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Spire Wellesley Hospital	SS2 4XH	Spire Healthcare
Spire Alexandra Hospital	ME5 9PG	Spire Healthcare
Spire Tunbridge Wells Hospital	TN3 0RD	Spire Healthcare
Spire Sussex Hospital	TN37 7PT	Spire Healthcare
Spire Gatwick Park Hospital	RH6 0BB	Spire Healthcare
Spire Portsmouth Hospital	PO9 5NP	Spire Healthcare
Spire Southampton Hospital	SO16 6UY	Spire Healthcare
Spire Bristol Hospital	BS6 6UT	Spire Healthcare
Spire South Bank Hospital	WR5 3YB	Spire Healthcare
St Andrew's Healthcare - Birmingham	B30 2XH	St Andrew's Healthcare
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Sudbury Healthcare Partnership Limited (Meadow Lan	CO10 2TD	Sudbury Healthcare Partnership Limited
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The Horder Centre	TN6 1XP	The Horder Centre
Hothfield Brain Injury Rehabilitation and Neurodisabili	TN26 1EL	The Huntercombe Group
The Huntercombe Hospital - Norwich	NR10 5RH	The Huntercombe Group
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Queensview Medical Centre	NN2 6LS	The Injury Care Clinics Ltd
The Injury Care Clinics Hq	PO16 8UZ	The Injury Care Clinics Ltd
The Retreat Hospital York	YO10 5BN	The Retreat Hospital
The Shambles	S40 1PX	Trent Pts
Friary House	DE22 3NL	Trent Pts
Lower Dale House	DE23 6WY	Trent Pts
Woodlands Lodge	DE22 3NL	Trent Pts
Tyneside Surgical Services At The North East NHS Sur	NE9 6SX	Tyneside Surgical Services Ltd
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Frimley Park Hospital	GU16 7UJ	Virgin Care Services Ltd
Milford Specialist Rehabilitation Hospital	GU7 1UF	Virgin Care Services Ltd
Farnham Hospital & Centre For Health	GU9 9QL	Virgin Care Services Ltd
Woking Community Hospital	GU22 7HS	Virgin Care Services Ltd
Royal Surrey County Hospital	GU2 7XX	Virgin Care Services Ltd
Ashford Hospital	TW15 3AA	Virgin Care Services Ltd
Weybridge Community Hospital	KT13 8DY	Virgin Care Services Ltd
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Tolworth Hospital	KT6 7QU	Your Healthcare
Kingston Hospital	KT2 7QB	Your Healthcare
Hinchingbrooke Hospital	PE29 6NT	Cambridgeshire Community Services NHS Trust

17 March 2014 Last updated at 10:08

Thousands of redundant NHS staff rehired

New figures indicate that almost 4,000 staff made redundant from the NHS in England, before last year's major restructuring, have since been re-employed.

Labour asked for the data to be released to Parliament.

The government blamed "unacceptably lax" contracts that allow staff to re-join the NHS a month after redundancy.

It says it's working on tough new plans to cap payouts, and has reduced administrative posts overall.

Labour shadow health secretary Andy Burnham said it would be galling for nurses who were battling over pay to see, as he put it, cheques handed out like confetti.

Auditors have previously reported that the average payout was £43,000.

The number of national health service staff estimated to have been made redundant and later re-employed almost doubled in the last year - from 2,200 managers - Ministerial responses to Parliamentary Questions have revealed.

The total now stands at 3,950.

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Overall, more than 10,000 full-time workers were made redundant from the NHS in England since the restructuring of the service.

Changes introduced in April 2013 have seen 150 primary care trusts, run by managers, replaced with 211 clinical commissioning groups, led by family doctors.

Health Minister Dr Dan Poulter said: "By reducing managers and administrators by over 21,100, we are freeing up extra resources for patient care - £5.5 billion in this Parliament and £1.5 billion every year thereafter."

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"it is absolutely clear that all the ingenuity and skill that we have brought to cushioning vulnerable people as far as possible from the effects of the economic circumstances cannot be stretched any further, and that some of the people we have responsibilities for may be affected by serious reductions in service—with more in the pipeline over the next two years."

Unfortunately, excellent though our local hospital is, we are facing a situation where 1,000 people will lose their care packages this year, and I am very concerned about that.

Jim Shannon: The Francis report makes some recommendations on mental health, which is in the social care category. One of those suggestions was the training of family members to look after those with mental health conditions better at home, so as to improve their quality of life and help rehabilitate them. I do not see much of that in the report. Would the hon. Lady like there to be more emphasis on family members who are under pressure and are helping others with mental health conditions at home?

Barbara Keeley: Indeed, and our most recent inquiries in the Health Committee are about mental health issues. There is a series of issues that need to be looked at. It is rare in a health debate for me not to mention carers. We need to be realistic about the fact that we are now putting a huge amount of pressure on those carers. Removing social care packages will affect our local hospital, but it will also affect those family members, because in the end who is the person who cares? It is the family member to whom the role falls.

To conclude the point about staffing issues in A and E, we found in our earlier inquiry that fewer than one in five emergency departments were able to provide consultant cover for 16 hours a day during the working week, and the figure is lower at weekends. The whole issue of mortality rates is very much linked to that, and we cannot ignore it. We must keep focusing on the problem with recruitment and the lack of consultant cover.

My right hon. Friend the shadow Health Secretary referred to the warnings by the president of the College of Emergency Medicine. During the time when the college was warning about these issues, Ministers were tied up in knots by the challenges of reorganisation. That is key. Ministers have insisted that they are acting now, but it is clear that those warnings from the CEM in 2010 did not get enough attention until recently. The staffing situation can hardly improve when so few higher trainee posts in emergency medicine are being filled. In the latest recruitment round, 156 out of 193 higher trainee emergency medicine posts went unfilled.

My final point is about the difficulties caused by the cost of the NHS reorganisation reforms. In the past few months the spotlight has fallen on unnecessary spending

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and waste. We all should be concerned about that. We know that emergency departments are spending £120 million a year on locums, and this could be getting worse. The Health Committee has also recently focused on redundancy costs, which have absorbed £1.4 billion of NHS funding since 2010, with £435 million attributed just to restructuring costs. The scandal of the scale of redundancy payments to NHS staff was made worse when we found out that such a revolving door was in operation. The Health Committee was told that of 19,100 people made redundant by the NHS, 3,200 were subsequently rehired by the NHS, including 2,500 rehired within a year and more than 400 rehired within 28 days. There were reports of payments of £605,000 made to an NHS executive whose husband also received a £345,000 pay-off, with both reported to have been subsequently rehired elsewhere in the NHS. That is a scandal. I know that the Minister said it would not happen again, but that is £1 million that could have been spent on patient care.

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): Will the hon. Lady give way?

Barbara Keeley: I would prefer not to. That money could and should have been spent on improving staffing, particularly nursing staffing. Those patients and family members who have been let down by NHS failures, of which we have heard innumerable examples, deserve to know that everything possible is being done to avoid such failures in future.

Of all the things I have talked about, safe staffing is crucial, as is transparency and staffing ratios. We increasingly have to take on board the fact that there is a funding gap in both the NHS and social care. Indeed, the chair of the British Medical Association said in his new year statement that the funding gap in the NHS is so bad that if the NHS was a country, it would not have even have a credit rating. That is what we are facing.

Alun Cairns: Will the hon. Lady give way?

Barbara Keeley: No, I do not have time.

Given that situation, we have to learn that precious NHS resources cannot be wasted on reorganisation and redundancies any

more, particularly where staff are being rehired. The NHS will reach its 70th birthday in 2018, so let us hope that all the measures we are talking about today, and the implementation of whole-person care under a Labour Government, will help it be in better shape.

4.21 pm

Alun Cairns (Vale of Glamorgan) (Con): Thank you for calling me to contribute to this debate, Mr Speaker. I am sorry that the shadow Health Secretary is not in his place. After repeatedly refusing to take any interventions from me during his lengthy speech, he said that I would have time to make my contribution later, and I wish he was here to hear it, because I will be referring to him and seeking his help and support.

I approach this debate with mixed emotions. I am extremely sorry about the need for the Francis report in the first instance and believe that there remain serious questions about why there was such a long delay before a thorough investigation took place into the lack of care and the misconduct at Mid Staffs. I pay particular

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tribute to my hon. Friend the Member for Stafford (Jeremy Lefroy) for his contribution earlier and for the role he has played in pursuing this matter right through to the end, and to my hon. Friend the Member for Stone (Mr Cash) for his contribution and for raising this matter from the outset. My heart goes out to those who suffered needlessly and to their families who campaigned for so long. It is also worth remembering that for every one person who went public and put their head above the parapet, there are probably tens who stayed quiet and are probably still silent on issues that will have affronted them.

On a positive note, I am pleased about the progress made over the past 12 months. I am also pleased about the strong action has been taken by the previous Health Secretary and by this one, and about the leadership and determination that the Prime Minister showed at the outset in 2010 in seeking to root out the issues. The present Health Secretary has taken direct action to ensure: that nursing numbers are published; that there is data transparency; that details on surgery outcomes by consultant will be available for inspection; and that named consultants will be available for older patients. Those positive interventions will make a significant difference and will go a long way to preventing any recurrence.

Ultimately, the staff involved deserve the credit for the change, but the Health Secretary has been key to being the patients' champion. A culture has developed where we can rightly champion the NHS and can even question it. We have now come to a point where we can criticise the NHS without being seen as undermining it. All of the best organisations welcome feedback, particularly negative feedback, because it gives the best chance of putting problems right to prevent any recurrence.However, my mixed emotions are far more complex than that. As I see changes and improvements taking place in England, I remain concerned about what is happening to the national health service in Wales and the impact that that is having on my constituents. It is quite obvious from this debate that the concerns that have been raised are shared by Members on both sides of the House, which is something that we should view positively. However, I am not so sure that those concerns are shared in all quarters, especially by Members on the Labour Front Bench. Again, I must pay tribute to the right hon. Member for Cynon Valley (Ann Clwyd) for her determination and persistence in rooting out these issues wherever they occur—be it in Wales, Scotland, Northern Ireland or England.

It is fair to say that political points can be made about the cuts to the NHS budget in Wales, but I fear that the situation is even more serious and dangerous than that. Any criticism of the NHS in Wales is now dismissed as party political or politically motivated. It is the identical culture that existed at the time of the Mid Staffordshire crisis.

Only two weeks ago, my hon. Friend the Member for Bristol North West (Charlotte Leslie) discovered that Professor Sir Bruce Keogh, the NHS medical director in England, had last November written to his counterpart in Wales, Dr Chris Jones, raising concerns about the mortality rates at some Welsh hospitals—at six in particular. It has now come to light that that action was prompted by the right hon. Member for Cynon Valley. In the e-mail, Professor Keogh, who had investigated 14 hospitals in England for the same reason, offered his assistance. I

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have a copy of his letter here. It was not a criticism; it merely questioned the data and offered help should there be any need for further investigation.

There was no response from Dr Jones, which is worrying in itself. Most alarming, however, was the response from the Welsh Health Minister when the matter became public. Mark Drakeford rightly pointed out that simple comparisons cannot be made because of the different ways in which data are collected. However, in response to calls for an inquiry, he said that he was "coldly furious" and that it was

"a concerted political attempt by the Conservative Party to drag the Welsh NHS through the mud."

He even had the audacity to accuse the NHS in England of being in crisis. He clearly felt that attack was the best form of defence. What worries me most is the blatant rebuttal without wider consideration. The politics appear to be more important than the patients. This was a letter from one clinician to another, yet it was a politician using every political tactic possible to undermine its contents.

A pragmatic approach would have been to point out the differences in the collection of the data and to have reassured patients. I suspect that the reality was that the Welsh Health Minister was responding in the full knowledge of all the other statistics on the NHS in Wales, such as those on waiting times and diagnostic delays, which could well contribute to higher mortality rates. Again, a pragmatic approach would have been to announce an investigation, or at least to seek out the root causes of the apparent high mortality rate according to the way in which the data were collected.

It is ironic that the Welsh Health Minister has today announced a change in the way the data are collected. Obviously, that is

some shift, but I note that it has come out only after the political games had taken place. It is two weeks since my constituents were alarmed by the accusations that I had dragged the Welsh NHS through the mud.

In researching for this debate, I looked at recent cases that have become public in the NHS in Wales. There are troubling similarities with those that led to the Francis report. Lilian Hopkins received treatment from a local health board that treats patients from my constituency. For several days, a sign was left above her bed that said "Nil by mouth". That left Mrs Hopkins too weak to lift a glass of water. Her prosthetic limb was not removed for two weeks, when she was left in bed for that time. Screams of pain at night were treated with sedation. At an earlier date, her family had asked for an investigation. It was promised, but not conducted. Three nurses have been arrested for falsifying records.

This is the same local health board where the police are investigating the circumstances surrounding a man who waited four hours in an ambulance outside the hospital, only to die at the same A and E department some hours later. The right hon. Member for Cynon Valley has listed several examples that I could refer to, but these are examples that I have picked up in the past couple of weeks.

The Royal College of Surgeons published a report last July that claimed that 152 patients have died over the past five years while waiting for cardiac surgery across two local health boards alone in Wales. The royal college also stated in its report that 2,000 cardiac operations were either cancelled or not scheduled between January

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and March last year. The report says that south Wales is the only part of the UK where patients are regularly dying on cardiac surgery waiting lists. It says that the provision of urgent and emergency surgery is simply inadequate.

I should like to be able to report that the situation has improved since the publication of that report last July, but it has not. Some patients are now being sent across the border to England to be treated in the independent sector, which strikes me as emergency action; instead, attempts should be made to identify the culture and issues that potentially parallel the Mid Staffordshire crisis.

I could point to lots of data, but I shall pick up just a few of the differences between Wales and England. Urgent cancer waiting times have not been met in Wales for the past five years. On average response times, in Wales 58% of patients are seen within eight minutes in category A calls. In England, the figure is 72%. One of the most worrying statistics, which Professor Sir Bruce Keogh particularly identified, relates to diagnostic services. In his e-mail, he pointed to the statistic that in Wales 26,000 patients are waiting more than eight weeks for diagnostic services. In England, 9,000 patients are waiting longer than six weeks. We need to bear in mind the difference between the populations: 3 million people in Wales and 50 million in England, yet 26,000 people are waiting for diagnostic services in Wales and 9,000 waiting in England. The statistics speak for themselves.

Peter Watkin Jones, a lawyer involved with the Mid Staffs inquiry, has said that a culture change is needed in the NHS in Wales. Having heard the shadow Health Secretary's contribution, I do not think he recognises that. Again, I was sorry he felt that attack was the best form of defence. The right hon. Member for Cynon Valley has said that high mortality rates are a smoke signal indicating that something is wrong. The Royal College of Nursing has said that its members do not always have time for training and staff development in Welsh hospitals.

If the right hon. Member for Leigh (Andy Burnham) genuinely wants the lessons of Mid Staffs to be learned, if he wants to ensure that patients in Wales do not have to suffer the same indignity and if he wants to play a positive role in informing health care across the UK, I ask him to agree to make every effort to influence his colleagues in Wales to respond positively to the questions that are being asked, to put party politics aside and to introduce an effective inquiry for the sake of my constituents and those across the whole of Wales; otherwise, everything that he has said today will simply be hollow.

4.35 pm

Kevin Barron (Rother Valley) (Lab): I reread the executive summary of the Francis report yesterday when I was on a train journey, and I decided that in today's debate I would like to look at one of the most crucial aspects of his findings in respect of what happened at Mid Staffs.

On page 62, at paragraph 1.102, the summary states:

"The senior officials in the DH have accepted it has responsibility for the stewardship of the NHS and in that sense that it bears some responsibility for the failure of the healthcare system to detect and prevent the deficiencies at Mid Staffordshire sooner

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than it did. There is no doubt about the authenticity of their expressions of shock at the appalling story that has emerged from Mid Staffordshire. However, it is not possible to avoid the impression that it lacks a sufficient unifying theme and direction, with regard to patient safety, to move forward from this point in spite of the recent reforms put in place by the current Government."

It goes on to say:

"Where there are perceived deficiencies, it is tempting to change the system rather than to analyse what needs to change, whether it be leadership, personnel, a definition of standards or, most importantly, culture. System or structural change is not only destabilising but it can be counterproductive in giving the appearance of addressing concerns rapidly while in fact doing nothing about the really difficult issues which will require long-term consistent management. While the DH asserted the importance of quality of care and patient safety in its documentation and its policies, it failed to recognise that the structural reorganisations imposed upon trusts, PCTs and SHAs implementing such policy have on occasion made such a focus very

difficult in practice."

It is my contention that we could probably say that of every reorganisation of the NHS, certainly in my three decades in politics.

The summary goes on to discuss the lessons learned and related key recommendations:

"The negative aspects of culture in the system were identified as including: a lack of openness to criticism; a lack of consideration for patients; defensiveness; looking inwards not outwards; secrecy; misplaced assumptions about the judgements and actions of others; an acceptance of poor standards; a failure to put the patient first in everything that is done."

It goes on:

"It cannot be suggested that all these characteristics are present everywhere in the system all of the time, far from it, but their existence anywhere means that there is an insufficiently shared positive culture."

Again, it is my contention that that sums up not just the past 30 years but perhaps the past 60 years of our national health service.

The summary goes on to say that achieving change

"does not require radical reorganisation but re-emphasis of what is truly important".

All parties in the House should recognise that it is not the reorganisation but the re-emphasis of what is important that is significant. Paragraph 1.119 lists how that can be achieved:

"Emphasis on and commitment to common values throughout the system by all within it; readily accessible fundamental standards and means of compliance; no tolerance of non compliance and the rigorous policing of fundamental standards; openness, transparency and candour in all the system's business; strong leadership in nursing and other professional values; strong support for leadership roles; a level playing field for accountability; information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation."

I was not surprised by any of that.

The right hon. Member for Sutton and Cheam (Paul Burstow) was a member of the Select Committee on Health in the previous Parliament between 2005 and 2010, and I had the privilege of chairing that Committee. In 2009 the Committee looked at patient safety in the NHS. We visited one of only four hospitals that were part of a patient safety project on how to look after patients inside hospitals, never mind outside. We looked at some of the major issues at the time, such as how different parts of the NHS interacted and their failure to communicate with one another properly. Much of the time they were working with different regulations, and occasionally the inspectorate was not sure what it

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was responsible for inspecting. This whole restructuring has been going on for a very long time, and it has been more confusing to people working inside.

I am pleased with how the Government have reacted to some of the Francis report's main recommendations, but I take issue with them on one point. If we are to change the culture inside the NHS, we really need to look at the duty of candour. The Government have accepted the report's recommendation on a duty of candour for organisations, but they have rejected the recommendation to extend that duty to individuals. I think that is fundamentally wrong.

I spent nine years as a lay member of the General Medical Council, which regulates doctors, and for the first few years I would sit on fitness-to-practise committees. I think that the only way we shall get change is if individuals have responsibility for the duty of candour, not just organisations. I believe that the Government have got that fundamentally wrong. If they really want to tackle the issues that led to the awful situation at Mid Staffs, they need that duty of candour to extend to individuals.

On the Government's decision on the duty of candour, the Patients Association has stated:

"We question that if individuals are not already motivated by their own professional code, how will a duty on their employer encourage them to come forward?"

That is absolutely right. It continued:

"Without this fundamental change within the NHS, the Duty will just be providing lip service to the issue of patient safety and patients will struggle to see any real improvements."

That is a big assumption, but on balance I agree. It is something that the Government, no matter who is in Richmond House, need to tackle throughout the NHS.

I have in my hand a copy of the Health Committee's report on patient safety, which was published in July 2009. We looked at patient safety across the health care system and compared it with what was happening abroad. We visited New Zealand, which has a comparable health system—I accept that the country has only 4 million occupants, compared with our 60-odd million. We looked at why the culture here is the way it is, why people are not open and why they do not learn from mistakes that other health professionals have made. Often those mistakes are not reported because people fear they will get into trouble. We took evidence from the British Airline Pilots Association and learned that any mistake a pilot makes in an aeroplane is whizzed around the world so that other pilots understand it and learn the lessons immediately. That is not the case in our health service.

I want to mention two of the Committee's findings from New Zealand. The first relates to investigating complaints. I do not think that leaving the duty of candour to organisations, as the Government suggest, will work well. New Zealand has a statutory body—I have mentioned it before in the House—called the Health and Disability Commissioner, which resolves complaints. People can go to the commissioner to request investigations, and they can do so anonymously if they do not want their colleagues to know about it. It is completely independent of the health care system. It works, and it has been working for many decades.

Another area we looked at in New Zealand—again, I accept that it is a very small country—was compensation and redress. I know from my experience of 30 years in Parliament that when people complain about something

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that happened to them in their local hospital that they are unhappy about, they are treated as if they are going to get into litigation and that it will cost a lot of money; immediately the barriers come up. That culture is not good for our health service, it is costing massive amounts of money for us as taxpayers, and it is certainly not good for the individual concerned. I do not know how many times I have been told that all the patient wanted was an admission that the hospital got it wrong and an apology; they did not necessarily want money. New Zealand has a redress system that some might call a no-fault liability system. Here, it would mean getting rid of lots of lawyers who make massive amounts of money and careers from public money for NHS litigation. Just those two areas hold back changing what is wrong in our system.

Barbara Keeley: I wonder whether my right hon. Friend has had similar cases to a difficult one that I had for months involving someone whose wife died in terrible circumstances at home. He was badly let down by the care she received and he wanted redress. He found that people were happy to have meetings with him and to talk to him, and were sympathetic and supportive, but whenever something was put in writing, it was absolutely dreadful. He was very offended and horrified by everything that was in writing, and that is the chilling effect of lawyers because they checked everything. It ruins the support that can be given after a difficult bereavement and when someone has a real case. Things can be said, but they cannot be written down.

Kevin Barron: I agree entirely. The system is defensive and people do not get a satisfactory response, but the lessons are not learned. Issues are not reported for fear of the consequences. The Minister is a doctor. He will know that if as a junior doctor he had seen a senior doctor doing something wrong and had gone public about it, it might have affected his career. Some young doctors' careers have been affected. That is not good for the system, and it is certainly not good for patients.

I am a wholehearted supporter of the national health service and the way it is funded. There is none better in the world, and we can use it without question. It may be different in different parts of the country, but access to health care in this country is second to none in the world for the whole population as opposed to just those with money. Could it better? Yes, and what the Francis report said was a lesson for all of us, and for the national health service. We should change the culture, but we will not do that with reorganisation or by blaming one another in the Chamber for what is right or wrong. That just feeds the politics of the national health service. We must change the culture by putting the patient first, and after 60-odd years it is about time we did.

4.47 pm

Sir Tony Baldry (Banbury) (Con): It is a great pleasure to follow the right hon. Member for Rother Valley (Kevin Barron) who has chaired the Select Committee on Health and who made some extremely important points about accountability. This has been an interesting debate, much of which has focused—understandably, given its title—on what is happening in Staffordshire a year on from the Francis report into Mid Staffs trust. It is also understandable that considerable cross-party

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concerns have been raised about the NHS in Wales. The Francis report applied to the whole of England, and I want to make some observations as a non-Staffordshire Member of Parliament who has benefited from it.

Much has happened during the last year—for example, the appointment of Stuart Rose, former head of Marks & Spencer, to advise the Government on leadership. His brief is to explore how the 14 NHS trusts placed in special measures can be helped to tackle concerns about their performance. David Dalton, chief executive of the Salford Royal NHS Foundation Trust, is exploring how NHS providers can collaborate in networks or chains, effectively building on an initiative last autumn in which high-performing NHS hospitals were invited by the Secretary of State to provide support for hospitals placed in special measures.

I suspect that much remains to be done to tackle relational aspects of care, including ensuring that patients are treated with dignity and respect and are able to communicate effectively with doctors and other staff. Indeed, the NHS as a whole, including GPs, will probably need to do a lot more in future to support patients to manage their own health and well-being and involve them as partners in care. Sir David Nicholson, the head of NHS England, who retires shortly, has described this concept as "the empowered patient"—in essence, the need for us all to get better at managing our own health problems to reduce the burden on hospitals.

Everyone has had to learn lessons as a consequence of the Francis inquiry, but it is not appropriate or, indeed, fair, continually to castigate those working in the NHS, whether they be nursing staff or managers. On the contrary, we need to ensure that NHS staff are supported to do the job for which they have been trained. Not unreasonably, as in other aspects of life, there will be a close correlation between staff experience and patient experience. Patients receive better care when it is given by staff working in teams that are well led and where staff consider that they have the time and resources to care to the best of their abilities. One reason ward sisters have always been so highly valued is that they are an extremely good example of team leaders, as experienced nurses who have developed, and are able to pass on, a culture in which patients are treated with dignity and respect, and who motivate their colleagues to do the same.

If we are to have an NHS fit for the 21st century, we need continually to attract talent into it. We will not do that if people consider that those working in the NHS are all too often set up to fail. We also need to improve efforts to attract clinicians into leadership roles, as advocated by Roy Griffiths way back in 1983. As a senior and much-respected clinician and physician, Sir Jonathan Michael has been able to achieve as chief executive of Oxford University Hospitals NHS Trust much that I suspect

could not have been achieved by a chief executive who was not a clinician. We should value the role of managers in the NHS instead of constantly criticising them. Successful leadership in the NHS needs to be collective and distributed rather than residing in just a few people at the top of NHS organisations. The involvement of doctors, nurses and other clinicians in leadership roles is essential.

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The NHS is an organisation that is constantly evolving. The NHS of today is very different from the NHS of 30 years ago, when my father retired as a consultant physician, and the NHS of 30 years ago was very different from the NHS on the day that it began. Both my parents worked in the hospital service on day one of the NHS, my father as a young registrar and my mother as a theatre sister. There is a danger that our perceptions of the NHS, and of what hospitals should look like, become frozen in time, with James Robertson Justice as a snapshot of hospital care. The type and nature of illnesses that hospitals are having to treat changes over the years; so too, therefore, does the hospital layout. I recollect that my father had four Nightingale wards, two male, two female, with 15 beds along each wall and 30 beds to a ward, filled almost entirely with patients dying from lung cancer. Lung cancer is still a killer, but not in anything like the numbers then. We need to recognise that hospitals are changing. In that regard, I very much welcome the work of the Royal College of Physicians through its future hospital commission—an initiative that has not received anything like the publicity and debate that it merits.

The current pattern of acute care is based on the model of district general hospitals providing comprehensive emergency and elective services for relatively small populations—a model developed back in the 1970s. A whole number of factors are changing that model. For example, advances in medical technology mean that it is now possible to treat many patients much more speedily and less invasively. Hysterectomies that might previously have involved a woman patient remaining in hospital for up to 10 days can now be performed through keyhole surgery involving a much shorter stay. There is clear evidence from the Royal College of Surgeons that specialisation can achieve better outcomes. Indeed, the concept of the general surgeon, or surgeon specialising in general medicine, is now pretty much obsolete. Almost all surgeons practising in the NHS today specialise, to the benefit of their patients, in surgery on a particular part of the anatomy.

On the other side of the equation, there are significant demographic changes, resulting in increasing numbers of elderly people. The elderly population is set to expand exponentially as we post-war babies, with much longer average life expectancies than our grandparents, start to reach our 70s and 80s. Many more frail elderly people have long-term medical conditions and an increasing number of people have multiple long-term conditions and—that terrible word—comorbidities.

I therefore very much support the 11 core principles of the Royal College of Physicians' "Future hospital" report. We need to ensure that NHS patients are at the centre of care—what Robert Francis described as a "patient-centred culture". We need to ensure that the NHS provides a seven-day-a-week service and that hospital trusts have a 24/7 approach. It is clearly unacceptable that mortality rates are significantly higher for patients admitted into hospitals at the weekend. GP out-of-hours services need to be improved and co-located, and hospital emergency departments need to integrate the urgent care pathway.

At the Horton general hospital in my constituency, an emergency medical unit is being developed to help strengthen the A and E unit and its rapid medical assessment capabilities and to try to ensure that people

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go to A and E only if they really need to. The links between generalist and specialist pathways are being strengthened, but I suspect that the 24/7 approach will lead to some reconfiguration of services, although that should not necessarily mean that they will become more remote. For example, Horton hospital now has a daily fracture clinic throughout the week and a renal dialysis unit, because it makes more sense for those services to be delivered there. However, emergency abdominal surgery is now carried out at the John Radcliffe hospital in Oxford.

In all of this, we need to remember that whoever is in government, and whichever political party or combination of parties is running the country, we need collectively to face the Nicholson challenge of saving significant amounts of money in the running of the NHS. If we cannot manage the Nicholson challenge, the NHS simply will face a black hole in funding and will fall, more or less, into managed decline.

Indeed, in a recent press report, Sir David Nicholson is reported as predicting that, if the NHS does not pursue a number of reforms, including enhanced primary care, more GPs and more specialisms, it faces

"a £30 billion hole in funding by 2021",

which is certainly within the political life expectancy of many of us in this House. He also observed, rightly, that

"the NHS is not frozen in aspic for us to worship as some great thing—it will decline and it will die if we don't recognise the choices that are available to us now".

Over the past year, following the publication of the Francis report, there has been considerable progress, including towards greater openness and transparency in the health service, including the implementation of a new statutory duty of candour. England now leads the world in transparency and openness about surgeons' clinical outcomes, so patients can access their surgeons' outcomes for particular procedures or operations, such as hip replacement. There has been considerable improvement in the Care Quality Commission's inspection model, the Government have ensured that a named consultant is in charge of someone's care throughout a hospital stay, and there is clear recognition that the NHS needs to provide a seven-day-a-week service.

We need to move forward with a health service that puts patients at the centre of care. A number of years ago, nursing was made increasingly a graduate profession, but whether one is a graduate doctor or a graduate nurse, patients still need tender loving care. I do not think that my mother, when she was a ward sister, was ever too proud—or considered it not to be part of her role, if necessary—to ensure that patients were comfortable in bed, to give them a bed bath, to make sure that they were eating properly or, if they should die, to ensure that they were laid out with dignity and care.

There have been concerns about health care support workers and we should welcome the recent review by Camilla Cavendish, which has made a number of recommendations on the training of and support given to health care assistants and how that can be improved. Health care assistants do extremely valuable work in hospital. They should be valued and properly regulated.

Last Friday I attended an open day for care workers, which was organised by Oxfordshire county council because, given the ageing population, we are going to need many more health care workers in hospitals and nursing homes and to give domiciliary support.

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We have yet to see the full benefits of commissioning and the extent to which commissioners can help improve and monitor the quality of NHS care. One thing that has interested me in this debate is the issue about who actually runs the NHS, because I assumed that once we had commissioning bodies, they would drive where the money was spent. We have also yet to see the full benefits of the new governance arrangements in the NHS, and of ensuring more joined-up working between the NHS and other providers, such as through health and wellbeing boards. Healthwatch Oxfordshire is certainly still getting into its stride as an organisation.

I hope that the House will have an opportunity, in a Back-Bench business or Westminster Hall debate, to discuss the Royal College of Physicians report on the future hospital programme. It is in the process of establishing development sites, which will implement and further develop the recommendations made in its report. I certainly hope that it will consider the Horton general hospital as one of those development sites, not only as one of the smaller general hospitals in the country, but as a hospital that serves a large geographical catchment area.

As Chris Ham, the chief executive of the King's Fund has observed, high-performing health care organisations

"benefit from continuity of leadership, organisational stability, and consistency of purpose".

I suspect that, having learned the lessons of Mid Staffordshire, we now need to concentrate on ensuring that there is continuity of leadership, organisational stability and consistency of purpose in the NHS.

5.1 pm

Mike Kane (Wythenshawe and Sale East) (Lab): Aneurin Bevan's father died in his arms from coal dust disease, and that drove his passion to establish the NHS when he came into government in 1948. We could put a major fault line down the middle of the Chamber between the two sides in this debate, but we could take away one win if we agreed on one thing underlying the Francis report—the development of a common patient-centred culture.

The Prime Minister mentioned Aneurin Bevan in Prime Minister's questions today, trying to assume his mantle as the guardian of the national health service, but I assure the House that the right hon. Member for Witney (Mr Cameron) is no Nye Bevan.

Bevan's "In Place of Fear" clearly set out the principle on which the NHS was founded. It is sometimes worth going back to such principles, as well as looking at its vision for the future. The principle was that

"no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means."

People died in Mid Staffordshire because of lack of means. I compliment the hon. Member for Stafford (Jeremy Lefroy) on an absolutely excellent speech, and on the care and compassion he has shown his constituents during the past few years.

I agree with the Secretary of State that much of the debate is about leadership. I welcome the fact that we will develop more leaders, because leadership in hospitals is a key way forward. I worked in education for many years and I know that, like schools, hospitals reflect the nature and ethos of their leaders. The more leaders we can create, the better the health service we can create.

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However, I also agree with my right hon. Friend the shadow Health Secretary. Bevan's principle in "In Place of Fear" was that no person would be denied medical aid by lack of means in a civilised society, but because of the top-down reorganisation that we currently face, we are in fear. It is no coincidence that several Greater Manchester MPs are in the Chamber for today's debate, because we are worried about the strategic leadership of Healthier Together, the organisation overseeing the changes in health care across Greater Manchester. Such top-down reorganisation is creating fear. It has sucked £3 billion out of NHS front-line services and in my opinion—I am not talking about winter pressures—it is putting patient care at risk, which is ultimately what the Francis report is all about.

That is no more apparent than in my constituency of Wythenshawe and Sale East. We knocked on 17,000 doors during the short space of a few weeks last month, and the single biggest issue raised was health care, particularly health care at Wythenshawe hospital. First, I want to praise the staff at the hospital, from top to bottom, and the service that they provide. I was born there and I had a minor medical procedure on my toe there recently. The staff were excellent, from top to bottom.

As my hon. Friend the Member for Worsley and Eccles South (Barbara Keeley) said, the reorganisation downgraded the accident and emergency facility at Trafford. That decision might have been right or wrong, but because of the rushed nature of the reorganisation and the fact that it was top-down, not bottom-up, it led to a lack of capacity at the neighbouring hospital at Wythenshawe. My right hon. Friend the Member for Leigh opened the Wythenshawe walk-in centre a year or two ago. That has been shut and the services have been transferred to Wythenshawe hospital.

What is happening to Trafford general hospital really grates on me, even though it is not in my constituency, because it was the first NHS hospital. It was opened by Bevan on 5 July 1948. He handed over the keys to the hospital.

The reorganisation has led to Wythenshawe hospital having to take the strain. It is failing the Government's guideline of

treating 90% of A and E patients within four hours. The chief executive of the University Hospital of South Manchester NHS Foundation Trust, which runs the hospital, said that the increased day-to-day admissions meant that 22 extra beds were required. That is a whole ward. To add to the organisational chaos that the top-down reorganisation has created, the hospital is now being investigated by Monitor, the Government regulator. It is almost a self-fulfilling prophesy.

To provide the extra accident and emergency space that is needed, surgical wards are being used. That has led to the cancellation of dozens of operations. At the last count, about 80 operations had been cancelled. The situation has led to nearly 1,000 ambulances having to queue down Southmoor road, which is just outside Wythenshawe hospital, this winter.

In the short week and a half that I have attended this Chamber, I have seen that debates can turn into statistical conventions. However, Members on both sides of the Chamber know—this was made clear by the stories from Mid Staffs—that there are real people in those ambulances and that it is 80 real people who have had

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their operations cancelled at Wythenshawe. It is not only those people who are affected; their families are affected too. Can we legitimately call ourselves civilised, to use Bevan's words, when sick people are being denied medical aid today? I do not think that we can.

I am grateful for the Secretary of State for agreeing to meet me to discuss Wythenshawe hospital and the A and E emergency. My litmus test will be Bevan's test. I hope that that will form the basis of my conversation with the Secretary of State. I will press him on that when I meet him.

5.8 pm

Mr Bernard Jenkin (Harwich and North Essex) (Con): I believe that the Francis report is becoming a major turning point in the life of our national health service, which is one of our great institutions and is probably treasured above every other institution that the British people hold dear. The Francis report has moved the NHS from being a rather impenetrable bureaucracy into something that is much more fallible, human and compassionate.

The Francis report highlighted the failings at Mid Staffordshire NHS Foundation Trust and stated that they were very much the result of a failure of leadership. As Francis said:

"The patient voice was not heard or listened to, either by the Trust Board or local organisations which were meant to represent their interests. Complaints were made but often nothing effective was done about them."

Damningly, he found:

"There is no evidence that the substance of any complaint was ever raised with the Board."

I shall come back to that point later. He also said:

"Such an approach completely ignored the value of complaints in informing the Board of what was going wrong, and what, if anything, was being done to put it right."

As Members have been saying, this reflected a culture of denial about failings and complaints not just at Mid Staffs, but across much of the NHS. We know that the problems were wider than this one trust. In a report last year the parliamentary and health service ombudsman, whose office is the responsibility of the Committee that I chair, the Public Administration Select Committee, carried out a survey of 94 trusts from across England and found that only 20% of boards were reviewing learning from complaints and taking resulting action to improve services; less than half were measuring patient satisfaction with the way complaints were handled; and less than two thirds were using a consistent approach to reviewing complaints data. One other finding, from memory, was that only 2% of trusts were considering complaint handling as a strategic issue to consider during a trust board awayday.

Jeremy Lefroy: Will my hon. Friend share his reaction to the news that the parliamentary and health service ombudsman is taking far more seriously complaints brought to her and instigating far more investigations than two or three years ago?

Mr Jenkin: Yes, I welcome that. My Committee works closely with the PHSO, Dame Julie Mellor. I paid a visit to the PHSO's office in London last week and listened to some of the complaints coming in by telephone. We have a lot to learn from the way she is changing things, but there is a lot we need to do to bring the institution

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of the ombudsman into the 21st century. My Committee is working on a report to be published shortly, which will make recommendations on that.

The role of boards in the leadership of NHS trusts has not been given sufficient attention. Many boards are changing their practices and improving, but the research that we have been given suggests that the chairman of the board of a trust is the most important person in setting the tone of the organisation. We inherited a system where executives took all the decisions and the role of boards was to oversee. No. In the private sector, the chairman of a company, even the non-executive chairman of a company, is the most crucial person for setting the tone, the values and the atmosphere in the organisation. We need to lay much more emphasis on the leadership of trust boards.

The Francis report prompted the NHS, Government and Parliament to question the prevalent management culture in the NHS, and it is the main reason why we are looking not just at the ombudsman, but doing an inquiry into how complaints are handled not just by the NHS, but by Government Departments and across public services. As part of our inquiry we took evidence from Sir David Nicholson, the chief executive of NHS England, and Chris Bostock, head of NHS complaints at the Department of Health.

The ombudsman told us that she found what she called a "toxic cocktail" within some NHS hospitals which combines a reluctance by patients, carers and families to complain, with a defensiveness on the part of hospitals and senior staff to hear and address those concerns. In oral evidence to our inquiry, Sir David accepted that when he said:

"I do think there is a real issue about defensiveness and a lack of transparency in the way that we work",

and he accepted that complaints are important for learning and improving.

A great deal has been said in this debate about processes, procedures, legal sanctions, rules and accountability, but those are for when things go wrong. What we want in our health service is a culture of listening, understanding, caring, learning and supporting. I shall say a little more about that. Sir David said that the need for openness is not always recognised in the NHS. He went on to say that

"we are publishing lots of data and information and people can connect together through social media and all the rest of it, things are opening out, but the leadership of the NHS…is having difficulty coming to terms with that and"—

a rather nice little understatement—

"is slightly behind it."

He accepted that that came down to leadership and culture. In a powerful admission from somebody who has been at the heart of the NHS for so long, he said:

"Undoubtedly, in broad terms, the NHS leadership is not equipped to handle some of the big issues that are coming forward, so we need to tackle that leadership. We need to work really hard on the culture of the system overall, because as you are going through that transition the importance of setting the right tone from top to bottom of the organisation is increasingly important…You need to make sure that you are learning the lessons and getting innovation from the system as a whole."

I am bound to add that, at the end of the session, I asked him about his own leadership. It is a credit to him that he explained that the diagnostic process that NHS leaders go through had been applied to him. He said:

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"What it said about me was that first of all I was strong on the pace-setting. Give me a target and I will make it happen… Secondly, the feedback was that I was good at setting out a vision of what the future might look like. My weaknesses were around facilitating and coaching, and actually they are the issues that in a modern NHS will be much more highly prized than perhaps the last one."

I know that Sir David Nicholson has come in for an awful lot of stick and criticism, but there was a degree of self-knowledge there, and he expressed much regret in front of our Committee for what he had missed.

Francis recommended changes to the law, and the Government are implementing those recommendations. However, I agree with the Select Committee on Health that enshrining duties and standards of care in statute is simply not enough. In fact, statutory changes are almost irrelevant to the day-to-day life of people working in the NHS. The word we hear often is "culture", and that is what needs to change and is changing. The key change needs to be to attitudes and behaviour within the NHS, particularly among those in leadership positions, who set the tone of the organisation that they lead. Leadership is central to that—not just the leadership of trusts, but leadership across the organisation at all levels.

The Secretary of State is right to emphasise the importance of compassion in the NHS and the need to support those who are required to show compassion every day. Management need to feel and respect that compassion and reflect it in how they treat their staff, otherwise, as one colleague said to me, patients become objects, not people. The way health care staff feel about their work has a direct impact on the quality of patient care as well as on an organisation's efficiency and financial performance. If those in the upper tiers of management are not also involved in feeling compassion for the patient, they place too great a burden of compassion on front-line staff. The people on the front line need support from those up the management chain, and compassion has to come from the top.

High-quality, patient-centred care depends on managing staff well, involving them in decisions, listening to what they have to say, developing them and paying attention to the physical and emotional consequences of caring for patients. Funnily enough, that point was made by a commercial witness to the Public Administration Committee's inquiry into complaint handling, Mark Mullen, the chief executive of First Direct. He told us that

"there is a relationship between how you treat your people and how you ask or expect or want your people to treat their customers…it is virtually impossible to create a positive outcome with customers unless you have created a positive relationship with your own employees."

I wish to leave the House with that serious thought—how NHS staff feel about their work has a direct impact on the quality of patient care, as well as on efficiency and financial performance. That is what this is about.

I am taking a close interest in the NHS leadership academy, which the Secretary of State referred to. It clearly has a clear role to play, although it is very small at the moment. It deals only with potential trust chief executives—senior leadership in challenging roles. It is early days, and we need to involve the academy with trust boards, trust chairs, the leadership of NHS England and even the Department of Health. The academy must give priority to the values of compassion, openness and transparency, listening to and learning from complaints

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and accepting and learning from failure. It is not about people going off to Harvard, learning how to develop fantastic strategies and coming back with a personal vision that they impose on their organisation. That is not the kind of leadership the NHS

needs, and indeed, such leadership does not work in business either. That is true not just for a few leaders, but for every leader of every team in every trust and GP practice in NHS England and the Department of Health. It is a much bigger agenda for the NHS leadership academy than currently envisaged, but we need that ambition if there is to be speedy and permanent change in the culture of the NHS, the attitudes of the people in it, and the way they behave.

There is a great deal of excellent practice in the NHS, as in most large organisations, but it does not seem to be gathered in any systematic way so that learning can be shared. One consequence of that is that there does not seem to be a shared understanding of the kind of leadership that makes excellent practice more likely. Despite the scale and complexity of the health service, there is a common commitment to compassionate, safe, sustainable care among clinicians, managers, trusts, chairs and regulators, which could be the foundation for building a shared understanding of good leadership and practice. None of this will be a quick fix, but many building blocks of good practice are already in place. Gathering that learning together would strengthen and hearten leadership across the NHS. I believe that that is the real role of the NHS leadership academy as it builds its capacity, and I look forward to its developing in the future.

5.21 pm

Sarah Champion (Rotherham) (Lab): I welcome this debate because it has given us an opportunity to reflect, to learn and, hopefully, to not make some of the same mistakes again. I pay tribute to hon. Members who were directly involved with the events surrounding Mid Staffs. Their persistence in protecting their constituents and changing the culture has been remarkable and something we should all learn from. I particularly pay tribute to the hon. Member for Stafford (Jeremy Lefroy) for telling us how the staff at Stafford hospital have learned and are working as hard as they can to make changes, so that they can deliver an excellent service to all their patients.

The Francis report, published a year ago, made stark reading. It exposed the dreadful practices that no one should ever have to endure, with shocking stories of patients left in their own excrement, unfed, and pleading for water. My heart genuinely goes out to patients and their families who suffered such poor treatment at the hands of an NHS that was seemingly driven by apathy, not by quality of care.

One year on, have we learned the lessons that were so hard won? Robert Francis made many recommendations about how the NHS should put patients at the centre of care. He spoke of a structure of fundamental standards and measures of compliance. He discussed openness, transparency and candour throughout the system, all underpinned by statute. He also raised the need to improve support for compassionate, caring and committed nursing. A recent report by the Nuffield Trust reviewed

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the progress made, and there is some good news. Nursing is receiving a significant degree of attention, especially in ensuring fundamental standards of care, and the handling of patient complaints locally has been given renewed attention by the chairs of local clinical commissioning groups.

I think that complaints and compliments are key to improving practice, and like many Members, I use the Sheffield-based social enterprise website, Patient Opinion, which to date has shared 65,000 patient experiences of care and received millions of hits from the NHS, MPs, commissioners and the general public. There is clearly a desire for patients to share their experiences, and an NHS that wants to listen and learn. Is it not worrying, however, that an independent organisation is fulfilling that role? Although I am a huge advocate of Patient Opinion and fully support its work, the voice of patients and accountability should also come from within the NHS, not just outside it. In practice, under this Government patients still have little say in how their health care is commissioned or provided. As my right hon. Friend the Member for Leigh (Andy Burnham) stated, more than £10 million of the £43.5 million allocated to Healthwatch branches is still unaccounted for, so how can Healthwatch fulfil its role?

The Nuffield Trust also identified bad practice. I am saddened to hear that some national bodies have persisted in the behaviours towards hospitals that contributed to the problems identified by the Francis report. That suggests that there is still a fundamental lack of co-ordination between different NHS bodies, and elements of the system-based culture that led to the failings in the Mid Staffordshire trust, but while this is saddening, perhaps it should not be surprising.

For the changes Francis recommended to be implemented, they need to be fully adopted by the Government. Instead, the Government have spent £3 billion on a top-down reorganisation that nobody wanted and nobody voted for. Almost 1 million patients have waited more than four hours in A and E in the last 12 months and, as has already been pointed out, hundreds of mental health beds have been lost in the last two years. Last year, a third of people referred for counselling gave up because the waits were too long. Patients are still suffering at the hands of the Government.

If we do not urgently change the culture of the NHS to become more patient-centric, patients will continue to suffer. There needs to be a fundamental culture shift in the NHS that has not yet been achieved, and will not be achieved while the Prime Minister continues to put profits ahead of patients. The recent proposals to sell off our medical records are a perfect example of how “supposedly” patient-centred the Government are. Data collection and monitoring are essential, so it is a shame that the Government are stopping the collection of some datasets, such as health inequalities.

Staffing cuts are preventing patients from being at the centre of care. How can we provide patient-centred care when the Government are side-stepping the need for adequate levels of staffing, in terms of both volume and skills mix? How can we expect nurses to put into place systems, such as having a named nurse, when their numbers have been cut by around 7,000 since 2010? The Royal College of Nursing has said that it wants to deliver patient-centred care, but without the right skills mix in place, it is difficult for it to do so.

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Continued “efficiency savings”, driven by a Prime Minister who promised not to cut the NHS, make it virtually impossible for patients to receive a service suited to their needs. A continual focus on savings suggests to me that the Government have not learned from the Francis report. Patients are not always seen as individuals with individual needs and wishes. Our changing society means changing patients, and changing patients have changing needs. Today, nearly two thirds of people admitted to hospital are over 65, and an increasing number are frail or have dementia. Too often, hospital buildings and staff are not

equipped to deal with people who have multiple complex needs.

One of my concerns is that patient experience is still variable. We need to understand why experience differs and how we can make it consistently excellent for all. Will the Government commit to identifying and tackling the causes of inequalities in patient experience? Do they have the conviction to look at the needs of the patient and how they can be best met, rather than looking at existing provision and how patients can be shoehorned into it?

The problem is not necessarily what has been addressed by the Government, but what has not. The blame culture fostered by the Government leads to fear and finger pointing, rather than improved patient care. The Government need to commit to re-introduce a culture of learning, support, and quality patient care in the NHS. A blame culture will not get us anywhere: listening to patients, and taking their needs seriously, will.

5.28 pm

Grahame M. Morris (Easington) (Lab): I am honoured to be able to participate in this debate, and it is champion to follow my hon. Friend the Member for Rotherham (Sarah Champion) in the debate—

Bob Stewart (Beckenham) (Con): Champion!

Grahame M. Morris: Thank you very much, Bob.

I want to make three points. First, I want to consider the context of the Francis report. I have the honour of serving on the Health Committee; we have held several inquiries and had the opportunity to meet and question Robert Francis on several occasions, so I am pleased to participate in this debate to consider where we are, one year on.

I also want to touch on mental health. As often happens when one speaks at the tail end of the debate, that has been raised by other hon. Members, but the issue is close to my heart. The third issue I want to discuss is the impact on social care. Although the Secretary of State kept implying that Francis is about acute hospitals, in fact his recommendations extend across the spectrum. The ideas and proposals in the 290 recommendations are just as valid for mental health and social care as they are for acute hospitals.

Clearly, the failings at Mid Staffs were absolutely shocking. I am sure that Members on both sides of the House who believe in the values of the NHS will, like me, have been appalled by those terrible events, but it is important not to conflate those terrible events with a wider diagnosis of the state of the NHS. We should think of the tremendous dedication and effort put in by the hundreds of thousands of NHS staff—I think the NHS is the biggest employer in Europe outside of the

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red army; it is a substantial employer—who make it such a national treasure that is ingrained in our psyche. I want to place on record the thanks of Labour Members, and, I think, the whole House, for their efforts.

Bob Stewart: I'll intervene on that point.

Grahame M. Morris: Well, that's very kind of the hon. Gentleman.

Mr Deputy Speaker (Mr Lindsay Hoyle): Order. The hon. Member for Beckenham has only just come in. He perhaps ought to hear a little bit more of the debate to get the flavour of it before he intervenes. That would help his good self.

Grahame M. Morris: We should remember that most hospitals provide very high standards of care, and have dedicated and compassionate staff. I am not just talking about doctors and nurses, but ancillary workers, cleaners and support staff. I worked in a pathology department as a medical scientific officer for a number of years. We should remember that the NHS is an integrated service that relies on all of its elements to perform at a high level and deliver a high-quality service.

Clearly, what happened in Mid Staffs was alarming. There were unacceptable practices, including, as other Members have said, professional failings. The hon. Member for Stafford (Jeremy Lefroy), in a terrific speech that was considered, thoughtful and non-partisan, alluded to those professional failings. My right hon. Friend the Member for Rother Valley (Kevin Barron), a former Chair of the Health Committee, made the point strongly that many Labour Members feel there should be a duty of candour on individuals. That is one of the recommendations of the Francis report that was rejected by the Government but could well make a difference. There were clear signs that changes needed to be made and we need to ensure that failures are never repeated elsewhere.

When care failures are uncovered, the priority above all else is to make a candid assessment of what went wrong and what needs to be done to fix it. Francis was clear on the need for cultural change. That is exactly what happened in the wake of the Mid Staffs scandal. Despite attempts by some Government Members to undermine Labour's commitment to the NHS, for the record we should be aware that it was the then Secretary of State, my right hon. Friend the Member for Leigh (Andy Burnham), who is now in his place, who called in Robert Francis to lead the initial review into what had happened so that we could find out what went wrong and learn lessons for the future.

I accept the point made by the hon. Member for Stafford that we should not hark back to previous Administrations, but my recollection, as a relatively new Member from 2010, is that that was not something we engaged in. It was a huge issue for Labour, and for me personally, that people were dying due not to lack of care in a hospital setting, but to the length of waiting lists—people were dying on waiting lists. After 1997, the NHS was transformed. Spending had tripled to £104 billion when Labour left office. Under Labour, 100 new hospitals were constructed, and the Labour Government employed 89,000 more nurses and 44,000 more doctors than had been employed in 1997. The transformation of the

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NHS under the last Government was reflected in public satisfaction with the service, which rose from record lows before 1997 to

record highs.

There was a bit of contention during Prime Minister's Question Time, and subsequently during the opening speeches in the debate. The Secretary of State suggested that the number of nurses had risen, but my information from the Royal College of Nursing and FactCheck indicates that that is not the case. I hope that the record can be corrected, because staff numbers are a key issue. A number of Members have referred to it today, and Robert Francis cited staffing as a causative factor.

It would, I think, be irresponsible to assume that a combination of implementing the Francis recommendations—even all of them—and talking down the last Government will be sufficient to ensure the provision of high-quality care throughout the NHS. The truth is that the combination of cuts in alternative services—I am not just talking about the replacement of NHS Direct with the 111 service, the reduction in the number of walk-in treatment centres, the difficulties in gaining access to GP services and, indeed, the cost and disruption caused by the top-down reorganisation—is more likely to contribute to failures in care. It will certainly increase the pressure on accident and emergency departments.

The Francis report made it clear that the "overwhelmingly prevalent factors" in the failures at Mid Staffordshire

"were a lack of staff, both in terms of absolute numbers and appropriate skills".

It was made clear that ensuring that our hospitals are adequately staffed is key to ensuring that standards of care are high. That point was made by the hon. Member for St Ives (Andrew George), who I know has been campaigning on the issue for some time. A year on from the Francis report, a survey found that 39% of nurses believed that the staffing position had become worse rather than better, and 57% said that their wards remained dangerously understaffed. I hope that the Minister has noted that, because it must be cause for concern.

The hon. Member for Stafford told us that when he was first elected the NHS trust was running a deficit of £10 million, and the focus of the hospital management was on reducing the deficit in order to secure foundation trust status. What went through my mind then were figures given to the Select Committee, according to which nearly a third of NHS trusts are predicting deficits towards the end of the current financial year, and the possibility that similar pressures will be applied as a result. We are now seeing the spectre of clause 119 of the Care Bill, which we are to debate next week on Report and Third Reading. If it paves the way for rapid hospital closures—Labour Members fear that predatory private health care interests may seize the opportunity—that will be very dangerous. We must examine that issue very seriously.

According to evidence from the survey conducted, I think, by the RCN, not only are hospital wards increasingly understaffed, but nurses are being burdened with work that is preventing them from doing their jobs. I am sorry to fire statistics at the House, but, according to that evidence, 86% agreed that the amount of non-essential paperwork had increased in the last two years. There

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has thus been an historic recent increase in administrative duties. That has been keeping nurses in their offices or at their nurse stations, standing in front of computers or photocopying machines, instead of being available on the wards providing the TLC—that direct health care—that patients require.

Just this week the president of the Royal College of Psychiatrists warned the Government that the mental health sector is heading towards its own Mid Staffs-type scandal. I am very concerned about that. The figures for that field were given earlier, but the fact that the budget for mental health services is reducing in real terms should be a cause for concern. This Government gave a commitment to parity of esteem as between physical and mental health. That was promised and loudly trumpeted as a significant step forward, but in truth it has failed to materialise. There is a clear funding imbalance between acute providers and non-acute trusts, which will disproportionately impact on mental health services in the wake of the Francis report.

I also want to touch on the tariff reduction. In 2014-15 there will be an overall reduction in the tariff price—essentially, the price that hospitals are paid for procedures and operations they perform—of 1.5% for acute providers and 1.8% for non-acute trusts. A third of NHS trusts are predicting they will be in deficit at the end of the financial year, and this tariff reduction will only compound that problem. This means the efficiency target for mental health and community trusts is in practice a fifth higher than for acute trusts, so perhaps it is no wonder that we have a chronic bed shortage, highlighted by various newspapers and the BBC, with children and adolescents travelling long distances to access appropriate care and sometimes temporarily being put in police cells. This is not acceptable, and there are real concerns that programmes introduced by the last Labour Government to make talking therapies available to people with mental health conditions are not getting the priority they deserve. Last year half of all patients referred for counselling did not see a specialist, with a third giving up entirely because the waits were so long.

As I mentioned in an earlier intervention, 1,700 mental health beds have been lost over the last two years, and services are under such pressure that people with mental illnesses are ending up either in police cells or presenting at accident and emergency departments, as the right hon. Member for Sutton and Cheam (Paul Burstow) said. Those are completely inappropriate locations.

I want to mention the cuts to social care since 2009 and the impact they are having on the ability of the service to deliver quality care in the light of our review of the Francis recommendations. We should not forget that since 2009-10 some £1.8 billion has been cut from local authority budgets for adult social care. The cumulative spending power of my own local authority, Durham county council, is being reduced by 17.3% under this Government.

Areas such as mine with a legacy of coal mining or industry have higher care needs. These are the areas that are being hardest hit by cuts to local government. It is simply not possible to make cuts of this significance to local government without it having an impact on standards of care. Some 76% of community nurses agree that social care cuts have resulted in increased work pressures, with just 15% thinking that patients are receiving adequate support from social care services. Cuts mean that an

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increasing number of those with care needs are going without any support—the figure I have seen is about 800,000—and those receiving support are not even having basic needs met. We know about the 15-minute visits, and councils are now having to introduce or increase charges for services that may well have been free before or might be free in other parts of the country.

Care in the home and in the community is declining, and people are turning to their local hospitals—this is the point I am trying to make—as the default option. That means that those who should be taken care of at home are staying unnecessarily in hospital beds. Accident and emergency is the coal face—the pressure point—and any failures in the system show up there, putting even more pressure on an already burdened system. In "The Francis Report: one year on", Robert Francis said that there needs to be

"a frank discussion about what needs to be provided within the available resources…It is unacceptable to pretend that all can be provided to an acceptable standard when that is not true."

I agree with him. It is no good telling people that care standards will be improved or maintained while removing the support that is required to provide high standards of care, particularly social care. In conclusion, I agree with the Health Committee that legislation and regulatory bodies can only do so much to ensure that care standards are met if the necessary staff and resources are not available.

Mr Deputy Speaker (Mr Lindsay Hoyle): I now have to announce the result of Divisions deferred from a previous day.

On the motion relating to the draft Marriage (Same Sex Couples) (Jurisdiction and Recognition of Judgments) Regulations 2014, the Ayes were 360 and the Noes were 104, so the Question was agreed to.

On the motion relating to the draft Marriage of Same Sex Couples (Registration of Shared Buildings) Regulations 2014, the Ayes were 363 and the Noes were 100, so the Question was agreed to.

On the motion relating to the draft Marriage of Same Sex Couples (Use of Armed Forces' Chapels) Regulations 2014, the Ayes were 366 and the Noes were 103, so the Question was agreed to.

On the motion relating to the draft Consular Marriages and Marriages under Foreign Law Order 2014, the Ayes were 367 and the Noes were 100, so the Question was agreed to.

On the motion relating to the draft Marriage (Same Sex Couples) Act 2013 (Consequential and Contrary Provisions and Scotland) Order 2014, the Ayes were 365 and the Noes were 103, so the Question was agreed to.

On the motion relating to the draft Overseas Marriage (Armed Forces) Order 2014, the Ayes were 368 and the Noes were 98, so the Question was agreed to.

I now call Alex Cunningham.

5.48 pm

Alex Cunningham (Stockton North) (Lab): Thank you, Mr Deputy Speaker. It is an especial pleasure to follow my near neighbour in the north-east of England, my hon. Friend the Member for Easington (Grahame M. Morris), and I agree with everything he said. I was particularly interested in his reference to the reduction

in tariff costs, which made me think about the new hospital we were planning to replace the Hartlepool and North Tees hospitals. That is yet to be delivered, despite its being crucial to health care in the area we both represent. I am hoping that we may soon hear from the Government that they are going to approve the assistance we need to deliver it, which will help us cope in that part of the world with the reduction in the actual tariffs.

Our national health service is for millions one of the world's success stories of the second half of the 20th century, with teams of dedicated people—from porters and reception staff to nurses and consultants—who have risen to the challenge of change and innovated to do the best for our people. As a result, the NHS has survived and largely prospered despite the often unnecessary burden and restrictions placed on it by Government.

I am pleased to have learnt this afternoon that the future of the health service is in good hands: during this debate, I heard from my great niece, Meghan Quarne, who has just managed to secure a place at the Edinburgh medical school, so I am one very proud great-uncle this afternoon.

Yes, the NHS has been a success story, but there have been many failings that have devastated families, health professionals and politicians. We must never minimise the impact of failures that have occurred under different Governments at, for example, Bristol, Alder Hey and Mid Staffs. We must take action to ensure that we improve what we do in the NHS.

I also recognise that a number of trusts have been placed in so-called special measures. That is good not because of the things that are going wrong, but something is being done about the problems so I look forward to seeing the improvements that we all desire.

Of course it does no one any credit to play the political blame game. Members from current and previous Governments must recognise that things do go wrong, sometimes badly, and that everyone should work co-operatively to drive the improvements that we all want. That said, we must also recognise that the NHS is still a success story. It is treating more people with more complex conditions as well as the routine ones. However, the Francis report exposed an organisational subculture within parts of the NHS that was guilty of persistently compromising patient safety, jeopardising the quality of care and tarnishing the experience of the NHS as a first-class health care system.

In the most extreme examples, the failings identified in the Francis report have resulted in patients dying needlessly owing to dehydration and exposure—yes, severe neglect. It is unquestionable that such deficiencies resulted in suffering being needlessly caused to large numbers of patients. The report highlighted a wide-ranging and complex mix of failings, which included a board that was more focused on finance than on the quality of care received by patients; chronic understaffing that impacted on the ability to provide the care required; and a culture of poor practice and neglect that many staff felt powerless to challenge.

There can be no doubt that the situation was utterly abhorrent and should never have been allowed to arise, let alone be repeated. The NHS Confederation was candid, but accurate, in describing the failings at Mid Staffordshire as

"a nadir for the health service."

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In short, there are lessons to be learned from the ordeal—lessons that need to be learned quickly and thoroughly. The recommendations made by the Francis report some 13 months ago were therefore squarely aimed at addressing and improving that frame of mind within trusts through increased levels of transparency and by placing greater focus on the quality of care being delivered.

Although it is important that we recognise that genuine culture change is a slow and evolutionary process that could take time, particularly when some of the changes in question are centred on sensitive issues such as the ability to raise concerns, it cannot be an excuse for risking further neglecting patients by failing fully to address each of the core concerns that were identified.

It is therefore disappointing that the Government have taken an inconsistent, scattergun approach to the report's findings, ploughing ahead with a damaging top-down reorganisation of the NHS, cutting thousands of nurses and delivering a crisis in A and E. That course of action is destined to weaken and destabilise the NHS, not remedy the problems that have already been diagnosed. It must be a matter of concern that the recommendations that Francis made appear to be some considerable way off becoming a reality.

With the health service's resources being limited in the face of rising demand for health care, coupled with an increasingly complex system of commissioning services that can involve many layers of bureaucracy and administration, it is more important than ever that the Government acknowledge the limitations that exist to transforming the culture of the NHS through legislation alone.

Although the Government accepted the report's recommendation to introduce a duty of candour to organisations, they rejected the recommendation to extend that duty to individuals. My hon. Friend the Member for Easington mentioned that earlier. However, those individuals—the leaders and professionals in the NHS—are central to transforming care.

All parts of the NHS—from the ward to the board—have a role to play in creating a more open and honest health service. Every member of staff, regardless of role or seniority, should therefore see providing dignified, compassionate care to all patients as central to their duty. The vast majority of them do so, but I am still apprehensive because an organisational duty alone will not help individuals challenge an organisation with a dysfunctional culture. A simple duty on an employer will not encourage employees to come forward if they are not already motivated to do so by a professional code of conduct.

It is worth noting that an inherent tension remains between prioritising the quality of care delivered to patients and pushing the importance of financial performance. This is particularly true if increasing front-line staff numbers is viewed as the main route to improving safety and quality at the expense of an unnecessary and complicated reconfiguration of care pathways and services.

The Francis report identified one of the root causes of the terrible failures at Mid Staffordshire as a fundamental lack of staff, and many people have talked about that. Although some of the failings were the result of unprofessional behaviour on the part of individuals,

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the factor overwhelmingly responsible for many of the failings was a lack of staff. Yet, despite this finding, there are now thousands fewer nurses and front-line staff in the NHS than in 2010, with 7,000 front-line staff being made redundant between 2010 and 2013.

Achieving the excellent results and care that patients demand and deserve is dependent on a number of factors, and adequate staffing is certainly central to achieving that goal. However, excellent care requires not only the appropriate number of staff but, importantly, staff with the correct mix of skills. Those skills include a range of factors, including leadership, staff engagement and appraisal.

Although I appreciate the attraction of nationally set minimum ratios of nurses to patients, it is important that we recognise that this is an over-simplification that does not necessarily represent the safest way forward. Not only would a minimum staffing level remove the flexibility required to meet the changing needs of patients, but a nationally set minimum would run the risk of being seen to constitute a ceiling rather than a floor. Instead, appropriate staffing and the best mix of skills are perhaps best determined locally, based on robust evidence and local circumstances.

I well remember that, when I was a non-executive director of the North Tees and Hartlepool NHS Foundation Trust, we had a fantastic chief nurse—her name was Smith—who led a tremendous team. She inspected the wards. She took a team of people on to the wards. They talked to the patients. They looked under the beds. They dragged their hands across the top of the wardrobe units to test their cleanliness. They did a full and thorough check. They talked to the staff. They put nurses at the centre of patient care—something that is absolutely critical today.

Although there has been a small increase in the number of hospital-based nurses in the past year, a paper from the NHS

regulator, Monitor, analysing foundation trusts' plans for 2013 to 2016, shows how temporary increases in nurse numbers this year, 2013-14, will be outweighed by larger cuts to nurse numbers over the next two years. Indeed, the paper suggests that hospitals are planning to "significantly reduce nurses" from next April and that the temporary rise this year is just

"a short term fix for operational pressures".

Specifically, the analysis shows that, although trusts are planning to increase nurse numbers by 2% this year—around 3,400—that will be followed by 4% cuts in 2014-15 and around 6,900 will go the year after.

There has never been any excuse for neglect by nursing staff. There has never been any excuse for what happened at Mid Staffs. But if, as Francis said, a lack of staff was fundamental to the Mid Staffs failure, that is surely the central lesson for us all, including the Government, to learn.

5.59 pm

Sir Peter Bottomley (Worthing West) (Con): It is 10 years after the trust lost its three-star rating and went down to zero. It is nine years after most people monitoring hospital performance knew what the problems were. Whistleblowing began in 2007—the Royal College of Nursing knew that, but others did not.

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I should like to focus on recommendation 11 of the report that came out three and a half years ago. It deals with the candour required of staff, and it says that clinicians and their views should be represented at all levels of the hospital and the trust. A contrast to what happened at Mid Staffs is provided by a hospital in Seattle—the Virginia Mason medical centre—that decided, first, that if it made mistakes it would admit it and, secondly, that any member of staff could stop the process if there was a significant problem. I recommend a book by Charles Kenney called "Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience", which should be read—or a summary should be made available—by virtually everyone concerned with organised health care in this country.

Some of the lessons are simple but rarely put into practice. Let me make an analogy. My brother-in-law, Christopher Garnett, ran the London to Edinburgh line for the Great North Eastern Railway, and members of staff would say that he was the only manager who got on the train and asked everyone what he could do to help make their job more effective; they were used to managers telling staff what they could do to make the manager's job more effective.

The Virginia Mason medical centre looked at what it was doing, and it discovered that nurses spent a third of their time with patients. After changing how they worked, nurses spent 90% of their time with patients. Dr Gordon Caldwell of Worthing hospital in my constituency said that people should be in hospital only if it is doing them some good. They should have a named doctor and a named nurse, but he discovered that, probably throughout the health service—partly but not entirely because of the European working time directive—a patient's doctor and nurse probably did not speak to each other about the patient more than once a week. That is not good enough.

There is a series of issues, but the key one is empowering front-line staff. Dr Kim Holt, a clinician and leader of Patients First, with whom I am involved, warned in advance that Haringey children's services were no longer staffed by the right number of qualified senior clinicians. She made it plain that the baby Peter case was not just about a failure to bring together the child's records from the different parts of the health service to which the family had taken him. She said that the locum, who ended up with all the blame, could not possibly have done the job that she was asked to do. Kim Holt suffered under her employer—the trust. She stood up to it, and would not be bought off and silenced. I pay tribute to her for that.

I could speak at length about this, but I should like to end with a request both to the people at the top of the health service in England and to Ministers. I suggest that Ministers and NHS England meet the group of clinicians that Kim Holt can bring together with Roger Kline at Patients First, listen to their stories and ask where in the process of NHS management, each complaint or disciplinary case has got to. That involves managers, nurses, midwives, doctors and others. The Department of Health should make sure that that happens, but not necessarily in public. It should ask each of the managers involved what they have done all the way through each case and whether they would like to revise what they are doing. There are still too many whistleblowers being bullied, bribed, bought off or sacked 10 years after the Mid Staffs events told us what could go on.

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6.4 pm

Liz Kendall (Leicester West) (Lab): It is a pleasure to speak in this important debate. Members on both sides of the House have shown that we are determined to learn the true lessons from the appalling failings at Mid Staffordshire and to understand what needs to change to prevent them from happening again.

We have heard many serious and thoughtful contributions, but I want to start by paying tribute to the hon. Member for Stafford (Jeremy Lefroy), whose calm, considered, thoughtful and dignified approach to the issue and the work he has done on behalf of his constituents is a lesson to us all. My right hon. Friend the Member for Cynon Valley (Ann Clwyd) hit the nail on the head when she said that there is nothing to be gained by politicising these issues, but everything to be gained by understanding the lessons and being open about the problems so that they can be tackled properly.

My hon. Friend the Member for Stalybridge and Hyde (Jonathan Reynolds) and my right hon. Friend the Member for Rother Valley (Kevin Barron), along with many other hon. Members, emphasises the importance of openness. As a constituency MP, I have seen how the NHS too often tries to sweep patient complaints and mistakes under the carpet, ignoring them and pushing patients away. Being open early on, admitting mistakes and learning the lessons is a much better way forward.

A number of hon. Members spoke specifically about the process that Mid Staffordshire hospital is currently going through. My hon. Friend the Member for Stoke-on-Trent North (Joan Walley) and the hon. Member for Stafford rightly said that there is a lack of clarity about the process and the timetable. I hope that the Minister, when he responds, will give those hon. Members

and their constituents much greater clarity on what will happen.

My hon. Friends the Members for Rotherham (Sarah Champion) and for Wythenshawe and Sale East (Mike Kane) raised important points about making the system more accountable and how that is much harder since the NHS reorganisation, with all the different bodies—a point I will return to in a minute. My hon. Friends the Members for Worsley and Eccles South (Barbara Keeley), for Easington (Grahame M. Morris) and for Stockton North (Alex Cunningham) rightly talked about staff shortages and the serious impact they can have on patient care. If we are to get to the root of the problem, simply publishing data every month is not good enough. I was really pleased that the right hon. Member for Sutton and Cheam (Paul Burstow) talked about mental health. We have been talking mostly about physical health, but he was right to raise those concerns.

In the time available I cannot do justice to all the points raised today, or to the Francis report's 290 recommendations, so I will focus my comments on the two most fundamental challenges we now face: first, ensuring that the views of patients, their families and the public are heard and acted on, at every level and at all times; and, secondly, ensuring that there is clear leadership to make the service changes we need to improve safety and quality at a time of unprecedented pressures on the NHS. Unless we do that, there is a risk of the failings in Mid Staffordshire happening again.

Alun Cairns: Will the hon. Lady give way?

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Liz Kendall: I will give way to the hon. Gentleman this one time.

Alun Cairns: I am grateful to the hon. Lady for giving way, unlike her colleague earlier. In the spirit with which she has opened her contribution, and in relation to the comments made by the right hon. Member for Cynon Valley (Ann Clwyd), the comments of the Royal College of Surgeons and the example I highlighted of worrying cases in the NHS in Wales, will she make every effort to influence her colleagues in the Welsh Government, and indeed the Welsh Health Minister, to conduct a Keogh-type inquiry into the NHS in Wales?

Liz Kendall: Wherever there is evidence of poor care, it must be looked into. The hon. Gentleman did not mention that the Welsh Assembly has ordered a specific independent inquiry by experts outside Wales into aspects of care at the Princess of Wales and Neath Port Talbot hospitals, which I welcome.

Of all the lessons to be learned from Mid Staffordshire, the most important one is that the primary cause of the failures was the hospital and the trust board not listening to patients and their families, and not putting their needs and concerns first. Sir Robert Francis rightly says that there must be fundamental changes to ensure the real involvement of patients and the public in all that is done and to secure a common patient-centred culture throughout the NHS.

National Voices, a coalition of more than 130 patient, user and carer organisations, says that a concerted drive to listen to patients and carers must be a top priority for all trust boards and care organisations. It emphasises that over and above regulation, which it says has

"an important but limited role in ensuring quality and safety."

Ministers have rightly spoken about the need for effective regulation and have taken some welcome steps, but the Care Quality Commission and the new chief inspectors will not be the main way of preventing the sort of failings we saw at Mid Staffordshire. Regulation identifies problems when they have begun, rather than preventing them from happening in the first place. Regulators cannot be everywhere all the time, but patients and their families are, which is why their views must be heard from the bedside to the boardroom, and at the heart of Whitehall.

The Labour Government made important progress. They published, for the first time, data on stroke and cardiac care. That helped to improve standards for patients and was a powerful incentive for staff to make changes. The next step is to provide systematic and comprehensive patient feedback. That must move from being the exception to being the norm.

The Government's friend and families test is welcome as far as it goes but, as National Voices says,

"it is a crude measure on which the NHS would be unwise to place too much reliance."

It asks only whether patients would recommend an NHS service to others, but not why, and it does not provide the detailed, real-time feedback that patients want and staff need to improve the quality of care. Developments such as the patient opinion and care opinion websites offer a powerful way forward. They enable people to tell the story of their NHS or care experience online, in writing or on the phone. That gives

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patients a voice, allows other people to see what is being said about a service, and in a simple and cost-effective way provides staff with a direct incentive to improve.

The Secretary of State said we must all be champions for change, and hon. Members may remember that I wrote to everyone saying that as a Member of Parliament they should sign up because it is a great way for us to understand what is really going on. I have asked my hospital trust and other services to do the same. That will be a powerful way of making change happen.

We must also look at how staff are trained to ensure that they always put patients first. Places such as Worcester university are leading the way: patients and families help to interview people who are applying to be nurses and health care assistants; they help to develop the content of courses so that they include what really matters to patients; and they take part in teaching students. Ministers should have spent the last three years championing such initiatives instead of reorganising the training structures as a result of the Health and Social Care Act 2012.

Individual patient voices are not the only ones that must be heard. We need a strong collective voice for users. The Francis

report recommended investing in patient leaders to speak out on behalf of the public, to help to design services locally, and to hold them properly to account. Ministers claimed that that is what Healthwatch would do, but their rhetoric is simply not matched by the reality: national Healthwatch has nowhere near the same power, authority or levers to change services as NHS England, the Care Quality Commission or Monitor.

Local Healthwatch bodies are also weak. They were late out of the starting blocks and are woefully understaffed. Last week, we heard that £10 million of the £40 million budget that was promised for local Healthwatch has gone missing, despite the explicit recommendation in the Francis report that

"Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch".

If Ministers are serious about giving patients a strong voice locally, they must look again at the support that Healthwatch is getting on the ground.

A strong patient voice is more essential than ever before because of the huge pressures on local services. Across the country, the NHS is struggling to cope with the increasing number of frail elderly people ending up in hospitals that were designed for a different age. Twenty per cent. of hospital beds have older people in them who need not be there if they had the right support in the community or at home. Half a million fewer people are receiving basic help to get up, washed, dressed and fed as council care budgets are cut to the bone. Mental health services, especially for children, are under intolerable strain as money for vital community services is being diverted to cope with pressures elsewhere in the system. This is not good for patients and families, it puts staff under pressure, and it ends up costing the taxpayer far more as people end up in more expensive hospital care or, in the case of mental health patients, being transported hundreds of miles around the country.

The NHS needs radical change, not to its back-room structures but to its front-line services and support. Improving safety and quality means that some services must be concentrated in specialist centres and others must be shifted out of hospitals into the community

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and towards prevention, fully integrated with social care. Under the previous Government, plans had been drawn up to reorganise services in every English region through Lord Darzi's next stage review, but rather than pushing forward with those plans and making the changes that patients want and need, Ministers scrapped them simply because they were developed under the previous Labour Government. Instead, they embarked on a huge back-room NHS reorganisation, wasting precious time, effort and resources.

As several hon. Members have said, the new NHS structures are utterly confusing, with no clear lines of accountability or responsibility. There are now 211 clinical commissioning groups, 152 health and wellbeing boards, 27 NHS England local area teams, four NHS England regional teams—I am not sure what they are doing—23 commissioning support units, and 10 specialist commissioning units, alongside Monitor, the Care Quality Commission and NHS England. Can you make sense of that, Mr Deputy Speaker? Who is providing the leadership? Who is to be held to account? Across the country, people are doing their contract negotiations for next year, trying to make changes to services, and they say to me that there is no clear leadership in the system. That must change.

We have heard a lot about changing the culture in the NHS. That culture is about behaviour and the millions of personal interactions that happen every single day in the NHS. Getting those right will not happen through regulation alone but by giving patients and the public a powerful voice in every part of the system. This issue has had too little attention since the Francis report was published. Crucially, the culture is about leadership, and leadership comes from the top.

I warn Ministers not to be complacent about saying that the bullying culture has gone. On Friday, I met the chief executive of a trust who showed me an e-mail from the NHS Trust Development Authority, which is quite close to Ministers' doors. I will not be able to say exactly what it said because it contained swear words, but it said, in effect: "Open the beep beds; just beep do it." That was in an e-mail to a chief executive. The bullying culture is still going on. Ministers need to get a grip, particularly on what is happening at the NHS Trust Development Authority, which is causing real problems in the system.

Grahame M. Morris: This is more pervasive than something that happens at the highest level. When members of my trade union, Unite, from the Yorkshire ambulance service raised legitimate concerns about the impact on the service of privatisation and de-skilling, the reaction of management was to de-recognise the trade union. That is outrageous.

Liz Kendall: This is not leadership; this is not what we want in our health service.

Real leadership is about setting a vision and working with staff and patients to make it happen. Yesterday Sir John Oldham published the report of his independent commission on whole-person care, which was drawn up with people who have worked in the system and sets out the reforms that we need to ensure that our NHS and care services are fit for the future. Across the NHS, patients and staff are crying out for clear leadership. Until we get this right, we will not really have learned the lessons from the failings of Mid-Staffs.

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6.19 pm

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): The publication of the Francis report was an incredibly humbling day for our national health service. It was humbling not just for those of us in this place who care about our NHS, but for the many staff who work tirelessly to look after patients and for everybody involved in looking after people as part of our health and care system.

The central plank of the report highlighted the fact that a culture had developed at Mid Staffordshire that was not in the best interests of patients. Targets and bureaucracy had got in the way of delivering high-quality care, and far too often the management of the trust did not listen to the concerns of patients or to the sometimes valid concerns of front-line members of

staff.

Robert Francis made a number of recommendations in his report. The Government accepted the principles of the report and we have made great progress in implementing many of the proposals, which I will come on to later.

It is important that all parts of our health and care system learn lessons from things that have gone wrong in our health service. Front-line staff need to learn lessons where appropriate and managers need to learn to listen and respond to the concerns of front-line staff. We need to create a culture that is open and learn how to put things right in the future in order to improve patient care. That is what good health care is about, whether someone works on the front line of the service or whether they are involved as a commissioner, a manager or a Minister.

There have been many good contributions to the debate and I will do my best to touch on as many of them as I can in the time available. In particular, there has been strong advocacy for the local NHS. I pay particular tribute to my hon. Friend the Member for Stafford (Jeremy Lefroy) for his work and tireless advocacy over many years—including before he became an MP and certainly during his time in this place—on behalf of his local patients and the local hospital and staff who look after them in Mid Staffordshire. Without his long-standing efforts and those of my hon. Friend the Member for Stone (Mr Cash), we would not be where we are today and that part of the world would be less better represented. Importantly, they are the people who have asked consistently the difficult questions and allowed us to get to our current position of not just tackling poor care at Mid Staffordshire and putting right the challenges that that has thrown up, but looking at how we can improve pockets of bad care elsewhere in our health and care system.

Most hon. Members have focused on two particular themes, the first of which is the need to learn lessons from the Francis inquiry into what happened at Mid Staffs, for the benefit of the wider health and care system. We heard some very good speeches, particularly from the right hon. Member for Rother Valley (Kevin Barron), my right hon. Friend the Member for Banbury (Sir Tony Baldry) and my hon. Friend the Member for Worthing West (Sir Peter Bottomley). They discussed the broader lessons that can be learned and the importance of an open culture, of supporting clinical leadership and of recognising that perhaps staff are the best advocates of what good-quality patient care looks like in our health system.

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In his constructive contribution, my hon. Friend the Member for Cannock Chase (Mr Burley) noted that the challenges and difficulties faced in Mid Staffordshire arose because the management in particular were blinded by targets, financial incentives and drivers, and lost sight completely of what matters most in a hospital at all times, which is delivering high-quality, good patient care. The biggest lesson we can learn, as my hon. Friend made clear, is that we need always to make sure that the delivery of high-quality care is the first and only driver of what happens on the ward. It should never be about meeting a financial target. Of course, the two are not always mutually exclusive, but in this case it is very clear that things went very badly wrong at that trust.

As was pointed out by the shadow Minister, the hon. Member for Leicester West (Liz Kendall), a significant speech was made by my right hon. Friend the Member for Sutton and Cheam (Paul Burstow), who talked about the importance of parity of esteem between mental health and physical health. He did a lot in his time in government, and he has always been a keen advocate of that. I know that he is very proud, as the Government are, that the 2012 Act has for the first time enshrined in law genuine parity of esteem between physical health and mental health. That was touched on by the Francis report, and the Government can be proud of doing that. As he will know, we have also invested £450 million in improving access to treatment in mental health services. I know that he took that forward in government, and he can be very proud of that record.

Paul Burstow: Through the Minister, may I pose a question to my hon. Friend the Minister of State who has responsibility for care services? He told us that Sir David Nicholson had issued a clarification about area teams not doing enough to deliver parity of esteem, but that has not materially changed how the finances are arranged, with money being taken away from mental health to pay for Francis delivery in acute care. Will that be addressed?

Dr Poulter: My right hon. Friend is absolutely right to say that the first step in addressing financial disincentives for mental health, which have been in the system for many years—in fact, for decades—was to establish parity of esteem in law. He helped to achieve what for the first time has been done under this Government. The next step is of course to make sure that other measures are in place to encourage and incentivise the system to spend money appropriately. Members on both sides of the House agree that we should take pressure off acute services, and nowhere is that more important than in mental health. It is important to invest in improving access to psychological therapies and talking therapies to support people, and to put in place early intervention for those with mental health problems. That is quite important, so the Government are investing money in it.

It is also important to collect proper data on mental health for the first time. For many years, data have not been collected effectively to ensure that we know what good mental services look like, but the Government will make sure that we can deliver that.

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Andy Burnham: I thoroughly agree with the Minister about collecting data on mental health so that we can make proper judgments about the quality of services, but why has the Department of Health scrapped the annual survey of expenditure on adult mental health services?

Dr Poulter: It is very difficult for me to stand at the Dispatch Box and take any lessons from the right hon. Gentleman and the previous Government on mental health issues. Only this Government have taken serious steps to improve parity of esteem and enshrine it in law, and only this Government are investing in mental health on the ground, with £450 million that is particularly focused on talking therapies. If the previous Government had any interest in mental health, they had 13 years to make investments and to improve data collection to drive better commissioning, but they took no steps towards doing that, and I am afraid that their record on mental health was abysmal and very poor. Unfortunately, patients paid the price for that.

We are very proud of our record on mental health, but it will take several years to turn around the fact that there was no parity of esteem in the past. Investment is now going in on the ground and things are being put in better order. My right hon. Friend the Member for Sutton and Cheam played his part in that, and the 2012 Act was a huge step forward in delivering those improvements.

I will try not to get drawn away from the topic of the Francis inquiry, Mr Deputy Speaker—we are talking about the broader health and care service—but I mentioned mental health, which we can be proud of, because it was mentioned by Francis in his report.

It is also important to talk about some of the wider lessons that can be drawn from the Francis inquiry. The right hon. Member for Cynon Valley (Ann Clwyd) and my hon. Friend the Member for Vale of Glamorgan (Alun Cairns) spoke particularly about the need, apolitically, to make sure that the whole of the United Kingdom draws such lessons. I have had very productive meetings with counterparts in Scotland, and Wales can also learn lessons about the importance of transparency and openness, and about recognising potential areas of poor care.

I hope that shadow Ministers will take up those matters with their counterparts in Wales, because such a situation can only be to the detriment of patients there. That is not a political point, but one about good care. It is important for us to deliver that in the system at the moment. It is also important because English patients are treated in Welsh hospitals. My right hon. Friend the Secretary of State is very excited about that point, which is why he is a very strong advocate of the needs of English patients and why he takes a particular and important interest in what happens in Wales, quite rightly drawing comparisons between the two systems.

Robert Francis found, as we have discussed, that individuals and organisations at every level of our health service let down the patients and families whom they were there to care for and protect. That was a systemic failure on the part of everyone concerned and cultural change was needed throughout the system. To prevent the same thing from ever happening again, the Government are changing the culture by requiring transparency and openness, by empowering staff and supporting strong leadership, and by embedding the patient voice and listening when something goes wrong.

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Joan Walley: I have listened carefully to the Minister's response to the various contributions that have been made throughout the debate since 1.15 pm. I hope that he will respond to the points that I made about the current situation in Mid Staffordshire and north Staffordshire before he goes on to the generalities of the Francis report. Does he accept that it was a bombshell when we heard last Wednesday that the recommendations of the trust special administrator had not been accepted in full? We are in a state of limbo. Will he tell the House what is the state of play of arrangements in north Staffordshire and Stafford? We need to know that and cannot deal with the uncertainty.

Dr Poulter: Again, I will not deviate from the general theme of the debate and try your patience, Mr Deputy Speaker. The recommendation of the trust special administrator was that consultant-led services were to be transferred away from Stafford and that there would be a midwife-led unit for Stafford. I am sure that Members on both sides of the House are great proponents of midwife-led units and of increasing the choice that is available. The Secretary of State has made it clear that he accepts the TSA recommendations in full and that local commissioners will have to do a health economy review to assess whether capacity is available elsewhere, before services are moved in the way that was envisaged by the TSA. The Secretary of State has asked NHS England to work with local commissioners to identify whether consultant-led obstetrics could be safely sustained at Stafford hospital. That only happened last week. We will update the House in due course and perhaps statements will be made by NHS England.

Joan Walley *rose—*

Dr Poulter: I have given a very helpful reply to the hon. Lady, but I will give way once more.

Joan Walley: I say to the Minister and the Secretary of State that the use of the phrase "in due course" causes great concern. The new arrangements need to be in place in September 2014. Any delay to the acceptance in full of the recommendations in the TSA report will cause great uncertainty. The Government need to show that they are doing what the Francis report recommended and leading by example. Will they do that in the case of north Staffordshire and Mid-Staffordshire?

Dr Poulter: We are leading by example. As I outlined, the Secretary of State has accepted the TSA recommendation in full. A process is now under way involving NHS England and local commissioners. That was initiated last week. It is important that those conversations happen and that an update is brought forward in a timely manner. That is the right thing to do. It is not appropriate to rush decisions and processes because of a political agenda, rather than an agenda of benefiting the local patients and women concerned. I am concerned as a doctor and as a Minister that we must do the best thing by patients. Rushed decisions are not always the best thing for patients, because conversations need to happen between local commissioners and NHS England. I hope that the hon. Lady will be a little patient, because I am sure that the right decision will be made in due course.

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There are three key areas in which the Government have taken forward the recommendations of the Francis inquiry: encouraging a culture of transparency and openness in the health care system; empowering front-line staff and encouraging good leadership in the NHS; and putting the patient at the heart of everything that the NHS does. As we have discussed, the patient was not at the heart of everything that was done at Mid Staffordshire for a period. That is why we have to learn the lessons and ensure, as best we can, that that cannot happen again.

On transparency and openness, it is important to highlight how we have already delivered on the recommendations of Robert Francis's report. The CQC has appointed three chief inspectors for hospitals, social care and general practice who will ensure not only that the organisation is complying with the law, but that the culture of the organisation promotes the benefits of openness and transparency. Importantly, we now have clinically led inspections for the first time, which means that people who

really understand what good care looks like will be in charge of the inspection process. That clinical leadership in the inspection process and at the heart of what the CQC does has to be of benefit to patients, and the Government are proud that we have delivered that.

We have also introduced a new statutory duty of candour on providers, which will come into force this year. It will ensure that patients are given the truth when things go wrong and that honesty and transparency are the norm in every organisation.

Kevin Barron *rose—*

Dr Poulter: The right hon. Gentleman might wish to intervene in a moment, but first I will respond to his good points on the importance of the duty of candour. There is some disagreement between us, because he said that there should be a duty on individuals. He will be aware from his time at the General Medical Council that there is already a duty on professionals to act in the best interests of patients and raise any concerns about the quality of care. As a body, the GMC has learned lessons from Mid Staffordshire and reviewed its processes, but it is important to recognise that many front-line professionals at Mid Staffordshire tried to raise concerns. The culture at the trust was such that those in management positions did not always listen to them. If we want to support whistleblowers and people's ability to speak out freely for the benefit of patients, that has to be done at organisational level. Health care professionals are already under a duty through their professional obligations, which I hope reassures the right hon. Gentleman.

The right hon. Gentleman has been in the House for many years and will remember that problems of people not being able to speak out freely in their organisations date back to the Bristol heart inquiry. Professor Kennedy, who oversaw that inquiry, noted that it was the cultural problem in that hospital provider that prevented people from speaking out. The problem was not that people were not prepared to speak out—they recognised their professional obligations; it was that there was a wish at a senior level not to recognise problems. That is what we need to tackle. We are now almost 15 years on from the Kennedy inquiry into Bristol—I was a law student at Bristol university at the time—and the NHS has perhaps

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not learned the lessons that it needs to. I am sure that putting a duty of candour on to NHS organisations will begin to get us where we need to be.

Kevin Barron: Will the Minister consider what I said about how an independent statutory commissioner could examine complaints about patients' care, as happens in New Zealand? Will he get back to me about whether he thinks that is a good idea? The people who work in the institutions that he is talking about have no faith that anything can be changed.

Dr Poulter: I will talk about complaints a little later, but the right hon. Gentleman has made some important points. When we consider how to improve the delivery of care in our health service, it is important that we examine international comparisons. The system in New Zealand includes a different form of compensation, and perhaps that is partly why it has a more open culture—there could be many other factors. It is acknowledged much earlier in the process that something has gone wrong, and there is a genuine attempt to explain the situation to the family and say sorry. That is what good health care is all about.

No matter how good, well trained and dedicated staff are, things will sometimes go wrong in a health service. When they do, it is important that we are open and honest with patients and that we do our best to put things right if we can, or explain and apologise if we cannot. That is why we believe that the duty of candour needs to exist at organisational level. Of course, I am happy to write to the right hon. Gentleman, or meet him if he would like to talk through some of the issues that he raised today. He makes good points, and I know that he does so on a completely apolitical basis because he has the best interests of the health service at heart. We might disagree on other issues, but on this one it is worth having a meeting to discuss his views further.

Subject to the passage of the Care Bill, a new criminal offence will be introduced to penalise providers who give false or misleading information where that information is required to comply with statutory or other legal obligations. It means that those directors or other senior individuals, including managers, who consent to, connive in, or are negligent regarding an offence committed by the provider could be subject on conviction to unlimited fines or even custodial sentences. We must ensure that managers and those running the health and care service in a health care provider provide information in an honest and transparent way that is always in the best interests of patients.

Importantly, we are introducing through the Care Bill a single failure regime to ensure that failure is not only about the financial sustainability of the trust, but about whether a health care provider is providing good care, and the quality of that care. One problem in the past with the trust special administration regime has been that it is rarely used. When it is used, however, it is important to ensure that it is there to protect patients. Often in the past it was used only in a way that focused on financial failure. One important lesson to learn from Mid Staffs is that there should be a failure regime that also considers quality of care. Hospitals are not just about good accounts; they are primarily about delivering good care, which is why we need a single failure regime.

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My right hon. Friend the Secretary of State has been a tremendous advocate for the importance of quality of care in trust, and he should be commended for that. Thanks to him, we are now ensuring that we improve the TSA regime in that way.

Mr Jenkin: The Minister is outlining the legislative and regulatory changes that arise from the Francis report, but does he agree with the Health Committee, which attaches far more importance to the leadership academy mentioned by my right hon. Friend the Secretary of State? Is not the quality of leadership much more important to the day-to-day care that is delivered throughout the health service, and will the Minister say a bit more about that?

Dr Poulter: I am not sure whether my hon. Friend has seen my brief, but that was exactly the point I was coming to. He is absolutely right and he highlighted the issue earlier in a strong contribution to the debate. It is important to empower front-line staff to be advocates for patient care and to take leadership roles in hospitals. Clinical leadership is at the core of everything that needs to be done, and we must promote strong leadership throughout a health care organisation, and throughout the

sector.

We amended the Enterprise and Regulatory Reform Act 2013 so that a person has the right to expect their employer to take reasonable steps to prevent them from suffering detriment from a co-worker as a result of blowing the whistle. That has supported clinical workers and front-line staff in raising concerns and as whistleblowers. We established the NHS Leadership Academy in 2012 as the national hub for leadership development and talent management. Since it launched its NHS fast-track executive programme in January, there have been more than 1,600 applicants. We are also introducing a new fit and proper person test for directors of registered health care providers, which will allow the CQC to insist on the removal of directors who are responsible for poor care. Those strong steps are in place, and there are others, which I would be happy to discuss another time with my hon. Friend, to embed not just clinical leadership but good leadership throughout our health and care services.

Importantly, in delivering high-quality care and embedding good leadership, we must focus much more on outcomes rather than targets. That goes to the centre of what Robert Francis said, and is led by good clinical leadership. What matters in the health service is that we deliver high-quality care based on good outcomes of care for patients, and we must listen to patients about what good care looks like. The Government are delivering those things, which are at the centre of what Robert Francis recommended as lessons to be learned from Mid Staffs.

Finally, I mention the important issue of embedding the patient voice and listening when things go wrong. As the shadow Minister outlined, the Government have introduced the friends and family test, through which nearly 1.6 million patients have already given instant, real-time, feedback to the NHS about their care. Patients are saying what their experience of care is like. It is not about ticking a box or meeting a target; patients are feeding back information and saying, “Yes my care was good” or “No, my care was not as good as it could have

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been, and this is how it could be improved.” Good care is about ensuring that we deliver clinical excellence through clinical leadership, listening to patients, and ensuring that we feed back their experiences into delivering better services and a better experience of care. Those are things the Government are doing.

Through the chief inspectors of hospitals, social care and general practice, we are putting proper clinical leadership into the inspection process. We are also ensuring that all feedback from patients, whether concerns voiced on the ward or complaints made once they are back at home, makes a difference. I pay tribute in particular to the work done by the right hon. Member for Cynon Valley on the complaints process, on which there were valuable lessons to be learnt. I thank her for her efforts, which have made a big difference. We are still working on further measures we can put in place to ensure that complaints are listened to. This is all about listening to patients, learning lessons and delivering better care.

We are proud of our record in government in listening to patients and ensuring that we develop proper clinical leadership. We are also proud that, as a result of the Francis report and the measures put in place by my right hon. Friend the Secretary of State, we are beginning to deliver much greater transparency in our health service. It is also important that we have that transparency in the back office. I disagree with what the shadow Minister said about not needing to reorganise the back room. We have to deliver more transparency, better procurement and improvements in how we run the hospital estate. If we do that properly, there will be more money to deliver high-quality patient care.

The coalition Government—I know the Minister of State, Department of Health, my hon. Friend the Member for North Norfolk (Norman Lamb), agrees with me strongly on this—want to see a more productive NHS that is patient-centred and does not waste money in the back office that should be spent on patient care. I make no apologies for organisational steps such as the removal of many of the bureaucratic processes in place under the previous Government, thus saving £1.5 billion a year already. That is good, because it means that more money goes to the front line to deliver high-quality patient care.

The 65th year of the NHS was perhaps its most challenging—certainly in recent memory. The Francis inquiry threw up many challenges for our health and care system, but I believe we are meeting those challenges. Our Government are ensuring that our NHS remains a health service of which we can all be proud, not just today but for many years to come.

Question put and agreed to.

Resolved,

That this House has considered the matter of the Francis Report: One year on.

UK Statistics Authority
1 Drummond Gate
London
SW1V 2QQ

Telephone: 0845 604 1857
E-mail: authority.enquiries@statistics.gsi.gov.uk
Website: www.statisticsauthority.gov.uk

Chair of the UK Statistics Authority, Andrew Dilnot CBE

Rt. Hon. Andy Burnham MP
House of Commons
LONDON
SW1A 0AA

4 December 2012

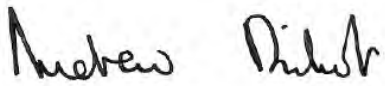
Dear Mr Burnham

PUBLIC EXPENDITURE ON HEALTH

Thank you for your letter dated 1 November regarding ministerial statements about public expenditure on health.

I have now completed my consideration of this matter. I have today written to the Secretary of State for Health, and I append a copy of my letter.

Yours sincerely



Andrew Dilnot CBE

UK Statistics Authority
1 Drummond Gate
London
SW1V 2QQ

Telephone: 0845 604 1857
E-mail: authority.enquiries@statistics.gsi.gov.uk
Website: www.statisticsauthority.gov.uk

Chair of the UK Statistics Authority, Andrew Dilnot CBE

Rt. Hon. Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
LONDON
SW1A 2NS

4 December 2012

Dear Mr Hunt

PUBLIC EXPENDITURE ON HEALTH

The Statistics Authority has been asked to consider, in the light of the published official statistics, various statements made by the Prime Minister, by yourself, and on the Conservative Party website. For example, you said in the House of Commons on 23 October that "real-terms spending on the NHS has increased across the country"[1] and the Conservative Party website states that "we have increased the NHS budget in real terms in each of the last two years".[2]

We are aware that there are questions of definition here. The year on year changes in real terms have been small and the different sources, including the Department of Health Annual Report and Accounts and the public expenditure figures issued by the Treasury, are not necessarily exactly the same.

The most authoritative source of National Statistics on the subject would seem to be the Treasury publication *Public Spending Statistics*, and I note that these figures were used in a Department of Health Press Release in July 2012. The most recent update to those figures was published on 31 October but the July 2012 release gives a more detailed breakdown. I attach a note prepared by staff of the Statistics Authority summarising some of the relevant figures from the two Public Spending releases.

On the basis of these figures, we would conclude that expenditure on the NHS in real terms was lower in 2011-12 than it was in 2009-10. Given the small size of the changes and the uncertainties associated with them, it might also be fair to say that real terms expenditure had changed little over this period. In light of this, I should be grateful if the Department of Health could clarify the statements made.

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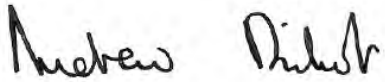
[1] HC Deb, 23 October 2012, c815

[2] http://www.conservatives.com/Policy/Where_we_stand/Health.aspx

I am copying this to the Cabinet Secretary, to the Permanent Secretary at the Department of Health and to the National Statistician.

Yours sincerely



Andrew Dilnot CBE

ANNEX - Public Expenditure on Health

Recent public debate about whether expenditure on health has been maintained in real terms has focused on the Total Departmental Expenditure Limits (DEL) for NHS (Health). NHS (Health) mainly covers expenditure by the Department of Health, much of which is used to fund the NHS in England, but also includes expenditure on the Food Standards Agency. These statistics were last published in *Public Spending Statistics July 2012*[3]. Table 1.8 of the bulletin presents the numbers in nominal terms, and table 1.9 presents the numbers in real terms (at 2011-2012 price levels). Table 1 below presents the published statistics from the July statistical bulletin along with the implied percentage changes in expenditure. The table shows real expenditure on NHS (Health) falling by 0.69 per cent between 2009-10 and 2010-11 and by 0.02 per cent between 2010-11 and 2011-12.

Table 1: Public Expenditure on NHS (Health); July 2012 estimates **£ million**

	2007-08	2008-09	2009-10	2010-11	2011-12
Total Departmental Expenditure Limits, nominal (table 1.8)	85,807	92,403	99,794	101,924	104,333
Percentage change in nominal expenditure		7.69%	8.00%	2.13%	2.36%
Total Departmental Expenditure Limits, real (table 1.9)	94,208	98,756	105,073	104,353	104,333
Percentage change in real expenditure		4.83%	6.40%	-0.69%	-0.02%

Source: *Public Spending Statistics July 2012*

HM Treasury published more recent statistics about public expenditure on 31 October 2012, in *Public Spending Statistics October 2012*[4]. This statistical bulletin only presents outturn budget expenditure in nominal terms, but also presents GDP deflators which can be used to convert the nominal expenditure into real terms. Table 2 below uses these GDP deflators to provide estimates of real expenditure on NHS (Health), at 2011-2012 price levels. The table shows that estimates for total nominal DEL (row 3) have not been revised since July for the years before 2010-11. The slight differences in the real expenditure estimates for these years (row 5) can be attributed to revisions to the GDP deflator. The table suggests that, on the basis of the most recently available statistics, real expenditure on NHS (Health) fell by 0.84 per cent between 2009-10 and 2010-11 and rose by 0.09 per cent between 2010-11 and 2011-12.

Table 2: Public Expenditure on NHS (Health), October 2012 estimates **£ million**

	2007-08	2008-09	2009-10	2010-11	2011-12
1. Resource DEL less depreciation (table 6)	81,838	88,033	94,611	97,638	100,483
2. Capital DEL (table 4)	3,969	4,370	5,183	4,159	3,787
3. Implied total Departmental Expenditure Limits, in nominal terms (1 + 2)	85,807	92,403	99,794	101,797	104,270
4. GDP deflator (2011-12 = 100) (Annex A)	91.095	93.581	94.989	97.715	100.000
5. Implied total Departmental Expenditure Limits in real terms (2011-12 prices)	94,195	98,741	105,058	104,177	104,270
6. Year on year per cent change in real expenditure on NHS (health)		4.83%	6.40%	-0.84%	0.09%

Source: *Public Spending Statistics October 2012*

Public Spending Statistics published by HM Treasury presents statistics on both a budgeting framework and on an expenditure on services basis. The budgeting framework provides information on central government departmental budgets, which are the aggregates used by

[3] http://www.hm-treasury.gov.uk/pespub_natstats_july2012.htm

[4] http://www.hm-treasury.gov.uk/9802.htm

the Government to plan and control expenditure. Budgets are divided into Departmental Expenditure Limits (DEL), which are firm plans for three or four years, and Annually Managed Expenditure (AME), which covers spending that is demand-led, less predictable and more difficult to control. Tables 1 and 2 above present statistics on the NHS (Health) that are based on the budgeting framework. Both the expenditure statistics and the GDP deflator estimates published by HM Treasury are subject to revision. So, future editions of *Public Spending Statistics* could show further changes to the estimates of real annual expenditure on NHS (Health).

The Rt Hon George Osbourne MP
Chancellor of the Exchequer

The Rt Hon Andrew Lansley MP CBE
Secretary of State for Health

4th July 2010

Dear Chancellor and Secretary of State

Final report of the Commission on Funding of Care and Support

I am pleased to enclose the final report of the Commission, and the supporting documents.

In the report, we outline our recommendations for reforming the adult social care system in England. We propose a new partnership between the individual and the state – one where individuals need to take reasonable and appropriate responsibility, but the state provides protection for those with the greatest needs.

We believe that the proposals we set out in our report meet the Terms of Reference we were set, and perform well against the criteria agreed with Government at the start of our work. We are recommending a way forward which we believe is fair, sustainable, and resilient – one which can be the basis of a long-term settlement. People would have choice over how to make their contribution, and our proposals are consistent with the drive for greater personalisation. There would be a much clearer offer from the state, allowing people to plan and prepare.

The combination of introducing a cap on an individual's care costs and raising the upper threshold in the residential care means-test would mean that instead of potentially losing almost everything, in future, no one would lose more than 30% of their assets. We expect new financial services products would emerge to offer people further protection of their assets.

In terms of value for money, our reforms will require extra state resources – just as any other form of shared responsibility model would. Any move from a means tested system (supporting only those with low means) to one which also focuses resources on those with the highest needs, will require increased public spending.

In our report, we set out the figures for the cost of our proposed long-term structural reforms. You will see that for a £35,000 cap (with a fixed general living cost contribution of £10,000) it would cost £1.7bn (based on 2010/11 prices). We are clear that extra state resources will be required in this area if we are to unlock greater private resources. Without the state taking on some of the risk, individuals will be unable to use their assets effectively and the involvement of the financial services

Skipton House, 80 London Rd, London SE1 6LH carecommission@dh.gsi.gov.uk

sector will remain limited. By spending this extra money, we believe that a new space is created for the financial services sector, and people will be encouraged to properly fund their care and invest resources earlier in their care journey. Individuals, families and carers will all have greater peace of mind and improved well-being.

The Commission has been clear from the outset (as set out in our input into last year's spending review) that the current system is in urgent need of greater resource. We welcome the commitment the Government demonstrated to social care in the spending review, but remain concerned that not all the additional resources seem to have found their way to social care budgets. In our report, we do not put a figure on the level of extra funding required for the current system today, although we do present evidence of a growing gap between demand and expenditure. We are of the view that the funding of the current system is a decision for the Government to take, year-on-year. However, without a properly resourced means-tested system the Commission is concerned that unmet need will continue to rise and further pressure could be put on other services, such as the NHS, and carers.

Over the course of our work we have engaged with many people and organisations, and have consulted extensively with third sector organisations and the financial services sector. I am confident that our proposals will receive broad, and widespread support.

It is now for the Government to consider our report, and the next steps. I would encourage you to move forward with pace. The system is in urgent need of reform. There have been many years of debate on how to take this forward; now is the time for action. I would be happy to continue to be involved in the process, should that be helpful.

I, and my fellow Commissioners, were delighted to be asked to advise on this important social policy issue. We are confident that our report sets out a way forward that is fair, effective and sustainable; and firmly believe that there is now a real chance of creating a system of which we can be proud.

I am copying this letter to my fellow Commissioners, Dame Jo Williams and Lord Norman Warner. I am also sending a copy of this letter and my report to the Prime Minister, Deputy Prime Minister, the Secretaries of State for Work and Pensions, Communities and Local Government, and Business, Innovation and Skills, the Chief Secretary, and Minister for Care Services.

Yours sincerely

Andrew Dilnot

Andrew Dilnot
Chair of the Commission on Funding of Care and Support

Skipton House, 80 London Rd, London SE1 6LH carecommission@dh.gsi.gov.uk

Accident waiting to happen

NHS check

ACCIDENT WAITING TO HAPPEN

Not safe in his hands: A&E under David Cameron

REVEALED: WORST WINTER IN THE NHS FOR ALMOST A DECADE AS CUTS, UNDER-STAFFING AND REORGANISATION LEAVE A&E SERVICES ON THE BRINK

Before the election, David Cameron said the NHS was safe in his hands. However, Accident and Emergency units have seen performance deteriorate significantly this winter. Labour has uncovered new evidence to show to patients are suffering delays at every stage of emergency:

- More ambulances missing 8 minute arrival target
- Patients waiting for hours in the back of ambulances
- More patients waiting more than four hours in A&E
- Patients waiting hours on trolleys for hospital beds

- **A&E waiting times are the worst in almost a decade and Government has missed its own reduced target for A&E patients for the last 17 consecutive weeks with only 94.7% of patients being seen within four hours so far this year**
- An extra 47,000 patients so far this winter have waited more than 4 hours in A&E compared to last winter, NHS data confirms
- **Over 100,000 extra patients have now waited longer than 4 hours for treatment in A&E since the start of the NHS 2012/13 year**
- Patients are waiting longer on trolleys – new year-to-date figures show an extra 23,000 waited longer than four hours on trolleys to be admitted than in 2011/12.
- **Delayed discharges from hospital have risen by 15% above 2010 figures**

- The health care regulator, the Care Quality Commission, has warned that 17 hospitals are under-staffed and cannot guarantee patient safety. 5,000 nursing jobs have been lost since David Cameron entered Downing Street.

The official figures are bad enough. But they do not tell the full story of the pressure on England's emergency service. A new survey by Labour of all ambulance trust reveals the scale of the chaos in A&E units

Key findings as follows:

- **An extra 10,400 patients were made to wait 30 minutes or more outside A&E units before being accepted by A&E compared with last winter – Paramedics warn of "dire" situation**
- Patients, in some areas, are being made to wait in ambulances for five over hours:
    - In Great Western Ambulance Trust a patient waited 5 hours and 42 minutes
    - In West Midlands Ambulance Trust a patient waited 5 hours and 5 minutes
    - In Southern Central Ambulance Trust a patient waited 4 hours and 56 minutes
- **With ambulances tied up in queues, fewer than 7 in 10 ambulances, in some regions, are reaching the most serious call outs within the 8 minute arrival time target**
- Paramedics warn services on brink of crisis:
    - ***"Families of sick people arrive at hospitals and expect to find them in a bed, but they are still outside in an ambulance. The frustration of ambulance staff is beyond belief"***

      Paramedic in the North East

- ***"Someone will die this winter as a result of no ambulance being available at the time of the emergency. It is not a matter of if, but when"*** Paramedic in Hertfordshire

Labour calls on David Cameron to:

- Ensure that every NHS trust is sufficiently staffed in order to provide safe care through the winter and develops a plan to bring all A&Es back up to national standards.
- Drop plans to close Lewisham A&E and other reconfigurations where a sound clinical case has not been made.

A&E

The NHS is in the midst of the worst winter in nearly a decade. This report now reveals new evidence that shows that the full picture of A&E services is much worse than official figures suggest.

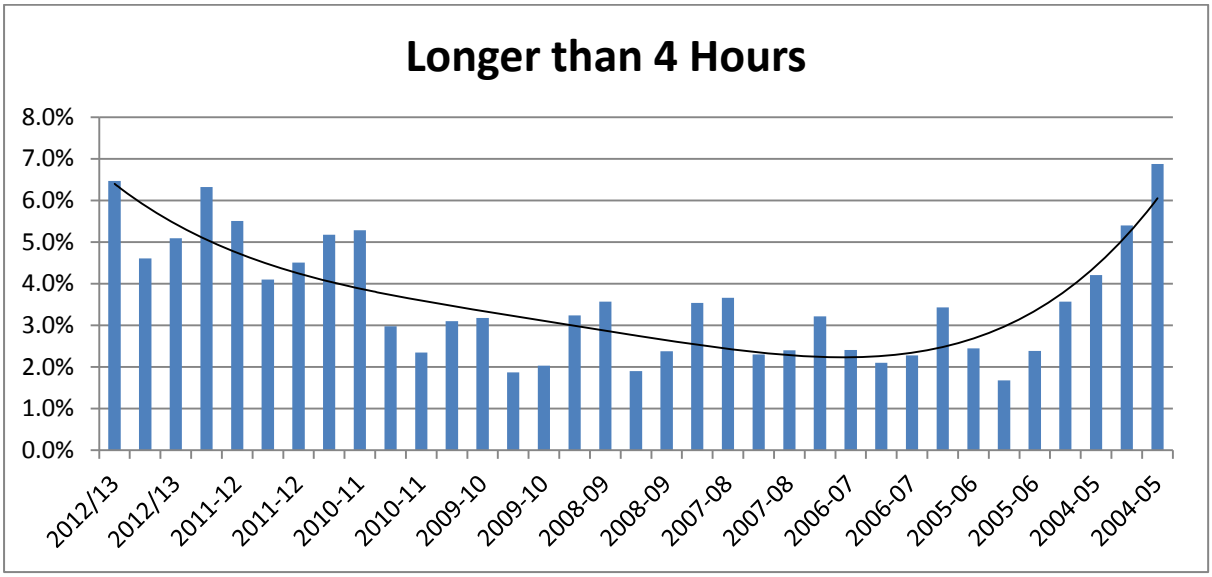
At every stage of a patient's journey, waiting times are getting longer. Patients have to wait longer for an ambulance to arrive; patients have to wait longer in ambulances, outside A&Es; patients have to wait longer in A&E before being treated; patients have to wait longer on trolleys before being admitted.

New evidence in this report shows a system that is under extreme pressure from all angles. A&E departments are now on the brink.

A&E waiting times are the worst in almost a decade

A&E performance is a key barometer of wider hospital performance and indeed the performance of the NHS. If they are staff shortages on the wards, pressure will back up to A&E.

Since the election, we have seen a marked decline in the percentage of patients being seen within four hours. The percentage of patients waiting longer than 4 hours in A&E has increased to levels not seen since 2003/04 and the trend shows that things are getting worse for patients. The trend line demonstrates this[1].



[1] Source: Weekly SitReps 2012/13 http://transparency.dh.gov.uk/2012/06/14/weekly-ae-sitreps-2012-13/

An extra 47,404 patients so far this winter have waited more than 4 hours in A&E compared to last winter, NHS data confirms

	Type 1 (Major Units)
Autumn/Winter 2011/12[2]	238,649
Autumn/Winter 2012/13[3]	286,053
Difference	***47,404***

This data shows the number of patients who have waited more than four hours from arriving at A&E to admission, transfer or discharge. This is a huge increase in the number of patients waiting longer than four hours (an increase of 20% on the previous year). This increase is unsustainable and is putting a major strain on services.

A Care Quality Commission report shows that 1 in 6 hospitals have inadequate staffing levels in A&E hospitals. A&E waiting times are a barometer of hospital performance as pressure anywhere in the hospital system creates a back up through A&E.

The national statistics show a worsening scenario, but there are many trusts that are underperforming these statistics. In some trusts, more than 1 in 4 patients are waiting longer than four hours. The table below shows the 10 worst performing trusts in the week ending 20th January 2013:

A&E attendances > 4 hours from arrival to admission, transfer or discharge	
Worst performing trusts in week ending 20/01/2013	**Percentage in 4 hours or less (type 1)**
North West London Hospitals NHS Trust	72.3%
Stockport NHS Foundation Trust	78.0%
University Hospitals Of Leicester NHS Trust	79.3%
Milton Keynes Hospital NHS Foundation Trust	82.5%
Brighton And Sussex University Hospitals NHS Trust	82.7%
County Durham And Darlington NHS Foundation Trust	83.5%
University Hospital Of North Staffordshire NHS Trust	84.2%
Buckinghamshire Healthcare NHS Trust	84.9%
University Hospitals Coventry And Warwickshire NHS Trust	85.0%
Ashford And St Peter's Hospitals NHS Foundation Trust	86.0%

[2] Week ending 25/9/2011 to week ending 8/1/2012
[3] Week ending 23/9/2012 to week ending 6/1/2013

102,216 extra patients have waited longer than 4 hours for treatment in A&E since the start of the NHS 2012/13 year. This is an increase of 18.5% on 2011/12

	A&E attendances > 4 hours from arrival to admission, transfer or discharge[4]			
	Type 1 Departments - Major A&E	**Type 2 Departments - Single Specialty**	**Type 3 Departments - Other A&E/Minor Injury Unit**	**All**
Weeks 1 to 42 2012/13	642,515	1,598	8,092	652,205
Weeks 1 to 42 2011/12	541,018	1,858	7,113	549,989
Difference	*101,497*	*-260*	*979*	*102,216*

This data reinforces the data already presented. More and more people are waiting more than four hours in A&E departments throughout England. This data is a real barometer of patient experience and the worsening data supports the anecdotal evidence that patients' experiences are deteriorating.

The data below shows the increased number of patients waiting on trolleys after being seen at A&E.

23,736 extra patients are waiting longer than four hours on trolleys waiting to be admitted

	Number of patients waiting more than four hours (but less than 12) from decision to admit to admission[5]
Weeks 1 to 42 2012/13	102,084
Weeks 1 to 42 2011/12	78,348
Difference	23,736

This demonstrates clearly that more people are being made to wait longer in A&E and afterwards are being made to wait longer before being admitted.

[4] Source: Weekly SitReps 2012/13 http://transparency.dh.gov.uk/2012/06/14/weekly-ae-sitreps-2012-13/
[5] Source: Weekly SitReps 2012/13 http://transparency.dh.gov.uk/2012/06/14/weekly-ae-sitreps-2012-13/

Delayed discharges from hospitals have risen by 15% above 2010 figures

Over the last two and a half years, the number of delayed discharges has increased by 15%. This is patients unable to leave hospital because there just aren't the services that they need available in the community. As such, the increase in the delayed discharging of patients has meant that resources are being diverted in order to care for them when services should be available to allow these patients to return home.

Year	Period	Acute[6]
2010-11	August	55,332
2012-13	December	63,743

This is compounded by the cuts to local services as a result of the reduction in council budgets. The National Audit Office has today published a report[7] detailing the level of expected cuts to social care services in local communities. As a result, the number of people who will have to remain in hospital due to a lack of community service will only continue to increase.

The statistics here show that the A&E departments throughout England are under pressure from every angle:

1. More people are waiting more than four hours to be seen
2. More people are waiting more than four hours to be admitted after the decision has been taken
3. More people are kept in hospital because there aren't services available to them outside of the hospital

New evidence obtained by Labour shows that the data above does not show the full extent of the pressure on the system. A Freedom of Information survey of all Ambulance Service Trusts in England has revealed some worrying trends. Some patients have had to wait in the back of an ambulance for over 5 hours after arriving at A&E before they can join the queue to be seen.

[6] The figure is by comparing the figures for December 2012 to August 2010 (this is when the data was first collected). These figures are for 'acute delays' and can be found here: http://transparency.dh.gov.uk/2012/07/11/delayed-transfers-of-care-2012-13/

[7] http://www.nao.org.uk//idoc.ashx?docId=45a00b55-dbc9-4281-88b8-cddef919b1db&version=-1

An extra 11,138 patients were made to wait 30 minutes or more outside A&E units before being accepted by A&E compared with last winter

The Department of Health have published weekly Situation Reports for the performance of key indicators in the NHS through winter.

One of these key indicators is the number of ambulances queuing for 30 minutes or more outside of A&E unable to transfer their patients into the hospital. The table below shows the figures comparing winter 2011/12 with winter 12/13:

Dates[8]	**Number of Ambulances queuing**[9]
30 November 2012 to 20 January 2013	42,950
2 December 2011 to 22 January 2012	31,812

This shows that this winter there were 11,138 more ambulances waiting over 30 minutes outside A&E departments. This is an increase of 35% from the year before.

At Health Questions on 15 January 2013[10], Dr Dan Poulter MP, Parliamentary Under-Secretary of State for Health, responded to a question in parliament on ambulance delays. He called the practice unacceptable and yet the statistics show it is getting worse on his Government's watch.

This extra 11,138 ambulances queuing for more than 30 minutes equates to an extra 214 patients every day waiting for longer for treatment. This is in addition to the waiting longer to be seen once inside A&E departments. This trend is unsustainable and A&E departments need to have the staffing levels to allow them to cope with number of patients that require treatment.

[8] Time periods are different as Department of Health data is aggregated at weekends and so a comparable time period has been chosen i.e.52 days long starting and ending on weekends

[9] Data taken from Daily SITREP reports published at http://transparency.dh.gov.uk/2012/10/26/winter-pressures-daily-situation-reports-2012-13/

[10] House of Commons Hansard, 15 January 2013, Column 729

Patients, in some areas, are being held in the back of ambulances outside A&Es for more than 5 hours

New data obtained by the Labour Party have shown that some patients are waiting for hours in the back of Ambulances because of the lack of capacity at A&E departments.

Freedom of Information requests from Ambulance Trusts[11] have revealed the longest wait experienced by a patient before being able to enter A&E from arriving there:

Trust Name	Longest wait experienced by a patient
West Midlands Ambulance Service NHS Trust	5 Hours, 5 Minutes - Solihull
Southern Central Ambulance Service NHS Trust	4 Hours, 56 Minutes
South West Ambulance Service NHS Trust	3 Hours, 38 Minutes
Yorkshire Ambulance Service NHS Trust	3 Hours, 48 Minutes
East Midlands Ambulance Service NHS Trust	2 Hours, 53 Minutes
Greater West Ambulance Service NHS Trust	5 Hours, 42 Minutes
London Ambulance Service NHS Trust	2 Hours, 34 Minutes

These numbers are not included in A&E waiting times data. This means that patients have to wait for up to nearly six hours before being discharged into A&E and then they have to wait in A&E until they are treated. This shows that the increase in A&E data does not show the full story of patient experience i.e. patients are waiting for longer and longer to get into A&E and then have to wait longer and longer in A&Es.

Paramedics and other staff are concerned about the state of the service that they are able to offer. One paramedic in the North East said:

"Somebody is going to die somewhere down the line and it could be the most vulnerable, children. Families of sick people arrive at hospitals and expect to find them in a bed, but they are still outside in an ambulance. The frustration of ambulance staff is beyond belief"[12]

Another paramedic in Hertfordshire said:

"I can only see things becoming more dire. Someone in South Hertfordshire will die this winter as a result of no ambulance being available at the time of the emergency. It is not a matter of if, but when"[13]

[11] Freedom of information requests were submitted to 11 Ambulance trusts. Responses were received from 7

[12] http://www.darlingtonandstocktontimes.co.uk/news/10158697.Anger_over_queues_of_ambulances_outside_hospitals/?ref=twtrec

[13] http://www.stalbansreview.co.uk/news/10141519.Paramedic_says_ambulance_service_is_in__state_of_collapse_/

In some regions, fewer than 7 in 10 ambulances are reaching the most serious call outs within the 8 minute target

Ambulances are expected to arrive at 75% or more Category A (most serious) call outs within 8 minutes of being called. Some Ambulance services throughout the country are failing to meet this standard:

Trust Name	Percentage of ambulances reachi Cat. A call outs within 8 minutes	Change from previous year
Southern Central	74%[14]	No Change
Yorkshire	68.5%[15]	**Down 4%**
East Midlands	69%[16]	**Down 4%**
London	67%[17]	**Down 5%**

Because more ambulances are being made to queue outside hospitals with patients, it means there are fewer available to respond to emergencies. As a result, trusts throughout England are unable to meet their response targets for the most serious call outs.

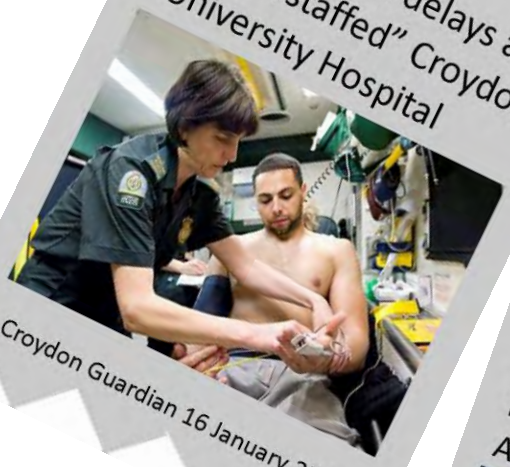
[14] Data supplied from FOI response is from 1st November to most recent data available. Southern Central did not indicate the most recently available date from which the data was drawn.
[15] This data is taken from the figures supplied by the FOI response and is data for December 2012
[16] Data range: 1st November 2012 to 31st December 2012
[17] Data range: 1st December 2012 to 18th December 2012

These are pressures that are being felt throughout the country. Local newspapers are full of examples of stories of ambulances queuing:

Wait for Ambulances putting lives at risk

Royston Weekly News: Thursday January 10 2013

Surge in A&E delays at "understaffed" Croydon University Hospital



Croydon Guardian 16 January 2013

Paramedic in Hertfordshire says East of England Ambulance Service is in 'state of collapse'

St Albans and Harpenden Review 4 January 2013

Dozens of Patients treated in Hospital car parks as A&Es stretched to limit

Manchester Evening News, 7 January 2013

Patients waiting up to two hours as ambulances queue outside hospitals

The Northern Echo 14 January 2013

Anger over queues of ambulances outside hospitals

Darlington and Stockton Times, 13 January 2013

Conclusion

This report paints a picture of overstretched and understaffed A&Es having a serious knock on effect on ambulance services.

Patients are waiting hours in A&E or being held up in ambulance queues outside. Ambulances are failing to reach the most serious call outs within the 8 minute target and paramedics are warning that services are on the brink.

The first priority for David Cameron must be to ensure all A&Es can provide safe care.

The CQC's state of care report from December found that 16% of hospitals had failed to meet the CQC standard of having adequate staffing levels. The report warned that: "Ensuring there are enough staff to provide a good service is a significant issue in many services."[18]

Labour calls on David Cameron to ensure all A&E are sufficiently staffed in order to provide safe care through the winter and develop a plan to bring all A&Es back up to national waiting time standards.

Secondly, rushed reconfigurations are being brought forward across the country without sufficient regard for A&Es and other services.

There is growing evidence of hospitals destabilised as they find it harder to function and stand on their own two feet following the reorganisation. Financial concerns are taking precedence over clinical issues, as we are seeing in Lewisham where an A&E unit is being closed through a back-door reconfiguration to solve the financial problems of a neighbouring trust.

If any A&E is to be closed it is essential that a full clinical review takes place. No A&E should be closed on cost grounds alone.

Labour calls on David Cameron to drop plans to close Lewisham A&E and any others where a sound clinical case has not been made.

[18] CQC State of Care Report 2012 http://www.cqc.org.uk/media/cqc-launch-state-care-report-2012

Seventh National GP Worklife Survey

Mark Hann[1], James McDonald[2], Kath Checkland[3], Anna Coleman[3], Hugh Gravelle[4], Bonnie Sibbald[5], Matt Sutton[2]

[1] Centre for Biostatistics, Institute of Population Health, University of Manchester
[2] Manchester Centre for Health Economics, Institute of Population Health, University of Manchester
[3] Health Policy, Politics & Organisation (HiPPO) research group, Centre for Primary Care, Institute of Population Health, University of Manchester
[4] Centre for Health Economics, University of York.
[5] Centre for Primary Care, Institute of Population Health, University of Manchester

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Correspondence

Correspondence about this report should be addressed to Matt Sutton, Room 1.304, Jean McFarlane Building, The University of Manchester, Oxford Road, Manchester, M13 9PL. Email: matt.sutton@manchester.ac.uk

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Executive summary

National surveys of GPs' working conditions and attitudes to primary care reforms were undertaken by the National Primary Care R&D Centre in 1998, 2001, 2004, 2005, 2008 and 2010. We undertook the seventh survey in this series in the autumn of 2012.

The surveys provide a consistent series over a long period on GPs' job satisfaction, stressors, hours of work and intentions to quit. Each survey has a nationally-representative, cross-sectional element and a longitudinal element. In 2012, there were 1,189 respondents in the cross-sectional element and 2,015 respondents in the longitudinal element. This report provides key findings from the survey and makes comparisons with previous surveys.

Clinical commissioning

Thirteen percent of respondents had a formal role at Clinical Commissioning Group (CCG) level and a further fifteen percent stated that they were their practice's commissioning lead. The majority of respondents agreed that GPs added value to pathway/service design, needs assessment, improving relationships with providers and contract negotiations/monitoring. However, respondents were divided on whether commissioning was part of their role as a GP. Respondents expressed concerns about the impact that CCG introduction had had on their personal workloads, the time that they could spend on direct patient care and continuity of care. Respondents also reported that the introduction of CCGs had led to decreases in referrals and practice prescribing, and increased integration between primary and secondary care. Seventy-seven percent of respondents stated that their practice was a member of the most appropriate CCG. Sixty-eight percent of respondents thought that practice income should not be related at all to CCG performance.

Job satisfaction

The level of overall job satisfaction reported by GPs in 2012 was lower than in all surveys undertaken since 2001. On a seven-point scale, average satisfaction had declined from 4.9 points in 2010 to 4.5 points in 2012 in both the cross-sectional and longitudinal samples. This change is robust to the changing age-sex composition of GPs, which has remained relatively stable in recent years. The largest decreases in job satisfaction between 2010 and 2012 were in the domains relating to 'hours of work' and 'remuneration'. The changes were much smaller in the other specific domains of job satisfaction.

Hours of work

Respondents to the 2012 survey reported working an average of 41.7 hours per week. This is a small increase (0.3 hours) compared to the 2010 survey. The percentage of GPs who indicated that they worked at least one weekday evening session in a typical week had changed very little (58% in 2012; 57% in 2010), but the percentage who indicated that they worked at least one weekend session in a typical week had declined considerably (from 15% in 2010 to 10% in 2012). There was no change between 2010 and 2012 in the proportion of GPs reporting undertaking out-of-hours work: in 2012, 21% did so, for a median of 4 hours. Fewer GPs reported that their practice offered extended hours access at the weekend (32%) and on weekdays (76%) than in 2010. Respondents also reported devoting a similar percentage of their time to direct patient care (62%) as in 2010.

Stressors and job attributes

In 2012, as in 2010, GPs reported most stress due to 'increasing workloads' and 'paperwork' and least stress due to 'finding a locum' and 'interruptions from emergency calls during surgery'. Reported levels of stress increased between 2010 and 2012 on all 14 stressors, generally by 0.2-0.4 points on a five-point scale. Reported levels of stress are now at their highest since the beginning of the National GP Worklife Survey series in 1998.

Many attributes of GPs' jobs had changed very little between 2010 and 2012. In 2012, the proportion of respondents reporting that they 'have to work very intensively' was 95% and 84% reported that they 'have to work very fast'. Fewer than 10% thought that recent changes to their job had 'led to better patient care'. However, 83% stated that their job 'provides me with a variety of interesting things'.

Intentions to quit

The proportion of GPs expecting to quit direct patient care in the next five years had increased from 6.4% in 2010 to 8.9% in 2012 amongst GPs under 50 years-old and from 41.7% in 2010 to 54.1% in 2012 amongst GPs aged 50 years and over.

Conclusion

The 2012 survey reveals the lowest levels of job satisfaction amongst GPs since before the introduction of the new contract, the highest levels of stress since the start of the survey series, and a substantial increase over the last two years in the proportion of GPs intending to quit direct patient care within the next five years.

Background

The National Primary Care Research & Development Centre undertook postal surveys of General Practitioners' working lives in 1998 (Sibbald et *al.*, 2000), 2001 (Sibbald et *al.*, 2003), 2004 (Whalley et *al.*, 2005, 2006a), 2005 (Whalley et al., 2006b, 2008), 2008 (Hann et al., 2009) and 2010 (Hann et al., 2011). The seventh in this series was undertaken in the autumn of 2012.

This series of questionnaires spans over a decade and continues to provide a unique resource for tracking long-term trends, as well as identifying the key policy and environmental issues impacting on GPs' working lives.

The 2012 survey performed a number of important functions:

- to contribute to the ongoing tracking of GPs' satisfaction and pressures at work through a series of primary care reforms;
- to provide further evidence on trends in GPs' hours, activities and intentions to quit general practice; and
- to gauge GPs current involvement in, and opinions on, clinical commissioning, at the point where CCGs were being established in shadow form and prior to their role in commissioning coming into effect formally from April 2013.

Methods

The data were collected via a postal questionnaire survey administered to a sample of GPs between September and November 2012.

Target sample

The target sample consisted of GP providers, salaried GPs and GP retainers practising in England. Data were obtained from:

- the annually collated General Medical Services (GMS) Statistics database maintained by *The Information Centre for health and social care*[1] (containing GMC number, age, gender and contract status of all GPs in contract with the NHS in England as of 1st October each year); and
- NHS Prescription Services data available from Connecting for Health (at http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/genmedpracs), which records contact data for current (and historical) GP prescribers.

Following the methodology employed in previous surveys, two samples of GPs were drawn from the subset present on both the 2011 GMS Statistics database and the prescriber list:

1. A cross-sectional sample – a random sample of 3,000 GPs, excluding GP registrars, representing approximately 1/12th of the GP population;

2. A longitudinal sample of 3,280 GPs who responded to: the 2010 survey (2,350 GPs); the 2008 survey but not the 2010 survey (855 GPs); or to all three of the surveys conducted in 2001, 2004 and 2005 (75 GPs).

The random sample of 3,000 GPs was drawn first. Those GPs eligible for the longitudinal sample but not already selected as part of the random sample (2,984 GPs) were added to form the overall study sample. After removing 'duplicate records' (e.g. individual GPs holding more than one contract for whom two had been selected), the final total target sample contained 5,973 GPs.

[1]

Response rate

Reminders were sent at three and six weeks after the initial mailing. Each mailing included a covering letter, the survey questionnaire and a reply-paid envelope. Respondents were asked to return the questionnaire blank if they did not wish to participate and wanted to avoid receiving reminders.

The response rate in the cross-sectional survey was 40% (1,189 of 2,995: up on the 36% achieved in the 2010 survey) and in the longitudinal sample was 62% (2,015 of 3,274: also up on the 59% achieved in the 2010 survey).

Some of the questionnaires were completed by a different GP to whom the invitation was addressed. Cross-referencing the age and gender reported by the respondent with that of the intended recipient recorded on the GMS Statistics database suggested that 251 of 1,167[2] questionnaires in the cross-sectional sample (21.5%) were completed by a different GP than the GP to whom the letter was addressed. Proportionately, this happened more frequently in the cross-sectional element of the survey than the longitudinal element (15.2%; 301 of 1,984[3]).

The achieved samples in previous GP satisfaction surveys have been reasonably representative of the entire GP populations at those times. Adjustments for observed differences between the achieved samples and the populations have made little difference to key statistics. Furthermore, while previous surveys have shown an inverse relationship between average satisfaction and response rates, previous analysis has shown that this relationship does not lead to bias in the estimated changes in mean satisfaction or in the estimated effects of the determinants of satisfaction (Gravelle, Hole and Hussein, 2008).

The age, gender and contract type compositions of the entire GMS database and the cross-sectional sample of respondents are summarised in Table 1. There is good representation of all groups. However, respondents aged between 50 and 59 are over-represented compared to the entire GP population, whilst other age groups are under-represented, especially the very youngest (under 35 years) and very oldest (60 years and over) groups. Respondents are more likely to be GP providers than in the GP population.

[2] 22 questionnaires had missing age and/or gender.
[3] 31 questionnaires had missing age and/or gender.

Table 1: Representativeness of the cross-sectional element of the survey

	All GPs (2011 – excl. Registrars)	2012 Worklife Survey Respondents
N	34,245	1,189
Age (years)		
< 35	4,026 (11.8%)	89 (7.7%)
35 – 39	5,253 (15.3%)	161 (13.9%)
40 – 44	5,149 (15.0%)	147 (12.7%)
45 – 49	6,130 (17.9%)	190 (16.4%)
50 – 54	6,056 (17.7%)	285 (24.7%)
55 – 59	4,191 (12.2%)	209 (18.1%)
60 +	3,440 (10.0%)	75 (6.5%)
Gender		
Male	18,621 (54.4%)	631 (54.6%)
Female	15,624 (45.6%)	525 (45.4%)
Contract type		
Provider	26,827 (78.3%)	996 (86.2%)
Other + Locum	7,418 (21.7%)	160 (13.8%)

Note: Information on age and/or gender and/or contract type was missing for 33 respondents.

Samples analysed

Depending on the focus of the analysis, we use different samples throughout this report: (i) the cross-section sample only; (ii) the longitudinal sample only and (iii) a pooled sample, representing all respondents to the 2012 survey. The sample used for each table is indicated in the table notes. In general, where a question has been asked in previous surveys, and the primary purpose is to compare a representative sample of GPs in 2012 with a representative sample in earlier years, we include only the 1,189 respondents in the cross-sectional sample in 2012. Where possible we complement this analysis with analysis of the same individuals over time, using the 2010-2012 longitudinal sample. This serves to assess the robustness of the findings from the comparison of two repeated cross-sections and provides more detailed consideration of how the distributions of the variables have changed over time. Where a question has not been asked in previous surveys, and the primary purpose is an accurate representation of the current situation, we present figures based on all available responses from the pooled sample (e.g. in the clinical commissioning section).

Questionnaire content

To permit tracking of long-term trends, many of the questions used in the 2012 survey were the same as those used in previous surveys. The questionnaire contained sub-sections covering: personal, practice, job and area characteristics; job stressors; job attributes;

intentions to quit or retire; job satisfaction; clinical commissioning; and the GPs' role in patient health, work and wellbeing. The main content is outlined below.

Personal, practice, job and area characteristics

Questions included: age; sex; contract type; estimated hours of work (during surgery hours and out-of-hours); estimated allocation of time between direct and indirect patient care and administration; and practice size (numbers of doctors, nurses and patients).

Job stressors

Respondents were asked to rate the amount of pressure they experience from each of 14 potential sources of job stress on 5-point response scales.

Job attributes

GPs were asked to indicate the extent to which they agreed or disagreed (on a 5-point scale) with 15 statements relating to their job control, workload, job design and work pressures.

Intentions to quit or retire and other changes in work participation

GPs were asked about the likelihood (rated on a 5-point scale) that they would make certain changes in their work life within five years, including: increasing work hours; reducing work hours; leaving direct patient care; and leaving medical work entirely.

Job satisfaction

Job satisfaction was measured with the reduced version of the Warr-Cook-Wall questionnaire that has been used in previous surveys. This asks about nine individual domains of job satisfaction as well as satisfaction overall. Each item in the measure is rated on a 7-point scale, ranging from 'extremely dissatisfied' (score=1) to 'extremely satisfied' (score=7).

Clinical commissioning

GPs were asked about their current involvement in clinical commissioning and any previous involvement in GP-led commissioning. They were also asked about the added value that GPs bring to commissioning and how the introduction of clinical commissioning groups had impacted on them and their patients locally.

GPs' role in patient health, work and wellbeing

This section of the questionnaire was developed for the 2010 survey in conjunction with policy customers in the Health Work and Well-being Delivery Unit, led from the Department for Work and Pensions. The 19 items selected relate to GPs' views on: the relationship of work to health; GPs' role, training and confidence in supporting patients with health problems into work; their views on the fit note; and the availability of services to support patients into work. The findings from this section of the questionnaire are available in a separate report (Hann and Sibbald, 2013).

Clinical Commissioning

Current commissioning involvement

GPs were asked whether they currently had a role within the Clinical Commissioning Group (CCG) to which their practice belonged. Of 2,930 respondents, 383 (13%) reported having a formal role at CCG level (e.g. Office Holder; Committee Member; Workstream Lead). A further 441 GPs (15%) reported that they were commissioning lead for their practice (but did not have a formal role at CCG level).[4] These 824 GPs were asked to report how many hours per week, on average, they spent on this role: the reported median was 3 hours [IQR = (2, 8) hours; based on 598 responses].

Of those with a formal role, 114 (29.8%) were female. Of those who were their practice's commissioning lead, 136 (30.9%) were female. Overall, 34.4% of males have a CCG role versus 20.0% of females. GPs aged fifty years or over were the group most likely to have either a formal role (14.2%) or be their practices' commissioning lead (16.0%), compared to both GPs aged under 40 years (10.9% and 10.4% respectively) and GPs aged 40 to 49 years (12.1% and 15.5% respectively).

Over half of respondents (51%; N = 1,460) reported that another GP in their practice had a formal role at CCG level. GPs aged under 40 years were most likely to do so (55.2%), whilst GPs aged fifty years or over were least likely (49.4%). Only 2% (N = 58) reported that they did not know whether another GP in their practice had a formal role at CCG level.

When asked about their future involvement in clinical commissioning, less than 1 in 10 of GPs (9%; N = 252) indicated that they would like a formal role at CCG level in the future. Eight-three percent (N = 2,298) said that they did not want a formal role in the future, and 8% (n = 231) reported being undecided. GPs aged under 40 years gave the most positive response: 14.3% expressed their desire for such a role, compared with 7.4% of GPs aged 40 to 49 years and 8.7% aged fifty years or over.

Previous commissioning involvement

GPs were asked about leadership roles that they had held in previous forms of GP-led commissioning (Table 2). Of 2,930 respondents, previous involvement with Practice Based

[4] 23 GPs reported having both roles and are classified as having a formal role.

Commissioning (18.6%) and Primary Care Groups (16.0%) was most common. Only 46 GPs (1.6%) indicated that they had previously had a leadership role in Total Purchasing Pilots.

Table 2: Leadership Role in Previous Forms of GP Commissioning

Practice Based Commissioning	18.6%
Primary Care Groups	16.0%
Fundholding (inc. Community Fundholding)	13.9%
Primary Care Trusts	12.0%
Alternatives to Fundholding (e.g. Locality Commissioning)	7.0%
Total Purchasing Pilots	1.6%

Based on responses from the 2012 combined cross-sectional and longitudinal samples (N = 2,930).

Opinions on clinical commissioning

More than two-thirds of respondents (68%) thought that practice income should not be related to CCG performance at all. Twenty percent of GPs thought that up to 5% of practice income was an appropriate figure. Only 3% of respondents thought that in excess of 10% of practice income should be related to the performance of CCGs.

More than three-quarters of GPs (77.1%) agreed that their practice was a member of the most appropriate CCG: only 3.9% disagreed, whilst 5.8% were uncertain.

GPs were 'split' as to whether commissioning was part of their role; 36.6% agreed to some extent whilst 41.0% disagreed to some extent. The percentage in agreement varied by age with GPs aged fifty years and over most likely to disagree to some extent (under 40 years = 34.3%; 40 to 49 years = 40.7%; fifty years or over = 42.6%). GPs aged under 40 years were the most likely to neither agree nor disagree. Table 3 shows respondents' views on the added value of GP involvement in clinical commissioning. The majority of respondents agreed to some extent that GPs added value to pathway and service design (86.7%), needs assessment (70.4%), improving relationships with providers (64.8%) and contract negotiation and monitoring (57.8%). Only a small minority of respondents disagreed with these statements or stated that they did not know if GPs added value.

Table 3: Views on the added value of GP involvement in clinical commissioning

	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know
Commissioning is part of my role as a GP	15.3	25.8	21.2	28.9	7.8	1.1
GPs add value to needs assessment	2.5	5.4	18.0	53.0	17.4	3.7
GPs add value to pathway/ service design	1.5	1.7	8.3	53.8	32.9	1.8
GPs add value to contract negotiation & monitoring	4.3	12.8	21.7	39.9	17.9	3.5
GPs add value to improving relationships with providers	3.2	6.7	21.5	44.6	20.2	3.8
My practice is a member of the most appropriate CCG	1.3	2.6	13.2	42.7	34.3	5.8

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N = 2,903 – 2,918.

Table 4 shows respondents' views on how the introduction of CCGs has affected aspects of their job, their patients and the local health economy. The vast majority of GPs (82.4%) indicated that their overall workload had increased to some extent following the introduction of CCGs. Only 6 respondents reported a decrease in their workload.

GPs were most likely to report that CCGs had not changed other aspects of their job, the care they provided, their patients and the local health economy. However, those who did report changes in these dimensions were likely to report a decrease rather than an increase in: the time they spent on direct patient care (35.2% decreased vs. 12.8% increased), the number of referrals they make (37.1% vs. 4.2%), practice prescribing expenditure (39.8% vs. 5.7%) and continuity of care for patients (31.8% vs. 8.8%). A greater percentage of GPs reported an increase rather than a decrease in the integration of primary and secondary care (22.2% vs. 17.6%).

Table 4: GPs views on the introduction of Clinical Commissioning Groups

To what extent have CCGs affected …	decrease a lot	decrease a little	no change	increase a little	increase a lot	don't know
Your overall workload	0.1	0.1	15.1	37.7	44.7	2.3
Time spent on direct patient care	6.0	29.2	49.9	8.3	4.5	2.1
Number of referrals made	2.0	35.1	56.3	3.3	0.9	2.4
Level of practice prescribing expenditure	3.4	36.4	49.2	4.6	1.1	5.4
Integration of primary and secondary care	6.6	11.0	54.3	20.6	1.6	6.0
Continuity of care for patients	10.0	21.8	54.5	7.8	1.0	5.0
Health inequalities	2.3	8.6	68.5	8.1	4.0	8.5

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N = 2,903 – 2,916.

Views on clinical commissioning by current CCG role

The views of the 383 GPs with a formal role at CCG level were compared with those of the 441 practice commissioning leads and, where applicable, the 2,106 respondents who reported having neither role.

Those GPs with a formal role reported spending a median of 6 hours per week on this role [IQR = (3, 12) hours; based on N = 364], whilst practice commissioning leads reported spending a median of 2 hours per week on this role [IQR = (1, 3) hours; based on N = 234].

GPs currently in a formal role were more likely to have had leadership roles in all previous forms of GP-led commissioning (Table 5). For example, 58% had such a role in Practice-Based Commissioning, compared to 29.3% of current practice commissioning leads and just 9.2% of GPs currently with neither role.

Table 5: Previous Leadership Roles in GP-led Commissioning by Current Role

	Formal Role at CCG level	Practice Commissioning Lead	Neither Formal nor Practice Lead
Practice Based Commissioning	58.0%	29.3%	9.2%
Primary Care Groups	40.7%	19.7%	10.7%
Fundholding (inc. Community Fundholding)	25.6%	17.0%	11.1%
Primary Care Trusts	37.1%	14.1%	7.0%
Alternatives to Fundholding (e.g. Locality Commissioning)	19.6%	8.6%	4.4%
Total Purchasing Pilots	5.5%	0.5%	1.1%

Percentages are based on "Yes" responses from the 2012 combined cross-sectional and longitudinal samples.

Over half of the GPs currently in a formal role at CCG level (51%) expressed a desire to continue with this role in the future. However, this sentiment was not so popular amongst current commissioning leads (9% wanted a future formal role) or GPs with neither role (3% wanted a future formal role).

Table 6 shows respondents' views on the added value of GP involvement in clinical commissioning by current CCG role. GPs with a formal role at CCG level were the most likely to agree to some extent (and, in particular, strongly so) that commissioning was part of their role as a GP; 76.3% responded in this way, compared to 50.1% of GPs who were practice commissioning leads and 26.6% of GPs who held neither position.

Respondents with a formal role were also most likely to agree to some extent and, in particular, strongly agree, that GPs added value to pathway and service design, needs assessment, improving relationships with providers and contract negotiation and monitoring. Again, practice commissioning leads were more likely to agree to some extent than GPs in neither role.

More than two-thirds of GPs with a formal role (67.2%) strongly agreed that their practice was a member of the most appropriate CCG. This figure was also considerably lower in the

other two groups (36.6% amongst practice commissioning leads; 27.9% amongst GPs with neither role).

Table 6: GPs views on the added value of their involvement in clinical commissioning by current CCG role

	current CCG role	strongly disagree	disagree	neither agree nor disagree	agree	strongly agree	don't know
Commissioning is part of my role as a GP	Formal	4.7	8.4	10.2	43.1	33.2	0.5
	PCL	11.2	19.1	18.9	40.8	9.3	0.7
	Neither	18.1	30.3	23.7	23.8	2.8	1.3
GPs add value to needs assessment	Formal	1.6	1.6	8.4	42.2	44.5	1.8
	PCL	2.3	4.6	17.1	54.7	18.7	2.7
	Neither	2.7	6.3	20.0	54.6	12.2	4.2
GPs add value to pathway/ service design	Formal	1.3	0.0	2.4	26.1	68.7	1.6
	PCL	1.1	0.7	6.2	55.4	36.2	0.5
	Neither	1.7	2.2	9.8	58.6	25.6	2.2
GPs add value to contract negotiation & monitoring	Formal	1.6	6.3	13.4	38.5	38.7	1.6
	PCL	5.2	13.4	22.7	38.4	17.7	2.5
	Neither	4.6	13.8	23.0	40.4	14.1	4.1
GPs add value to improving relation-ships with providers	Formal	1.6	1.6	11.2	32.4	51.4	1.8
	PCL	4.8	5.7	19.8	49.3	18.4	2.1
	Neither	3.2	7.8	23.7	45.9	14.8	4.6
My practice is a member of the most appropriate CCG	Formal	1.6	1.6	5.8	21.0	67.2	2.9
	PCL	0.5	2.8	14.1	44.5	36.6	1.6
	Neither	1.4	2.8	14.4	46.3	27.9	7.2

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N for Formal Role at CCG level = 381 – 383; for PCL = 434 – 440; for neither role = 2,082 – 2,095. PCL = Practice Commissioning Lead.

Table 7 shows respondents' views on how the introduction of CCGs has affected aspects of their jobs, their patients and the local health economy, by current CCG role. GPs that reported having a clinical commissioning role, regardless of this role, were more likely to indicate that their overall workload had increased to some extent than GPs reporting having neither role. The former group were also more likely to indicate, to some extent, a decrease in the time they spend on direct patient care (a considerable decrease for a significant minority with a formal role) and the number of referrals they make.

GPs with a formal role at CCG level were most likely to report a decrease in practice prescribing expenditure (51% did so) and indicate that they believed primary and

secondary care were now more integrated (47.5%). Their views on changes in continuity of care for patients and health inequalities were also more 'favourable' than practice commissioning leads and GPs with no CCG role, although these differences are much less pronounced than others.

Table 7: GPs views on the effect of the introduction of CCGs by current CCG role

To what extent have CCGs affected …	current CCG role	decrease a lot	decrease a little	no change	increase a little	increase a lot	don't know
Your overall workload	Formal	0.0	0.0	7.6	31.9	60.2	0.3
	PCL	0.2	0.2	6.1	39.2	53.5	0.7
	Neither	0.1	0.1	18.3	38.4	40.0	3.1
Time spent on direct patient care	Formal	19.0	32.7	37.5	7.1	3.2	0.5
	PCL	5.2	44.8	39.6	7.1	3.0	0.5
	Neither	3.7	25.2	54.4	8.8	5.0	2.8
Number of referrals made	Formal	2.9	43.1	50.7	2.1	0.5	0.8
	PCL	1.6	40.5	53.2	3.2	0.7	0.9
	Neither	2.0	32.5	58.0	3.5	1.0	3.1
Level of practice prescribing expenditure	Formal	6.0	45.0	43.5	3.9	0.5	1.1
	PCL	3.6	36.1	53.5	3.4	1.4	2.0
	Neither	2.9	34.8	49.4	4.9	1.2	6.8
Integration of primary and secondary care	Formal	2.9	6.8	41.8	41.5	6.0	1.0
	PCL	8.6	9.8	56.7	20.6	1.1	3.2
	Neither	6.8	12.0	56.0	16.8	0.9	7.5
Continuity of care for patients	Formal	5.2	19.9	50.3	19.4	3.1	2.1
	PCL	11.4	20.5	57.1	7.7	0.9	2.5
	Neither	10.6	22.4	54.7	5.6	0.6	6.1
Health inequalities	Formal	2.1	19.6	66.3	6.3	2.1	3.7
	PCL	2.1	6.6	73.0	8.4	4.8	5.2
	Neither	2.4	7.0	68.0	8.4	4.2	10.1

Cell figures represent within-row percentages, based on responses from the 2012 combined cross-sectional and longitudinal samples. Range of N for Formal Role at CCG level = 379 – 383; for PCL = 440 – 441; for neither role = 2,084 – 2,093. PCL = Practice Commissioning Lead.

Job Stressors, Job Attributes and Intentions to Quit

Job stressors

Levels of job stressors in 2012

Respondents were asked to rate 14 factors according to how much pressure they experienced from each in their job on a five-point scale from 'no pressure' (=1) to 'high pressure' (=5). Summary statistics for the cross-sectional sample are provided for each stressor in Table 8.

The stressors are ranked in descending order of the mean score. GPs reported most stress with increasing workloads, paperwork, having insufficient time to do the job justice, increased demand from patients and changes imposed by their primary care organisation. They reported least stress with interruptions by emergency calls during surgery and finding a locum. More than 8 out of 10 GPs reported experiencing considerable or high pressure from increasing workloads and paperwork. Just 3 out of 10 GPs experienced the same levels of pressure from interruptions by emergency calls and finding a locum.

The ranking of stressors by mean scores and the percentages reporting high pressure (4 or more) is very similar (particularly for the items generating the greatest stress levels) and we therefore use mean scores throughout the remainder of this section.

Table 8: Levels of job stress in 2012

Job Stressor	Cross-sectional sample	
	Mean rating	% reporting considerable/ high pressure
Increasing workloads	4.40	86.20
Paperwork	4.22	80.85
Having insufficient time to do the job justice	4.18	77.65
Increased demand from patients	4.05	74.81
Changes imposed from the PCO	3.98	69.91
Dealing with problem patients	3.70	58.26
Long working hours	3.68	59.19
Dealing with earlier discharges from hospital	3.62	56.06
Unrealistically high expectation of role by others	3.44	50.80
Worrying about patient complaints/ litigation	3.32	43.53
Adverse publicity by the media	3.26	44.02
Insufficient resources within the practice	3.15	37.37
Interruptions by emergency calls during surgery	2.92	29.30
Finding a locum	2.74	31.19

% considerable/high pressure = % rating 4 or 5. Range of N for cross-sectional sample = 1,151 – 1,183.

Changes in job stressors from 2010

The changes in mean stress ratings between 2010 and 2012 in the cross-sectional sample are shown in Table 9. The stressors are ranked from the largest increase in rating to the smallest increase in rating. Average stress ratings reported on the same questions in the 1998, 2001, 2004, 2005 and 2008 surveys are also shown.

On all 14 factors, average stress ratings have increased between 2010 and 2012. The greatest increases were observed in relation to increasing workloads, dealing with earlier discharges from hospital, unrealistically high expectations of the role by others, having

insufficient time to do the job justice and paperwork: an increase in excess of one-quarter of a 'point' was observed in mean stress ratings on these five factors since 2010. Very modest increases were observed in relation to finding a locum and adverse publicity from the media; other stressors increased by between 0.20 and 0.24 'points'.

On 6 of the 14 factors (workloads, dealing with earlier discharges from hospital, having insufficient time to do the job justice, paperwork, long working hours and dealing with problem patients), mean stress ratings are at their highest level since the beginning of the National Worklife Survey series. On 4 more factors (high role expectations by others, increased demand from patients, worries about patient complaints and insufficient practice resources), mean stress ratings are at their highest level since 2001.

Table 9: Changes in mean job stressor ratings – cross-sectional samples

Job Stressor	Mean Stress Rating							Change
	1998	2001	2004	2005	2008	2010	2012	'10 – '12
Increasing workloads	3.78	4.24	4.08	3.79	4.04	4.02	4.40	+0.38
Dealing with earlier discharges from hospital	2.93	3.21	3.25	3.14	3.23	3.27	3.62	+0.35
Unrealistically high expectation of role by others	3.17	3.53	3.20	2.70	3.14	3.11	3.44	+0.33
Having insufficient time to do the job justice	3.41	4.14	3.99	3.61	3.88	3.88	4.18	+0.30
Paperwork	3.47	4.18	4.15	3.86	3.97	3.96	4.22	+0.26
Increased demand from patients	3.77	4.09	3.74	3.62	3.70	3.81	4.05	+0.24
Changes imposed from the PCO	3.44	4.00	3.82	3.76	4.01	3.74	3.98	+0.24
Long working hours	3.13	3.60	3.43	2.90	3.41	3.44	3.68	+0.24
Worrying about patient complaints/ litigation	3.26	3.57	3.20	3.07	3.06	3.08	3.32	+0.24
Dealing with problem patients	3.50	3.42	3.28	3.13	3.37	3.48	3.70	+0.22
Insufficient resources within the practice	2.42	3.19	3.13	2.86	2.98	2.94	3.15	+0.21
Interruptions by emergency calls during surgery	2.87	2.94	3.00	2.73	2.75	2.72	2.92	+0.20
Finding a locum	2.71	3.19	3.64	3.24	2.45	2.61	2.74	+0.13
Adverse publicity by the media	2.66	3.57	3.09	2.86	3.65	3.20	3.26	+0.06

Stressors ranked from greatest positive change to least positive change between 2010 and 2012.

Job attributes

Respondents were asked to indicate the extent to which they agreed or disagreed with a set of statements designed to measure the extent of job control, the nature of job design and work pressure. Responses were recorded on a five-point scale: strongly disagree, disagree, neither, agree, strongly agree.

Levels of job attributes in 2012

Table 10 shows that respondents were most likely to agree to some extent with the statements that they had to work very intensively (95%), that they had to work very fast (84.1%) and that their job provided a variety of interesting things (82.5%). In addition, approximately 7 out of 10 GPs agreed to some extent that they did not have time to carry out all their work, that they were required to do unimportant tasks, detracting from more important ones, but that they always knew what their responsibilities were. Respondents were least likely to agree with the statements that work relationships were strained (21.5%), clear feedback about their performance was received (21.4%) and that changes to the job in the last year had led to better patient care (10%). Sixty-two percent of GPs disagreed to some extent with this latter statement.

Table 10: Job attributes in 2012

Job Aspect	% disagree/ strongly disagree	% agree/ strongly agree
(W) Have to work very intensively	1.02	95.01
(W) Have to work very fast	3.13	84.09
(C) Job provides variety of interesting things	4.41	82.54
(P) Do not have time to carry out all work	11.67	73.37
(P) Required to do unimportant tasks, preventing completion of more important ones	11.75	71.17
(D) Always know what responsibilities are	11.82	70.19
(C) Choice in deciding how to do job	22.72	53.21
(D) Involved in deciding changes that affect work	32.46	46.32
(C) Working time can be flexible	33.08	41.71
(C) Choice in deciding what to do at work	32.83	38.66
(D) Consulted about changes that affect work	40.17	37.71
(C) I can decide on my own how to go about doing my work	31.50	37.68
(P) Relationships at work are strained	54.54	21.54
(D) I get clear feedback about how well I am doing my job	38.95	21.42
(D) Changes to job in last year have led to better patient care	61.96	9.97

(C) = Job Control, (W) = Workload, (D) = Job Design, (P) = Work Pressures. Figures are based on the 2012 cross-sectional sample. Range of N = 1,179 – 1,184.

Changes in job attributes since 2010

The percentage of respondents to the 2012 survey agreeing to some extent with each of the 15 statements are compared to previous surveys in Table 11. The percentage of respondents agreeing with statements regarding workload (fast/ intensive) and work pressures (insufficient time; unimportant tasks; relationships) has shown the greatest increase between 2010 and 2012: these are generally aspects of the job with which GPs also most frequently agree (and have done so since 2005). A greater percentage of GPs (+3.0%) in 2012, compared to 2010, also agreed to some extent that they received clear feedback about how well they were doing. All other aspects of job control and design showed a decline in the percentage of GPs in agreement in 2012. This was particularly evident in relation to being able to decide what to do and how to do the job and being involved in deciding changes that affected the job. Since 2005, GPs' responses imply that working speed and intensity have increased most (greatest positive change in agreement: +13%), but that changes to the job are not resulting in better patient care (greatest negative change in agreement: -20%).

Table 11: Trends in Job Design and Work Pressures, Workload and Job Control

Job Issue	% agree/ strongly agree				Change
	2005	2008	2010	2012	'10 – '12
(P) Do not have time to carry out all work	66.7	68.7	67.1	73.4	+6.3%
(W) Have to work very fast	70.7	77.1	77.9	84.1	+6.2%
(P) Required to do unimportant tasks, preventing completion of more important ones	69.7	71.7	67.2	71.2	+4.0%
(P) Relationships at work are strained	n/a	n/a	18.7	21.4	+3.7%
(W) Have to work very intensively	81.6	91.0	91.5	95.0	+3.5%
(D) I get clear feedback about how well I am doing my job	17.6	n/a	18.4	21.4	+3.0%
(C) Working time can be flexible	46.8	44.8	42.6	41.7	-0.9%
(D) Consulted about changes that affect work	34.4	34.6	39.7	37.7	-2.0%
(C) Job provides variety of interesting things	81.5	83.2	84.7	82.5	-2.2%
(D) Changes to job in last year have led to better patient care	30.1	13.6	13.2	10.0	-3.2%
(D) Always know what responsibilities are	57.8	68.3	73.5	70.2	-3.3%
(C) I can decide on my own how to go about doing my work	n/a	n/a	41.3	37.7	-3.6%
(D) Involved in deciding changes that affect work	48.7	48.8	50.5	46.3	-4.2%
(C) Choice in deciding how to do job	62.5	58.4	58.6	53.2	-5.4%
(C) Choice in deciding what to do at work	28.3	44.7	44.7	38.7	-6.0%

Notes: Job attributes are classified into four groups: (C) = Job Control, (W) = Workload, (D) = Job Design, (P) = Work Pressures. n/a indicates that these questions were not included in the survey that year. All figures are based on the respective cross-sectional samples.

Intentions to quit

Likelihood of leaving direct patient care

Respondents were asked how likely they were to leave direct patient care within the next five years. This has been shown to be a valid predictor of intentions to quit and actual quitting behaviour (Hann, Reeves & Sibbald, 2011). For older GPs, intentions to leave direct patient care may be dominated by early retirement plans. Respondents were, therefore, asked at what age they planned to retire and how likely this was to happen. Using this information we can distinguish planned retirements from other reasons for leaving direct patient care.

Table 12 shows the likelihood of leaving direct patient care stratified by whether or not the GP was currently aged less than 50 years. Approximately 3 out of every 10 (31.2%) respondents indicated that there was a considerable or high likelihood that they would quit direct patient care within five years. Amongst those aged 50 years or over the corresponding figure was over half (54.1%), with the vast majority of these (241 out of 306 = 78.8%) indicating that the likelihood was high. In contrast, fewer than 1 in 10 GPs aged under 50 years indicated that there was a considerable or high likelihood of leaving direct patient care within five years (8.9%): more than half (52.8%) stated that there was no likelihood.

Table 12: Likelihood of leaving 'direct patient care' within five years in 2012

Likelihood of leaving 'direct patient care' within five years (2012)	All GPs (N = 1,149)		GPs aged <50 (N = 583)		GPs aged ≥50 (N = 566)	
	N	%	N	%	N	%
None	408	35.5	308	52.8	100	17.7
Slight	250	21.8	155	26.6	95	16.8
Moderate	133	11.6	68	11.7	65	11.5
Considerable	92	8.0	27	4.6	65	11.5
High	266	23.2	25	4.3	241	42.6

Figures are column percentages based on the cross-sectional sample in 2012. The GPs' age was missing in 16 cases (where 'likelihood of leaving' had been expressed): these are excluded from the analysis.

Of the 566 GPs aged 50 or over (average current age = 55 years), 551 reported the age at which they planned to retire. The average reported age of planned retirement was 61 years, with a range of 52 to 76 years. When asked how likely it was that this would happen, 34.5% stated 'definite', with another 42.7% 'very likely' and 21.4% 'quite likely'. Over half (55.2%, 304 of 551) of the respondents aged 50 or over planned to retire at an age within the next five years, and 87.2% of these said that it was either definite or very likely that this would happen. Only 11 of the 509 respondents aged under 50 (2.2%) who reported the age at which they were planning to retire reported an age that was within the next five years.

Table 13 shows that 'intentions to quit' are at their highest levels compared to previous surveys. The percentage of all respondents to the 2012 survey expressing considerable or high quitting intentions is considerably greater than in 2010. This is, in the main, due to the increase in quitting intentions expressed by GPs aged 50 or over.

Table 13: Trends in Intentions to Quit

Considerable/high intention to leave direct patient care within five years	All GPs	GPs aged <50	GPs aged ≥50
1998	15.3%	5.6%	n/a
2001	23.8%	11.4%	n/a
2004	23.7%	13.1%	n/a
2005	19.4%	6.1%	41.2%
2008	21.9%	7.1%	43.2%
2010	21.9%	6.4%	41.7%
2012	31.2%	8.9%	54.1%

n/a indicates that these figures were not presented in the corresponding reports/articles. All figures are based on the cross-sectional samples in the respective years.

Likelihood of changing working hours

Respondents were also asked to indicate whether the likelihood that they would either increase or (separately) reduce their working hours within the next five years. Possible responses to both questions were: none; slight; moderate; considerable; and high.

Table 14 shows that the majority (63%) of all respondents stated that there was no likelihood of them increasing their working hours over the next five years. Approximately 22% reported that there was a moderate, considerable or high likelihood. As with

intentions to quit, there were notable differences between GPs aged less than fifty and GPs aged fifty and over: in the former group, 29.4% stated that there was a moderate, considerable or high likelihood of working increasing hours, whereas in the latter group this figure was 13.7%. Five percent of GPs in each age stratum indicated a high likelihood of increasing their working hours. Over half of all respondents (55.7%) reported that there would be a moderate, considerable or high likelihood that they would be reducing their working hours within five years. However, nearly as many GPs reported that there would be no likelihood of working reduced hours as a high likelihood. Again, there were differences by age: a greater likelihood of reducing working hours was more prevalent amongst GPs aged fifty and over (74.2% moderate, considerable or high) than GPs aged less than fifty (37.8%). Almost half of the former group expressed a high likelihood of so doing.

Table 14: Likelihood of changing working hours within five years in 2012

Likelihood of changing working hours within five years (2012)	All GPs		GPs aged <50		GPs aged ≥50	
	Increase	Reduce	Increase	Reduce	Increase	Reduce
	%	%	%	%	%	%
None	62.9	25.6	50.7	36.9	75.7	13.9
Slight	15.4	18.7	20.0	25.3	10.7	11.9
Moderate	8.4	12.5	12.3	14.5	4.3	10.3
Considerable	8.3	14.6	12.0	12.0	4.4	17.3
High	5.1	28.6	5.1	11.3	5.0	46.6

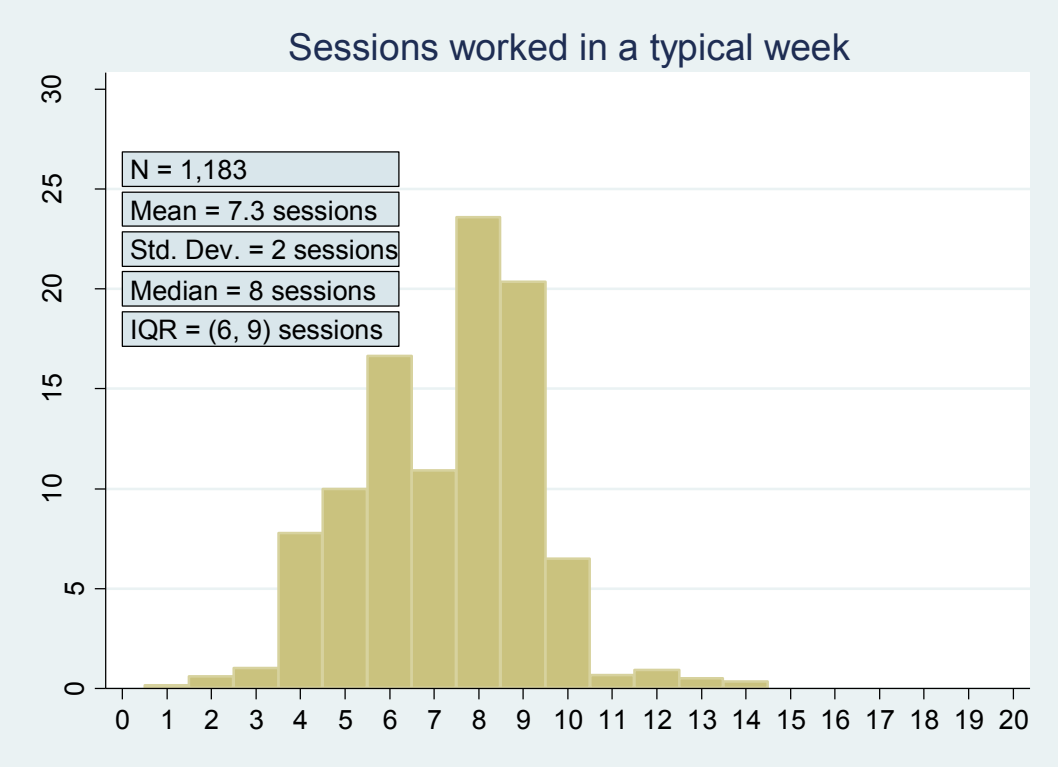
Figures are column percentages based on the cross-sectional sample in 2012. N = 1,149 for 'increase hours' (586 <50; 563 ≥50); N = 1,147 for 'reduce hours' (585 <50; 562 ≥50). GPs whose age was missing were excluded from the analysis.

Hours of Work

Sessions worked per week in 2012

We asked respondents how many sessions they worked in a typical week. Figure 1 shows that, in 2012, respondents most frequently reported working either 8 or 9 sessions per week, with a secondary peak at 6 sessions (corresponding to part-time working). The median number of sessions worked in a typical week was 8 (inter-quartile range = 6 to 9), whilst the mean number was 7.3 sessions per week (standard deviation = 2 sessions). The mean number of sessions worked in 2012 is lower than that observed in the 2010 survey (7.5 sessions; standard deviation = 2 sessions). Table 15 reveals that the reason for this is the substantial decline (approximately 6%) between 2010 and 2012 in the number of GPs working more than 8 sessions per week (in particular, 8.5 or 9 sessions per week), and the corresponding increase in the number of GPs working between 4 and 7 sessions per week (in particular, 5.5 or 6).

Figure 1: Distribution of sessions worked in a typical week in 2012



Data are based on the cross-sectional sample in 2012.

Table 15: Number of Sessions Worked in 2010 and 2012

Number of sessions worked in a typical week	2010	2012
	% of GPs	% of GPs
#sessions ≤ 4	9.5	9.6
4 < #sessions ≤ 5	9.0	9.9
5 < #sessions ≤ 6	12.9	16.7
6 < #sessions ≤ 7	9.6	11.0
7 < #sessions ≤ 8	23.7	23.4
8 < #sessions ≤ 9	25.0	20.5
9 < #sessions ≤ 10	6.8	6.4
#sessions > 10	3.6	2.6

Figures for '% of GPs' are column percentages based on the respective cross-sectional sample (N = 1,061 in 2010; N = 1,183 in 2012).

We also asked GPs to indicate when they worked their sessions. This was to identify those who were working 'anti-social hours'. Of the 1,177 GPs who reported when they worked their sessions, 684 (58.1%) indicated that they worked at least one weekday evening session in a typical week, a slight increase from 2010 (57.2%), whilst 118 (10.0%) indicated that they worked at least one weekend session in a typical week, a decrease from 2010 (15.1%).

Average hours worked per week in 2012

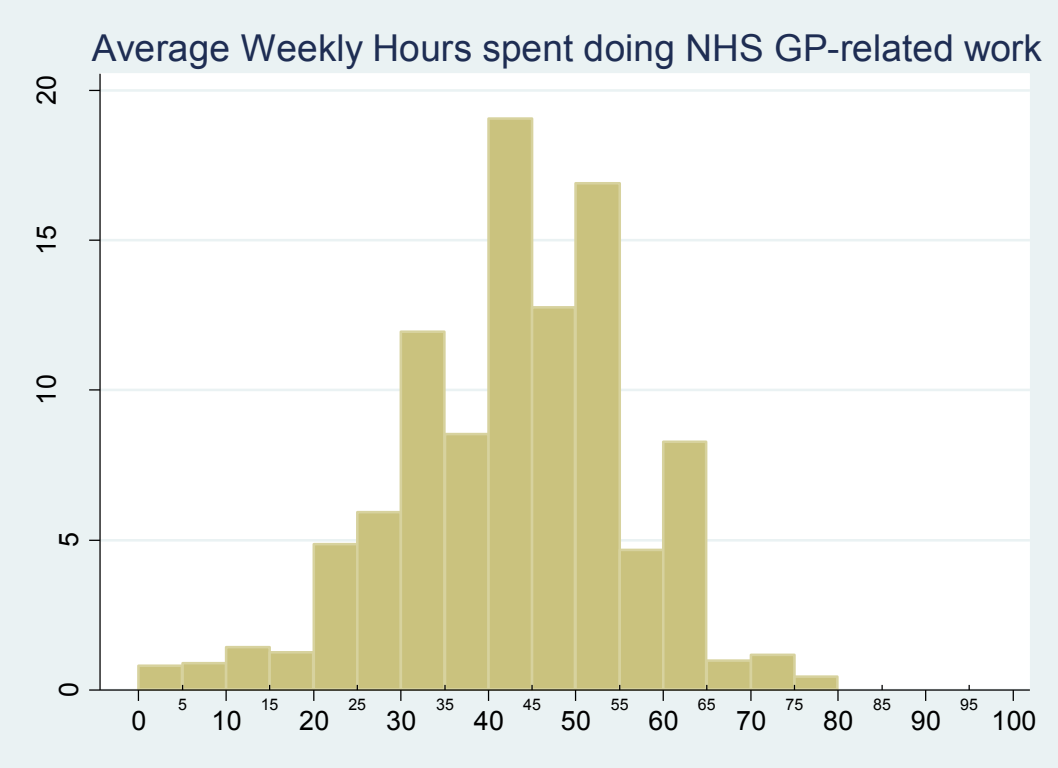
GPs were asked:

> *How many hours do you spend, **on average, per week**, doing NHS GP-related work? (Please include **ALL** clinical and non-clinical NHS work but **EXCLUDE OUT-OF-HOURS WORK**)*

The mean number of weekly hours that the 1,112 respondents reported working was 41.7 (standard deviation = 13 hours) and the median number was 42 hours (Inter-Quartile Range = 32 to 50). The distribution of average weekly hours worked in 2012 is shown in Figure 2.

Nearly one-third of respondents (31.7%) reported working between 40 and 50 hours per week, whilst just over 20% reported working either 30 to 40 hours per week (20.4%) or 50 to 60 hours per week (21.6%). More than one in ten GPs (10.9%) reported that they worked 60 hours or more per week.

Figure 2: Distribution of 'Average Weekly Hours Worked' in 2012



Data are based on the cross-sectional sample in 2012.

Trends in average hours worked per week

The average number of hours worked per week increased slightly between 2010 and 2012 (Table 16), though the change is not statistically significant (t=0.53; p=0.594). An increase of a similar magnitude was also observed in the longitudinal sample. Average weekly hours spent on NHS GP-related work increased from 42.4 (standard deviation = 12.8 hours) in 2010 to 42.8 (standard deviation = 13.2 hours) in 2012 in this sample, though this too was not statistically significant (t=0.89; p=0.374).

Table 16: Summary statistics for average weekly hours worked: 2008 – 2012

Year	N	Average	Std. Dev.	95% C.I.
2008	634	42.1	13.0	41.1, 43.1
2010	1,054	41.4	12.9	40.6, 42.2
2012	1,112	41.7	13.0	40.9, 42.5

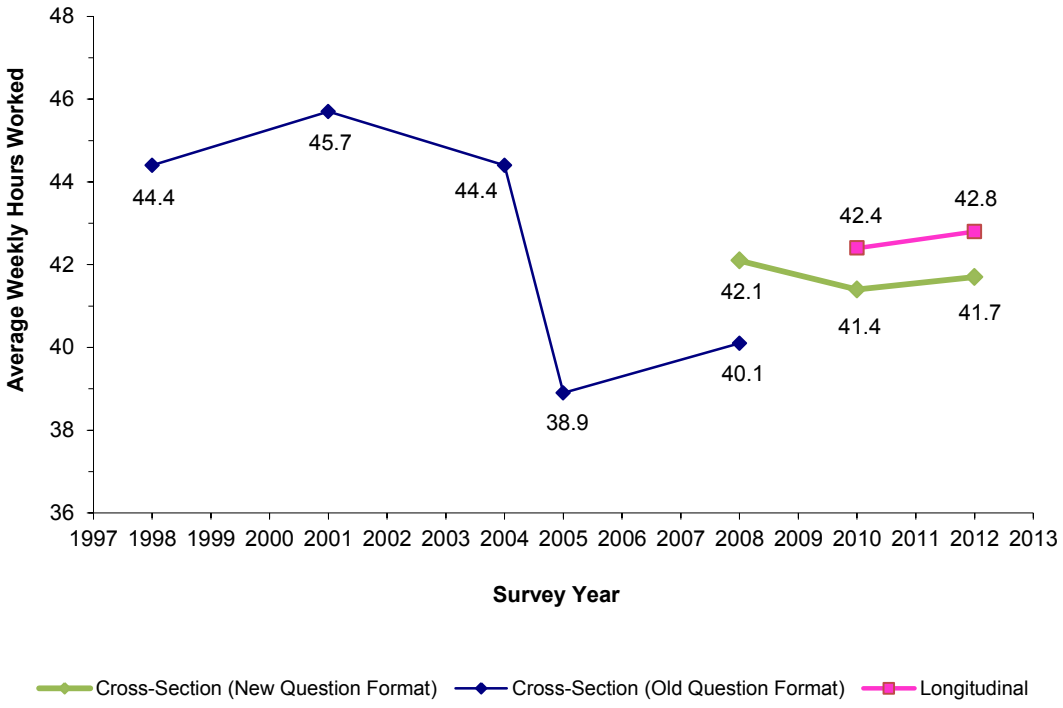
Figures are based on the cross-sectional samples in the respective years. In 2008, two different phrasings of the hours of work question were asked, with GPs randomly assigned to one or the other.

Prior to 2008, hours of work was elicited using a different phrasing of the question to that in 2010 and 2012:

How many hours per week do you typically work as a GP?
(Please exclude any hours on call)

To enable comparison of the series over time, the two question formats were asked of random halves of the 2008 survey. Figure 3 illustrates these series graphically.

Figure 3: Trends in average weekly hours worked: 1998 – 2012



The figures for the longitudinal sample are based on data from GPs who responded in 2010 and 2012 (N = 1,498).

Association of Hours Worked to Sessions Worked

There was a substantial positive correlation between the number of sessions worked in a typical week and the number of hours spent doing NHS-related work in both years (0.65 in 2010; 0.58 in 2012). In 2012, GPs who indicated that they worked more than 8 sessions in a typical week also reported that they spent, on average, around 50 hours undertaking NHS-related work. Generally, the average number of hours worked per week was greater in 2012 than in 2010 for the corresponding number of reported sessions worked (Table 17).

Table 17: Number of Sessions Worked and Average Hours Worked by GPs who work that number of sessions in 2010 and 2012

Number of sessions worked in a typical week	2010		2012	
	% of GPs	Average Hours Worked	% of GPs	Average Hours Worked
#sessions ≤ 4	9.5	23.7	9.6	26.0
4 < #sessions ≤ 5	9.0	30.5	9.9	31.3
5 < #sessions ≤ 6	12.9	35.0	16.7	35.4
6 < #sessions ≤ 7	9.6	39.4	11.0	41.4
7 < #sessions ≤ 8	23.7	46.3	23.4	46.0
8 < #sessions ≤ 9	25.0	47.3	20.5	50.1
9 < #sessions ≤ 10	6.8	49.6	6.4	50.0
#sessions > 10	3.6	55.1	2.6	53.5

Figures for '% of GPs' are column percentages based on the respective cross-sectional sample (N = 1,061 in 2010; N = 1,183 in 2012). Figures for 'hours worked' are based on the average number for GPs who also report how many sessions they work in a typical week.

Out-of-Hours work

Respondents were asked if they undertook any out-of-hours work and, if so, on average, how many hours per week. Twenty-one percent (240/1,160) of respondents in the cross-sectional sample reported undertaking some out-of-hours work. This included 198 GP providers (19.6% of all providers who responded to the survey) and 42 non-provider GPs (25.6% of all such GPs in the survey). Overall, the proportion of GPs participating in out-of-hours work is unchanged from 2010 (where 218 out of 1,053 respondents reported doing so). This figure (218) consisted of 185 GP providers (20.4% of all such survey respondents) and 33 non-providers (22.8%). Compared to 2010, the proportion of GP providers participating in out-of-hours work has decreased slightly whilst the proportion of non-provider GPs participating has increased.

Of the 240 respondents who reported undertaking out-of-hours work in 2012, 232 reported how many hours they spent on average per week. The median number of hours was 4

(inter-quartile range = 2 to 6), identical to that in 2010. The vast majority of GPs (84%) who reported working out of hours did so even though their practice had opted-out of out-of-hours working (Table 18).

Table 18: Practice opt-outs and out-of-hours work in 2012

Has your practice opted out of 'out-of-hours' work?	N (%) [of 1,172 GPs]	Median weekly hours spent doing out-of-hours work (N)
Yes	1,059 (90.4%)	4.0 (192)
No	113 (9.6%)	3.0 (37)

Figures are based on the cross-sectional sample. Median weekly data on hours worked are calculated only for GPs stating that they undertook some out-of-hours work.

Data from the longitudinal sample broadly mirrors that of the cross-sectional sample, with one key difference. In 2010, 346 out of 1,545 respondents (22.4%) reported working out-of-hours (for a median of 4 hours); this percentage had declined to 16.9% (259 out of 1,536 respondents) in 2012 (median number of hours worked = 4). Two-hundred and nine GPs stated that they undertook some out-of-hours work in both years.

Extended opening hours

We asked GPs whether their practice offered extended hours access. Table 19 shows that 31.9% of respondents said that their practice offered access at weekends (372 of 1,165), 75.7% on weekdays (882 of 1,165) and 23.8% on both weekdays and at the weekend (277 of 1,165). All of these figures have decreased compared to the corresponding data from 2010, in particular that for weekend access (39.8%). Only 16.1% of respondents (188 of 1,165) replied that their practice did not offer any extended hours access; this is an increase compared to the corresponding figure in 2010 (10.2%).

Table 19: Extended Hours Access in 2010 and 2012

Does your practice have Extended Hours Access	2010	2012
	N = 1,054	N = 1,165
On Weekdays	858 (81.4%)	882 (75.7%)
On Weekends	419 (39.8%)	372 (31.9%)
On Weekdays & Weekends	330 (31.3%)	277 (23.8%)
No Extended Hours Access	107 (10.2%)	188 (16.1%)

Data are based on 'valid' responses from the respective cross-sectional samples.

Percentage of time spent on various activities

In addition to asking GPs the number of hours worked on average per week, the questionnaire asked GPs to indicate how much time they spent on different aspects of their work, namely:

- Direct patient care (e.g. surgeries; clinics; telephone consultations; home visits)
- Indirect patient care (e.g. referral letters; arranging admissions)
- Administration (e.g. practice management; PCO meetings; etc)
- Other (e.g. continuing education/ development; research; teaching; etc)

Table 20 shows the average percentages reported by respondents in the cross-sectional samples in 2005, 2008, 2010 and 2012 and in the longitudinal sample. In 2012, 62% of a GPs' time was devoted to direct patient care, with 19% devoted to indirect patient care and 11% devoted to administration.

The respondents in the 2012 cross-sectional sample reported devoting a lower percentage of their time to direct patient care than respondents in the 2005, 2008 and 2010 cross-sectional samples. There has been a 0.7% increase in the percentage of time devoted to indirect patient care between 2010 and 2012. The changes in the longitudinal sample (in both 2010 and 2012) broadly mirror those for the cross-sectional sample. Respondents in the longitudinal sample reported small increases in the percentage of time devoted to indirect patient care and administration between 2010 and 2012, at the expense of time devoted to direct patient care.

Table 20: Percentage of time devoted to different activities, 2005-2012

Type of activity	Cross-sectional sample				Longitudinal sample	
	2005	2008	2010	2012	2010	2012
Direct patient care	63.3	63.0	63.1	62.3	62.5	61.4
Indirect patient care	18.2	17.5	18.6	19.3	18.4	19.0
Administration	11.3	12.0	10.7	10.9	11.2	11.9
Other	7.1	7.5	7.6	7.5	7.9	7.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Figures are column percentages. Numbers may not sum to 100% due to rounding errors. N = 868 for the 2005 cross-sectional sample; 1,280 for the 2008 cross-sectional sample; 1,015 for the 2010 cross-sectional sample; 1,154 for the 2012 cross-sectional sample. N = 1,526 for the longitudinal sample.

Job Satisfaction

Questions on job satisfaction have been included in GP surveys since 1987. This section of this report provides summary statistics on these elements of the survey and analysis of recent trends. Respondents were asked to rate their satisfaction on nine specific domains and for their job 'overall' on a seven-point scale from 'extremely dissatisfied' (=1) to 'extremely satisfied' (=7).

Job satisfaction levels in 2012

Summary statistics for the cross-sectional sample are provided in Table 21. Mean overall job satisfaction is 4.54 points. Just over half of the respondents (56.7%) reported being satisfied with their job overall (scores of 5 or more), whilst less than one-quarter (22.5%) reported being dissatisfied (scores of 3 or less).

The nine individual aspects of the job are ranked in descending order of the mean score in Table 21. Respondents reported most satisfaction with their colleagues and fellow workers, physical working conditions and the amount of variety in the job. These domains had both the highest mean satisfaction scores and the greatest percentage of GPs indicating 'satisfaction': at least 3 out of every 4 respondents were satisfied with these aspects of the job and dissatisfaction was rare. Respondents displayed least satisfaction with their hours of work: fewer than half were satisfied (46.2%), whilst more than one-third (36.5%) were dissatisfied.

The ranking of job domains is almost identical whether we use the mean scores or the percentages reporting dissatisfaction or satisfaction. In the remainder of this section we summarise the job satisfaction responses using the mean scores.

Table 21: Summary statistics for job satisfaction in 2012

Job domain	Mean	% dissatisfied	% satisfied
Colleagues and fellow workers	5.56	6.45	83.36
Physical working conditions	5.30	11.61	77.28
Amount of variety in job	5.28	9.67	77.01
Amount of responsibility given	5.16	11.56	71.68
Opportunity to use abilities	5.08	13.34	72.56
Freedom to choose own method of working	4.78	17.83	63.33
Remuneration	4.56	22.52	55.72
Recognition for good work	4.52	23.20	56.90
Hours of work	4.09	36.45	46.22
Overall Satisfaction	**4.54**	**22.48**	**56.74**

% dissatisfied = % rating 1, 2 or 3; % satisfied = % rating 5, 6 or 7. Figures are based on the 2012 cross-sectional sample. Range of N = 1,171 – 1,181.

Changes in satisfaction ratings from 2010

The changes in mean satisfaction ratings between 2010 and 2012 in the cross-sectional sample are shown in Table 22. The satisfaction domains are ranked from the largest change in ratings between 2010 and 2012 to the smallest change. Average satisfaction ratings for 1998, 2001, 2004, 2005 and 2008 are also shown.

The mean level of overall satisfaction of 4.54 in the cross-sectional sample in this survey is 0.33 points lower ($t=-5.60$; $p<0.001$) than the mean level reported in 2010 (Table 22). Mean levels of satisfaction have also decreased, to varying degrees, on seven of the nine individual domains. The most notable declines are in satisfaction with remuneration (0.31 points) and hours of work (0.30 points). Satisfaction with colleagues and fellow workers (by 0.02 points) and physical working conditions (by 0.07 points) have increased since 2010: these are the two highest ranked satisfaction domains in 2012.

Overall job satisfaction is at its lowest level since 2001. In terms of the overall series, satisfaction with particular aspects of the job such as remuneration, hours of work and amount of responsibility given are at a 'mid-point': that is, they are higher than in the surveys undertaken before the introduction of the new contract (1998, 2001 and 2004) but lower than in the surveys undertaken since. Levels of satisfaction with other aspects of the job are, in general, also higher in 2012 than in the years prior to the introduction of

the new contract. Levels of satisfaction with physical working conditions and (with the exception of 2010) variety in the job have never been so high.

A corresponding decrease of 0.38 points ($t=-10.90$; $p<0.001$) in overall satisfaction was observed in the longitudinal sample of 1,565 GPs who participated in both the 2010 and 2012 surveys (Table 23). Of the 1,541 respondents who reported their overall job satisfaction level in both years, 313 (20.3%) reported being more satisfied in 2012 than in 2010, 570 (37.0%) reported being equally as satisfied and 658 (42.7%) reported being less satisfied in 2012 than in 2010. Mean levels of satisfaction declined on all nine individual domains; remuneration and hours of work exhibiting the greatest changes, complementing the findings of the cross-sectional sample.

Table 22: Average satisfaction ratings over time

Satisfaction domain	Mean Satisfaction Rating							Change
	1998	2001	2004	2005	2008	2010	2012	'10 – '12
Remuneration	3.48	3.51	4.38	5.30	4.73	4.87	4.56	-0.31
Hours of work	3.70	3.32	3.94	4.86	4.21	4.39	4.09	-0.30
Amount of responsibility given	4.99	4.59	5.05	5.43	5.20	5.33	5.16	-0.17
Freedom to choose own method of working	4.87	4.35	4.66	5.00	4.65	4.91	4.78	-0.13
Recognition for good work	4.21	3.57	4.28	4.80	4.46	4.65	4.52	-0.13
Amount of variety in job	4.94	4.76	5.06	5.26	5.23	5.38	5.28	-0.10
Opportunity to use abilities	4.64	4.27	4.85	5.19	5.01	5.11	5.08	-0.03
Colleagues and fellow workers	5.31	5.37	5.60	5.65	5.49	5.54	5.56	+0.02
Physical working conditions	4.99	4.86	4.91	5.08	5.07	5.23	5.30	+0.07
Overall Satisfaction	**4.65**	**3.96**	**4.62**	**5.21**	**4.68**	**4.87**	**4.54**	**-0.33**

Domains ranked by greatest change from 2010 to least change. Figures are based on respective cross-sectional samples. Range of N for 2005 = 882 to 887; for 2008 = 1,275 to 1,289; for 2010 = 1,048 to 1,061; for 2012 = 1,171 to 1,181.

Table 23: Change in satisfaction ratings from 2010 – longitudinal sample

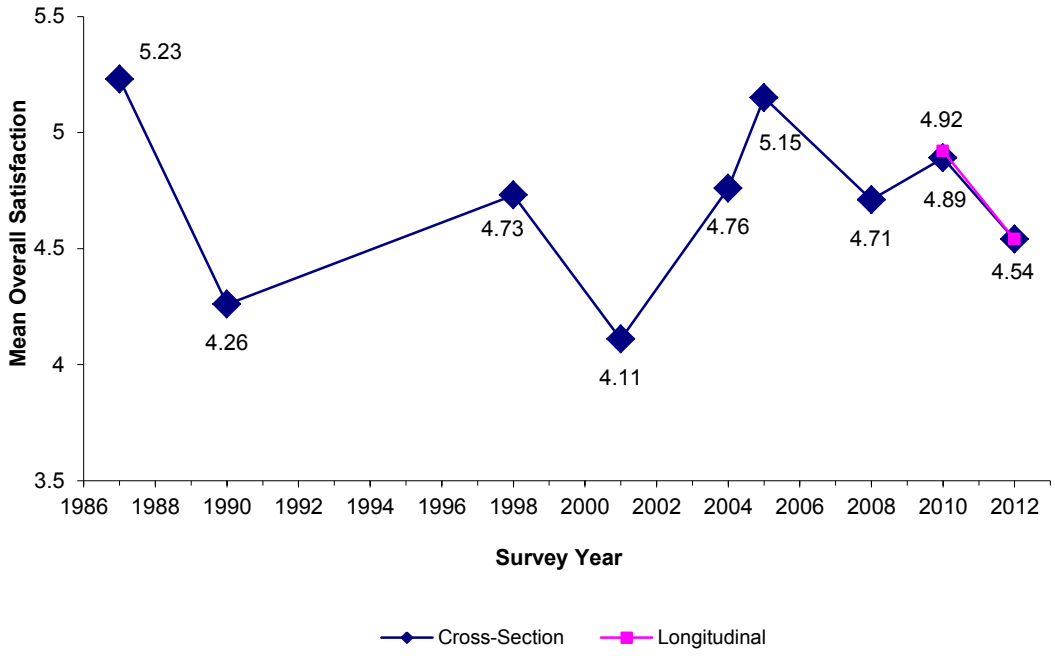
Job Aspect	Mean Satisfaction Rating		Change '08 – '10
	2010	2012	
Remuneration	4.95	4.58	-0.37
Hours of work	4.28	3.96	-0.32
Amount of responsibility given	5.33	5.14	-0.19
Recognition for good work	4.67	4.48	-0.19
Freedom to choose own method of working	4.90	4.72	-0.18
Opportunity to use abilities	5.20	5.08	-0.12
Colleagues and fellow workers	5.61	5.54	-0.07
Amount of variety in job	5.42	5.37	-0.05
Physical working conditions	5.31	5.26	-0.05
Overall Satisfaction	**4.92**	**4.54**	**-0.38**

Domains ranked by greatest change from 2010 to least change. Range of N for 2010 = 1,547 to 1,553; for 2012 = 1,545 to 1,555.

Long-term trends in job satisfaction: 1987 – 2010

Changes in overall job satisfaction may, in part, reflect the changing composition of the GP workforce. In order to control for such potential changes, we directly-standardised the levels of overall job satisfaction observed in each survey to the age-sex composition of provider and salaried GPs in the 2011 GMS Statistics database. Mean levels of overall job satisfaction between 1987 and 2012 are shown in Figure 4.

Figure 4: Trends in mean overall job satisfaction: 1987 – 2012



Cross-sectional series has been standardised to the age-sex structure of the 2011 GMS Statistics database, with the exception of 1987 and 1990 for which the necessary figures are not available.

Concluding remarks

Overall job satisfaction declined between 2010 and 2012, from 4.87 points to 4.54 points in the cross-sectional sample and from 4.92 points to 4.54 points in the longitudinal sample. Overall job satisfaction is at the lowest level since 2001. Satisfaction on seven of the nine individual domains of job satisfaction also declined to varying degrees between 2010 and 2012. These reductions in satisfaction were largest with respect to hours of work and remuneration. In addition, quitting intentions were more prevalent in 2012 than in 2010, especially in GPs aged fifty years or over.

The average number of hours worked per week has increased by less than half-an-hour compared to 2010, with respondents reporting working an average of 41.7 hours per week (42.8 hours in the longitudinal sample). Levels of stress associated with increasing workloads, paperwork and having to work long hours increased from the levels observed in 2010, and reported levels of stress are now higher than in any of the previous surveys. The number of GPs who reported working out-of-hours was unchanged: just over one-in-five reported doing so. There was a small decrease in the proportion of GPs stating that their practice offered extended hours access, especially at weekends.

GPs, on the whole, agreed that their involvement added value to clinical commissioning, although they were split as to whether commissioning was part of their role as a GP. The majority of GPs thought that the introduction of Clinical Commissioning Groups had increased their workload and reduced the amount of time they spent on direct patient care; otherwise, they reported little or no change to general practice in their local area. Thirteen percent of GPs reported having a formal role at clinical commissioning group level, whilst a further fifteen percent indicated that they were the commissioning lead for their practice. GPs who had a formal role viewed commissioning differently to practice commissioning leads: they spent more hours working in this capacity and had more favourable views on the added value of GP involvement in clinical commissioning. These GPs were also more likely to have had a role in previous forms of commissioning, as well as being more likely to state that they wanted to continue in such a role in the future.

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Health Committee

Written evidence from the British Medical Association (ES 26)

About the BMA

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 150,000.

Executive Summary

- The NHS is going through major structural change at a time of significant financial pressure, putting the system under strain and compromising the ability of the NHS to cope with demand. What is needed to address the current demands on urgent and emergency care is not further centrally dictated, whole system solutions but patient centred, locally negotiated and managed arrangements between care providers, which meet the needs of the local population.
- There is no evidence to support the contention that the increase in demand on emergency departments results solely from the changes which took place in 2004 to the way GPs out-of-hours (OOHs) services are arranged.
- [1]
- The increased pressure on emergency departments is caused by a range of complex issues including the current staffing and recruitment crisis in emergency departments, gridlock elsewhere in the system and increasing demand, particularly amongst frail and elderly patients. The flawed introduction of NHS 111 has further added to the pressure on out-of-hours and emergency care admissions. The Government needs to take urgent action, increasing the seniority, skills and expertise of those handling telephone triage services. No areas should go live with NHS 111 until it is clear beyond doubt that the service is safe.
- In addition to traditional A&E (now emergency) departments and out-of-hours primary care services, there are walk in centres and minor injuries units delivering urgent and non urgent care, adding to patient confusion and increasing demand. Greater clarity and information is needed for patients about the appropriate options for unscheduled care.
- Newly established clinical commissioning groups (CCGs) should be allowed to bed down and work with the full range of local care providers, including local authorities with their new responsibilities for public health, to find solutions which meet the needs of their local population, without further centrally dictated initiatives adding further pressure.

Introduction

1. Data from the Department of Health shows that emergency department[2] (ED) attendances were subject to a step change in 2003–04 and have followed a steeper trajectory since that date.[3] However, there are major issues around the collection of A&E data, and comparisons between new data sets and older methodologies show significant discrepancies. Until 2003–04, statistics on A&E attendances included "major" A&E units only. Thereafter, the introduction of walk-in centres and minor injury units led to attendances being recorded for these units as well. To this end, much of the increase relates to previously unrecorded attendances at these units. These units are treating less serious cases than those at A&E units.[4] A literature review undertaken by the Primary Care Foundation certainly came to the conclusion that the overall impact of the introduction of newer types of facility appears to have been to increase demand rather than substitute location.[5] Looking at Type 1 A& E facilities, attendances have increased at 1.7% per year over the nine year period to 2011–12 as against 1.5% per year over the preceding nine years. This does not support the suggestion that there has been a dramatic increase in attendance caused by changes to the GP contract introduced in 2004.[6] The inclusion of other facilities in the data collection did contribute to an average increase between 2002–03 and 2011–12 of 4.5% per year. This in turn suggests a measure of supply induced demand.

2. The attribution of changes in the volume of A&E attendances to changes in general practice behaviour is not supported by the information on patient demographics and timing of attendances. In 2011–12, 43.4% (7,651,005) of all A&E attendances were for patients aged 29 or under and 16.3% (2,875,643) were for patients aged 20–29.[7] This latter cohort tends to be a light user of general practice.[8] When looking at the day and hour of arrival of A&E attendances, the busiest day continues to be Monday, with 15.8% of all attendances (2,781,531). The busiest time of arrival on that day is 10 am (hour) with 211,569 attendances (1.2% of all A&E attendances). There is little evidence of an increase in OOHs attendances and the vast majority take place between 8am and 7pm.

The Role of Community and Primary Care Services in the Delivery of Emergency Healthcare, and the Appropriate Structure for Service Delivery to meet the Demands of Different Geographic Areas Particularly Sparsely Populated Rural Areas

3. At the end of December 2004, GP responsibility 24-hour for patient care ended and responsibility for providing OOHs urgent care cover in most areas was transferred to Primary Care Organisations.[9] This was one of the key changes to the GP contract, intended to help address the serious recruitment and retention crisis in general practice at that time.[10] Many GPs still choose to provide OOHs services to their patients, either directly or by working for an OOHs organisation. Many GPs worked in GP co-operatives until 2004 and continued to do so after the contract changes. A number of OOHs co-operatives continue to provide care now; almost all out of hours services continue to employ large numbers of GPs.

4. The BMA believes it is wrong to suggest that the huge pressures on accident and emergency departments, as raised most recently by the Secretary of State for Health,[11] are caused solely by the changes in 2004 to OOH delivery of primary care. The Government's analysis of where responsibility lies for the huge and increasing pressure on emergency care is overly simplistic. The causes of the very real increased pressures on EDs are due to a range of complex issues including insufficient staffing in emergency departments, gridlock elsewhere in the health system (see paragraph 8) and an increasing demand on health budgets.

5. OOHs care suffered from historic underfunding prior to 2004. The BMA has been pressing for improvements in OOHs care for many years and believes that the introduction of competition for OOHs contracts has exacerbated the pressure on resources and not reversed the Government's neglect of this crucial service. The BMA has expressed concerns that the failure to invest in OOHs services and the perceived drive towards low cost OOHs providers by Primary Care Organisations was a key factor in forcing some successful OOHs to close. In the past three years, funding has remained static at a time when patient demand is increasing: GPs are undertaking increasing numbers of GP consultations[12] and the profession remain key providers of urgent care during the weekend and evenings.

6. Improvements in access to and information about OOHs services could be beneficial for patients and could ease pressure on emergency departments by encouraging greater self management.

Progress towards moving some Minor Injury and Urgent Care Services out of A&E and into more Accessible Community Settings

7. Anecdotal evidence from BMA members working in primary and secondary care suggests that the number of unscheduled care services available (such as EDs, urgent care centres, walk in centres and GP OOHs services) may, in part, be adding to the confusion experienced by patients when seeking appropriate urgent or emergency care. Evidence also suggests that the increase in the supply of newer types of emergency care facilities appears to have led to increased patient demand.[13] The BMA believes that patients would benefit from greater clarity and information about the variety of unscheduled care settings available. This would help improve patient awareness of the options available to them and the circumstances in which emergency services ought to be used. It is essential that patients have a better understanding of when self-care is ideal and appropriate. Recent research by Dr Foster shows that hospitals are under increasing pressure from a rising number of emergency admissions, particularly amongst frail elderly patients.[14] The research demonstrates that 29% of hospital bed days are taken by patients whose admission might have been avoided if their care was better managed.[15] The research also shows that within the hospital bed days taken by patients whose care should have been better managed outside a hospital, 11.9% of all hospital beds were occupied by people with a condition that should not require emergency hospitalisation, and a further 5.6% of all beds were occupied by people who have been readmitted as an emergency within a week of being discharged.[16]

8. The study suggests that improvements in community and primary care, as well as changes in hospital practices, could reduce these admissions. In our view such improvements would be very welcome but would require the recruitment of large numbers of trained district nurses and other community services at a time when budgets and establishments are being cut and community staff are retiring. Early assessment by senior medical staff can help tackle inappropriate or unnecessary hospital admissions. Deploying the expert opinions of senior doctors at an early stage ensures safe, fast and efficient care. Evidence has shown that it can reduce mortality (in stroke care[17] for example) and complication rates in patients.[18] However, work needs to be undertaken to address recruitment and retention of Emergency Medicine trainees as a priority.[19] Anecdotal evidence from BMA members suggests that an unacceptable level of work intensity restricts opportunity for training and weakens morale amongst emergency medicine trainees. Increasing the number of consultants in ED settings, particularly those with expertise in treating frail elderly patients, as well as greater access to district and community nursing staff and social services facilities, may help ease the pressure on emergency care facilities.

9. Introducing the changes mentioned above would help move some minor injury and urgent care services out of EDs and into more accessible community settings. In addition, the Kings Fund is clear that incentives are needed to flex capacity and create better flow through the system.[20] To that end, the Payment by Results system needs to be reformed as hospitals are currently incentivised to maintain income, at the same time as being penalised through being paid a marginal tariff rate of 30% for increases in emergency activity above 2008–9 admission levels. It is clear that any proposals to move care into primary and community services would need to be accompanied by adequate resources.

10. Greater sharing and adoption of best practice is also needed, along with a more collaborative leadership model, improved availability and quality of data to allow the system to be effectively managed and improved matching of demand with supply.[21] For example, the Health Foundation established a programme[22] to help two trusts examine patient flow through the emergency care pathway and develop ways in which capacity could be better matched with demand, preventing queues and poor outcomes for patients. Both trusts reported early indications of apparent reductions in mortality, maintained performance during difficult financial times and, in some instances, removal of considerable capacity while improving quality of care and reducing length of stay.

11. We note with concern, however, the mortality figures that have been linked to the closure of Newark A&E and await the results of the investigation that has recently been launched.

12. We do not see how ambulance services can be better integrated with primary care because the two parts of the service have no connection now: the only link since April 2013 has been the ability of CCGs to manage the commissioning of ambulance services.

The Ability of Ambulance Services to continue to meet Increased Emergency Demand whilst contributing to the Nicholson Challenge

13. Pressure on emergency services could be alleviated by increasing the seniority, skills and experience of those handling telephone triage services, paramedics and pre-hospital care and promoting a culture of decision making at an early stage in order to reduce unnecessary admissions.

Experience to Date of the Transition from NHS Direct to the NHS 111 Service

14. The BMA has consistently expressed serious concerns about the transition from NHS Direct to the NHS 111, the new telephone triage service for people with urgent but non-life threatening conditions. The BMA wrote to the then Health Secretary, Andrew Lansley, in February 2012 warning of the dangers of rushed implementation. The BMA also wrote to the Health Minister, Earl Howe, and NHS England Chief Executive Sir David Nicholson urging them to delay the launch of NHS 111 beyond 1 April 2013 due to concerns that many areas were not ready for the transition.[23] The BMA repeatedly asked for the implementation of NHS 111 services not to be rushed, as a smooth transition was essential for patient safety. Concerns were expressed about the decision to split call handling from service providers, which now appears to have been borne out. The Government has conceded that the launch of NHS 111 "did not go as smoothly as planned and that a number of providers have delivered an unacceptable service, especially at weekends."[24]

15. Serious problems were encountered with NHS 111 when the system was launched in a number of areas including Greater Manchester, parts of London, the West Midlands and the North East of England. In Manchester, where NHS 111 was launched on 21 March 2013, patients reported waiting for several hours for calls back. Reports also indicate that the North West Ambulance Service was overwhelmed by 999 calls from patients because of an inability to get through to NHS 111 and long waiting times for responses to calls. The BMA is also aware of similar concerns about transition to NHS 111 in South London with reports of patients experiencing delays before receiving calls back. NHS 111 was put on hold in Southwark, Lambeth and Lewisham until 9 April 2013 after problems with the service emerged in Bexley, Bromley and Greenwich. In both Manchester and London, GPs and other doctors took back call handling of patient calls because of safety concerns.

16. Not all regions implemented the NHS 111 service from 1 April 2013. The service is currently running in 22 areas of England; the service will be introduced on a phased basis with areas that are not currently ready having until 30 June 2013 to roll out the service. The BMA believes that NHS England needs to be more transparent about how the system is functioning across the country and that no area should have to go live on any particular date until it is clear beyond doubt that the service is safe and resources are being used appropriately.

17. The chaos affecting NHS 111 is placing an additional strain on other already over-stretched parts of the NHS, such as the ambulance service, EDs and GPs, as well as potentially putting patients at risk. Media reports suggest that at least 22 possible serious untoward incidents relating to NHS 111 have been reported since the service was launched.[25] The BMA believes that calls to NHS 111 must be responded to with immediate, sound advice and not be subject to any forms of delay. Despite being designed to alleviate pressure on the NHS, the flawed introduction of NHS 111 appears to be adding further pressure on OOHs care and emergency care admissions.

The Implications Of The Shift Away From Determining The Success of Ambulance Services via Indicators based on Response Time to the New Measures Designed to Assess Clinical Effectiveness

18. There is evidence of gaming[26],[27] arising from the response time targets set for ambulance services in the NHS. The study found that as a result of intense focus on the response time target, some ambulance trusts were purposefully not classing urgent calls from GPs as "category A."[28] The research also found that a number of trusts put higher numbers of ambulances in densely-populated areas where it was easier to meet the target, at the expense of rural populations. The shift away from performance managing ambulance trusts on response times in favour of clinical effectiveness is welcomed.

19. The BMA has repeatedly warned that targets imposed by the Government on the NHS can distort clinical priorities, with some patients being prioritised over others with greater clinical need. The BMA broadly welcomes the emphasis on outcomes as an approach to help assess performance.

The Causes of Delay in Handover from Ambulance Services to A&E or Transfer between Different Levels of Urgent Care, and Actions Required to Eliminate between them

20. Any action to eliminate delays in the handover from ambulance services to EDs or transfer between different levels of urgent care needs to take into account how NHS targets are applied, monitored and managed. Although the 4 hour A&E target can have serious perverse consequences, and is unachievable in some areas as the service is presently constituted, for many patients it contributed to better and more timely care. Gridlocks within the hospital need to be addressed, as noted by the Health Foundation, to eliminate delays.

Clinical Evidence about Outcomes Achieved By Specialist Regional Centres, Taking Account of Associated Travel Times, Compared with More Generalist Hospital Based Services

21. The London Trauma System appears to have resulted in improvements in both processes of care and patient outcomes since the network was completed in January 2011.[29] As part of the System, a consultant is now available 24/7 in each of the four major trauma centres, which has enabled immediate assessment and treatment of seriously injured patients. Assessments have shown that an additional 58 Londoners who were expected to die of their injuries have survived as a result of the introduction of the London Trauma System.[30]

22. A key criterion in the development of the centralisation of stroke care in London model was that all London residents should be within 30 minutes travelling time of a hyper-acute unit. Evidence suggests this has been achieved with an average travel time of about 15 minutes from home to hospital; patient outcomes have also improved.[31]

23. Outcomes data collected by the Vascular Society also supports the move towards performing major arterial surgery in larger volume units in order to further optimise outcomes.[32]

Aspects Of Care Which are Likely to Improve by Being Located in Regional Specialist Units and the Risks Associated with Removing Services from Existing A&E Provision

24. A recent review of stroke care in London highlighted that outcomes have been improved following a decision to concentrate specialist stroke care in eight hyper-acute units.[33] Other aspects of care may also improve by being located in regional specialist units, although it is clear that centralisation does not always lead to improved outcomes. Further research should also be conducted to ascertain whether outcomes are also improved in rural areas.

25. The BMA acknowledges that not all hospitals may be needed in their current form in the future. In some cases, clinically appropriate reconfiguration may involve the merger or closure of units, departments, or even whole hospitals.[34] The BMA believes reconfiguration is acceptable where it is evidence-based; clinically led in partnership with patients; safe; and maintains or enhances standards of care across a health economy.[35] Further integration between health and social care and co-operation between services are likely to have a beneficial impact on both patient care and demand for ED services.

The effectiveness of the existing Consultation Process for Incorporating the View of Local Communities in to ED Service Design

26. The BMA believes that any service reconfiguration ought to follow the principles outlined in our publication "Engaging in local healthcare developments", which include having a thorough impact assessment, including an examination of safety issues. The Government's four key tests for service change should also be applied.[36]

The Ability of Local Authorities To Challenge Local Proposals for Reconfiguration under the Revised Oversight and Scrutiny Powers Included in the Health and Social Care Act 2012

27. The BMA notes that new arrangements for local authority health scrutiny have been put in place as a result of the Health and Social Care Act 2012. If local authorities are to carry out their new responsibilities effectively, they will need to have a properly resourced and qualified public health team in place, led by a Director of Public Health, to provide an independent opinion of the impact on the population's health.

28. The BMA agrees that there may be some advantage in agreeing a timetable for decision-making.[37] It is also reasonable for local authorities to be able to consider the financial implications of plans when considering a referral as such factors are likely to be drivers for change in the current financial climate. While the cost of any proposed reconfiguration is a relevant factor, it is essential that local authorities are able to challenge the financial arguments for change and can refer plans for further scrutiny if deemed appropriate. Any such challenges should be recorded in the Director of Public Health's Annual Report.

29. The BMA has reservations about proposals to involve NHS England on some service reconfigurations, particularly as the Independent Reconfiguration Panel (IRP) has a proven track record and expertise in overseeing reconfiguration of NHS services. The BMA is concerned that referring service reconfigurations to NHS England could lengthen the reconfiguration process as well as increasing bureaucracy.

May 2013

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1 See response by Anna Soubry MP, Parliamentary Under Secretary of State for Health, to debate on A&E waiting times, Westminster Hall, 23rd April 2013: "One million more people—perhaps this is not understood by some hon. Members—are using A and E departments every year, and it is important that we understand why that is. We know that there are nearly 4 million more A and E attendances compared with 2004, when the previous Government carried out what I and others believe was a disastrous renegotiation of the GP contract, which has had a clear knock-on effect on access to out-of-hours services". http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130423/halltext/130423h0001.htm#13042356000135

2 The College of Emergency Medicine notes that while Departments of Emergency Medicine may be known by several names (Casualty, Accident and Emergency, or Emergency Department) Emergency Department may best reflect the nature of the work, and is also the name used in other countries such as the USA and Australia. The BMA refers to Emergency Departments as well as A&E departments throughout this submission, where appropriate. http://www.collemergencymed.ac.uk/Public/What%20is%20Emergency%20Medicine/?

3 http://www.nuffieldtrust.org.uk/data-and-charts/ae-attendances-england

4 Are accident and emergency attendances increasing? The King's Fund, 29 April 2013

5 What works best? Review of Urgent Care Centres. A discussion paper from the Primary Care Foundation October 2012

6 Data from Accident and Emergency Attendances in England - 2011-12, Experimental statistics, Health and Social Care Information Centre, January 2013 (as mentioned in paragraph two) demonstrates that the attribution of changes in the volume of A&E attendances to changes in general practice behaviour is not supported by the information on patient demographics and timing of attendances.

7 Accident and Emergency Attendances in England - 2011-12, Experimental statistics, Health and Social Care Information Centre, January 2013

8 https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/tren-cons-rate-gene-prac-95-09/tren-cons-rate-gene-prac-95-09-95-09-rep.pdf, page 16

9 Since 2004, GPs have been able to choose whether to provide 24-hour care for their patients or to transfer responsibility for out-of-hours services to primary care trusts (PCTs). From April 1 2013 this will be dealt with by NHS Commissioning Board Area Teams. NHS Commissioning Board Area Teams are responsible for providing services for the local population. Some NHS Commissioning Board Area Teams provide care themselves. Others provide care through external organisations. This means different areas can have slightly different services: http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/out-of-

hours-services.aspx

10 For a personal account of a GP's experience of providing OOHs care, please go to http://abetternhs.wordpress.com/2013/05/10/true-history/

11 Speech by Jeremy Hunt, Secretary of State for Health, at the Age UK Conference, 25 April 2013, http://www.gponline.com/channel/news/article/1180157/jeremy-hunt-speech-age-uk-conference-full/

12 Data provided for the Department of Health by Qresearch for the period from 1995 to 2008 shows a sustained increase in consultations per person per year: the mean number increased from 4.71 in 2003 to 5.45 in 2008: https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/tren-cons-rate-gene-prac-95-09/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf. The BMA is not aware of any more recent data.

13 What works best? Review of Urgent Care Centres. A discussion paper from the Primary Care Foundation October 2012

14 http://drfosterintelligence.co.uk/thought-leadership/hospital-guide/

15 However, research from the King's Fund suggests that that some interventions being used in the NHS, although designed to avoid admissions, do not work: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/avoiding-hospital-admissions-lessons-from-evidence-experience-ham-imison-jennings-oct10.pdf

16 http://download.drfosterintelligence.co.uk/Hospital_Guide_2012.pdf, page 10

17 *Reducing deaths from stroke: a focused review of the literature* Nursing Older People, October 2004

18 *Raising the benchmark for the 21st Century- the 1000 cataract operations audit and survey: outcomes, consultant-supervised training and sourcing NHS choice* British Journal of Opthamology,2007

19 Shape of the Medical Workforce, August 2011, Centre for Workforce Intelligence

20 Urgent and Emergency Care, A Review for NHS South of England, Kings Fund, March 2013

21 Page 4, Urgent and Emergency Care, A Review for NHS South of England, Kings Fund, March 2013

22 Improving Patient Flow, Health Foundation, April 2013

23 http://bma.org.uk/news-views-analysis/news/2013/march/gps-implore-government-to-delay-nhs-111

24 Earl Howe, Parliamentary Under Secretary of State for Health, Parliamentary Question on NHS 111 telephone service, 13 May 2013 http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/130513-0001.htm#1305137000230

25 http://www.pulsetoday.co.uk/commissioning/commissioning-topics/urgent-care/22-nhs-111-serious-untoward-incidents-reported-including-three-deaths/20002842.article

26 Bevan Gwyn and Hamblin, Richard (2009) Hitting and missing targets by ambulance services for emergency calls: effects of different systems of performance measurements within the UK. *Journal of the Royal Statistical Society: series A (statistics in society),* 172 (1). Pp. 161-190. ISSN 0964-1998 http://onlinelibrary.wiley.com/doi/10.1111/j.1467-985X.2008.00557.x/pdf

27 http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/guidance-foundation-trusts/monthl-8

28 Category A ambulance calls, which include the most serious life-threatening conditions, need to be responded to in eight minutes.

29 http://www.londontraumaoffice.nhs.uk/silo/files/lto-annual-report-2010-to-2011.pdf

30 http://www.londontraumaoffice.nhs.uk/silo/files/lto-annual-report-2010-to-2011.pdf

31 Tony Rudd: the legacy of NHS London- stroke programme

32 Outcomes after Elective Repair of Infra Renal Abdominal Aortic Aneurisym, Vascular Society, March 2012

33 http://www.kingsfund.org.uk/audio-video/tony-rudd-legacy-nhs-london-%E2%80%93-stroke-programme

34 The BMA's Consultants Committee passed the following motion at its conference in 2010: *That this conference recognises that things change with time, so not all current hospitals may be needed in their current form in future, so in some cases clinically-appropriate reconfiguration will involve merger or closure of units, departments, or even whole hospitals. However, all such change must follow the CCSC's principles on reconfiguration, dated 28 August 2007, whose key principles are as follows: Reconfiguration is acceptable where it is: evidence-based; clinically-led in partnership with patients; safe; and maintains or enhances standards of care across a health economy*

35 Engaging in local healthcare developments http://bma.org.uk/working-for-change/the-changing-nhs/reconfiguration-and-integration/reconfiguration

36 The Operating Framework for the NHS in England, Department of Health

37 The TSAs for Mid Staffordshire NHS Foundation Trust, for example, have clearly set out a 145 legal working day legal timeframe since it was announced that the Trust was clinically and financially unsustainable in its current form: http://tsa-msft.org.uk/about-the-tsa/

 Prepared 26th July 2013

George Osborne blocked cap on elderly care costs

George Osborne blocked a plan to cap social care costs that had been due to be announced this summer after a row with Andrew Lansley, The Daily Telegraph can disclose.

Mr Lansley's plan would have proved controversial because a new group of middle-class pensioners would have faced bills for care that had previously been free Photo: EPA

By Robert Winnett, Political Editor
7:00AM BST 02 Oct 2012

Mr Lansley had spent months drawing up a proposal to means-test people who receive care in their own homes, in the same way as those moving into a nursing home.

Money saved would have paid for the costs of capping social care bills, as proposed by the independent Dilnot review commissioned by the Government.

Although the plan would have stopped people having to sell their homes, it would also have proved controversial because a new group of middle-class pensioners would have faced bills for care that had previously been free.

Mr Lansley's plan was angrily rejected by the Chancellor during a meeting of the quad of senior ministers to discuss reform of social care. The then health secretary is understood to have been asked to present the proposal to Mr Osborne, David Cameron, Nick Clegg and Danny

Alexander.

Well-placed sources said that Mr Osborne asked Mr Lansley: “Why are you robbing Peter to pay Paul?”

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He replied that it was “Treasury officials” who had asked his officials to find a solution to introducing a cap on social care costs within the existing system without additional money. Sources claim that Mr Lansley was “extremely angry” at the reaction to the proposal.

Within two months of the meeting, the Health Secretary had been demoted in the Cabinet reshuffle and Paul Burstow, the care minister, was sacked from the Government.

The Coalition is working on a new plan to introduce the Dilnot recommendations. This is expected to involve up to £2 billion of taxpayers’ money and is unlikely to be implemented until after the next spending review in 2014.

It is estimated that, within the next two decades, the number of people aged over 85 in England will double to more than two million, prompting fears of a crisis in the care system. Currently, only those with assets worth less than £23,000, including their homes, qualify to receive state funding for the costs of their treatment in nursing homes. An estimated 40,000 people a year are forced to sell their homes to meet the cost of care, which typically reaches £26,000 a year.

Last year, Andrew Dilnot published his report calling for a cap of £35,000 to be placed on the care bills faced by elderly and disabled adults during their lifetimes. The state would cover costs above this level and individuals could take out insurance to pay fees up to the level of the cap. In an article for The Daily Telegraph last month, Mr Burstow warned that there was “no sense of urgency” in the Treasury about reforming the “often complex and confusing care system”.

“For too many, the experience is degrading, stripping them of their dignity and their asset,” he wrote. “The longer Government delays, the more older people and their families will feel betrayed.

In the summer, Mr Cameron indicated that he supported care reform, telling The Telegraph he was “confident” that a cap on costs would be possible “but we’ve got to find the money first”.

After the row with Mr Osborne in July, Mr Lansley announced a watered-down proposal that allows people to effectively borrow money from their local authorities to be repaid after they die.

outside London - but many will be left disappointed

Comments

In George Osborne

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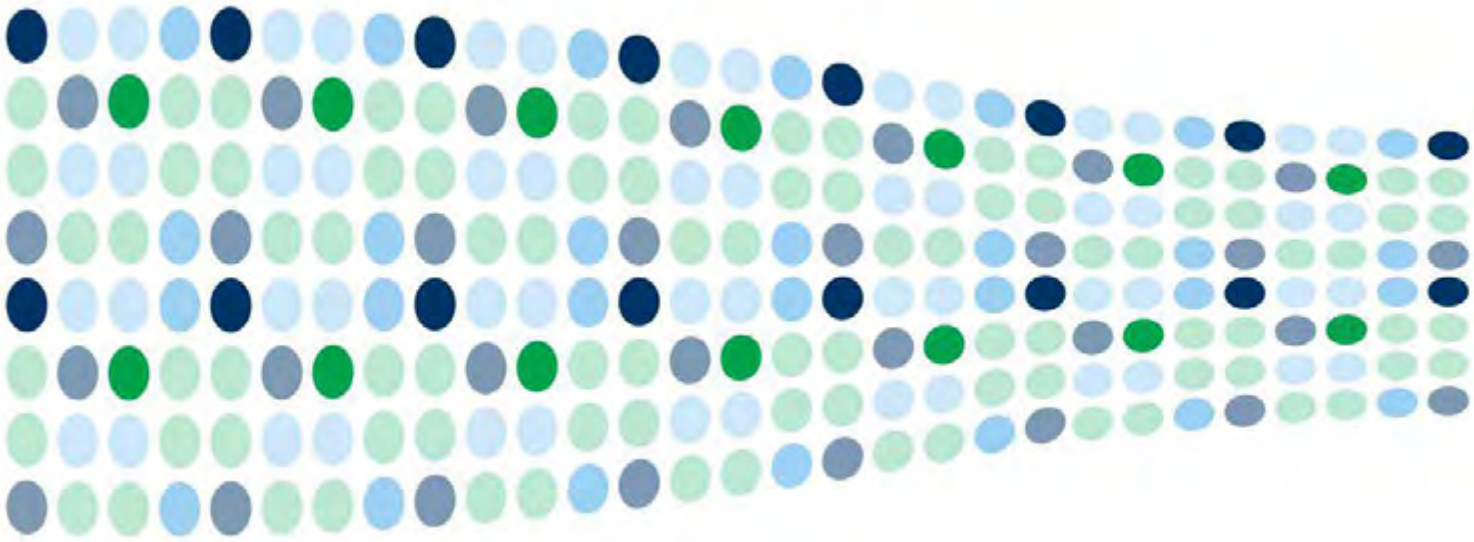
Data on Written Complaints in the NHS 2013-14



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This product may be of interest to patients, stakeholders, policy officials, commissioners and members of the public. Interests will range from comparisons of the NHS written complaint numbers at local, regional and national levels.

Author:	**Workforce and Facilities Team, Health and Social Care Information Centre**
Responsible statistician:	**Kate Bedford, Programme Manager**

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Contents

Summary

This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2013 and 31 March 2014. Data are collected via two forms; KO41a (NHS Hospital and Community Health Service (HCHS)) and KO41b (Family Health Service (GP including Dental) (FHS)). The data relates to the complaints arrangements introduced in April 2009.

Prior to 2013-14, FHS data was collected from Primary Care Trusts (PCTs).

This year (2013-14) FHS was collected from NHS England Area Teams who in turn collected the information on-line from individual practices. This means that for the first time data was supplied by individual practices to the HSCIC. Thus for 2013-14 a return rate is known, (77% GP and 43% Dental practices). Prior to 2013-14 PCTs provided an aggregated PCT return and in 2012-13 65 PCTs highlighted that at least 1 practice in their area failed to provide a response, which means the overall return rate was unknown.

The figures for the number of FHS written complaints indicate a rise between 2012-13 and 2013-14. However, due to the unknown response rate for 2012-13, it is not possible to accurately establish if the increase is due to a genuine rise or due to a greater number of practices providing information in 2013-14. Therefore direct comparisons between 2013-14 data and previous years for FHS and any overall NHS written complaint totals (where HCHS and FHS figures are added together) are not possible.

NHS HCHS data on its own is unaffected and year on year comparisons are possible.

For more information please read the Data Quality section of this publication.

Main findings[1] in 2013-14:

Total complaints (Hospital and Community Health Services and Family Health Services)

- Total number of all reported written complaints in 2013-14 exceeded 175,000 the equivalent of more than 3,300 written complaints a week and equivalent to 479.1 per day[2].

Hospital and Community Health Services (HCHS)

- Total number of all HCHS written complaints has increased by 4,990 (4.6%) from 109,000 in 2012-13 to 114,000 in 2013-14.

- By profession, Ambulance crews (including paramedics) has seen an increase of 28.5% from 4,440 in 2012-13 to 5,700 in 2013-14

- The number of complaints for the subject area Transport (ambulance and other) has increased by 1,190 (43.4%) from 2,740 in 2012-13 to 3,940 in 2013-14

[1] Figures over 1,000 have been rounded to the nearest 10, over 10,000 to the nearest 100 and over 100,000 to the nearest 1,000
[2] The written complaints per day is an average based on 365 days in a year

- The biggest proportion of HCHS written complaints by profession were for the *Medical* profession (which includes hospital doctors and surgeons) with 45.6% (52,100) of all HCHS written complaints. *Nursing, Midwifery and Health Visitin*g accounted for the second biggest at 21.7% (24,800). For 2012-13 the proportions were 47.1% and 22.1% respectively.

- 45.6% (52,300) of all HCHS written complaints reported are for the subject area All aspects of clinical treatment. This is a slightly lower proportion than last year's figure of 46.2% (51,100).

- The service area with the highest number of complaints was 'inpatient hospital acute services', with 34,400 (30.1%), a decrease of 450 (1.3%) from 2012-13 (34,900).

Provider and commissioning splits and mergers between organisations are also affecting changes in numbers. This needs to be taken into account when comparing organisational level data. Other reasons organisations have provided for large changes included better awareness of procedures, ward/hospital closures, better Patient Advice and Liaison Service (PALS) support and changes in car parking charges. See Data Quality section page 8 for further information regarding the accuracy and comparability of data.

Family Health Services (GP including dental) (FHS)

- Total number of all reported FHS written complaints in 2013-14 was 60,600.

- 40.3% (24,400) of all reported FHS written complaints reported were for the *Medical* service area

- 36.3% (22,200) of all reported FHS written complaints reported are for the subject area *Clinical*.

FHS 2013-14 data is not comparable with previous years – for more information please refer to the notes above and the Data Quality chapter.

Note: Figures over 1,000 have been rounded to the nearest 10, over 10,000 to the nearest 100 and over 100,000 to the nearest 1,000

Revisions and Issues

Introduction

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. The collection also captures complaints about NHS Direct and Walk-in Centres.

From April 2011, (in line with the Government's Transparency Agenda) it became mandatory for all organisations to supply the information. Prior to April 2011 Foundation Trusts (FTs) only supplied data voluntarily, which did not enable us to make year on year comparisons. Further details on the implications of FTs non-supply are contained in the Data Quality section of this publication.

The data have been published annually since 1997-98.

This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2013 and 31 March 2014. These data relate to the complaints arrangements introduced in April 2009. Although the 2009 regulations apply to complaints about both adult social care and the NHS, these data only cover NHS complaints.

The Department of Health reported that;

> "The government, in its response to the Health Select Committee report on Complaints and Litigation made clear in *Liberating the NHS*, remain committed to empowering individual patients, and agree it is important that NHS organisations view and manage complaints in a positive manner and use the information obtained to improve service delivery.
>
> The Government welcomes the Committee's acceptance that an increase in the number of complaints received by the NHS is not necessarily a reflection of the quality of services provided. The 2009 changes were designed to simplify the complaints arrangements and to make them more accessible. There was also significant publicity around the reforms that will have led to increased awareness of the system."

Data are collected via two forms; KO41a (NHS Hospital and Community Health Service) and KO41b (Family Health Service General Practice (including Dental))

2010-11

As it is now compulsory for all organisations to supply data, those FTs who had previously chosen not to respond were given the opportunity to submit data. Of the 29 FTs who did not submit data in 2010-11 six chose to provide this data, thus the 2010-11 data has been revised with an increase of 1,594 (1.1% for all complaints or 1.6% for just HCHS) from the figure published in 2010-11.

2011-12

A small number of organisations have indicated that their data submitted for 2011-12 was incorrect (see list below). As these numbers are relatively small and in line with the HSCIC's revision policy

we did not be amend 2011-12 figures but have highlighted the changes here for information purposes.

- Suffolk Community Healthcare (org code NHM): Last years should have been 22 (reported as nil)
- North Somerset Community Partnership Community Interest Company (org code NLT): The figure submitted for 2011/12 (reported as 6) was for NHS North Somerset which included the figures for North Somerset Community Partnership (NSCP). Since 1st April 2012 NSCP has been responsible for complaints as a stand-alone organisation. Total number of complaints for North Somerset Community Partnership for 2011-12 was 31.
- Specialist Health Services (org code NWL): Last year should have been 5 (reported as 3)

- Harrogate and District NHS Foundation Trust (org code RCD): Last year should have been 215 (reported as 196). However of these 215 complaints last year 19 records were submitted as part of the KO41(b) return. This trust mentions that they have been advised this year to submit all to KO41(a).

For the 2011-12 collection an additional data item was added to the KO41 data returns, "Number of Complaints Upheld." It is now possible to see how many complaints were upheld in addition to the number of complaints made to an organisation, which is not necessarily an accurate measure of performance. This was published as experimental statistics in 2011-12 and will continue to be classed as experimental statistics due to the wide variations and methods of collection adopted by different organisations. The experimental statistics can be found starting on page 32 of this publication. The upheld information is available at a national, regional and organisational level.

The classification of experimental statistics is in keeping with the UK Statistics Authority's Code of Practice. Experimental statistics are new official statistics that are undergoing evaluation.

Experimental statistics are published in order to involve users and stakeholders in their development, and as a means to build-in quality at an early stage. The UK Statistics Code of Practice states that *"effective user engagement is fundamental to both trust in statistics and securing maximum public value…"* and that as suppliers of information, it is important that we involve users in the evaluation of experimental statistics.

The UK Statistics Code of Practice can be accessed via the following web-link:
http://www.statisticsauthority.gov.uk/assessment/code-of-practice/code-of-practice-for-official-statistics.pdf

2012-13

KO41b, Family Health Services (GP including dental) (FHS).

Due to the number of PCTs unable to provide complete returns (65) for their GP Practices for 2012-13, we have been unable to make comparisons with 2012-13 FHS data and previous years. This also applies to any overall complaints totals (where HCHS and FHS figures are added together). HCHS data is unaffected. For more information please read the Data Quality section of this publication.

2013-14

The NHS has recently (April 2013) seen a structural change resulting in a transition of common functions into a variety of new organisations whose status is different to that previously presented in NHS written complaints publications.

KO41b, Family Health Services (GP including dental) (FHS).

This year FHS data was collected from NHS England Area Teams who in turn collected the information on-line from individual practices. This means that, for the first time, data was supplied by individual practices to the HSCIC. Thus for 2013-14 a return rate is known, (77% GP and 43% Dental practices). Prior to 2013-14 PCTs provided an aggregated PCT return and in 2012-13 65 PCTs highlighted that at least 1 practice in their area failed to provide a response, which means the overall return rate was unknown.

The figures for the number of FHS written complaints indicate a rise between 2012-13 and 2013-14. However, due to the unknown response rate for 2012-13 it is not possible to accurately establish if the increase is due to a genuine rise or due to a greater number of practices providing information in 2013-14. Therefore direct comparisons between 2013-14 data and previous years for KO41b (FHS) and any overall NHS written complaint totals (where HCHS and FHS figures are added together) are not possible.

NHS HCHS data on its own is unaffected and year on year comparisons are possible.

For more information please read the Data Quality section of this publication.

2013-14 consultation

Officials are continuing to review and evaluate the effectiveness of the complaints data to ensure that it is both an accurate reflection of the number of complaints made to the NHS, how many are upheld and importantly is user friendly. To this end there is currently an open consultation, which closes on the 5th September 2014. Details of the proposed changes and how to respond to the consultation can be found at: http://www.hscic.gov.uk/complaintsconsultation

If you are reading this document after the 5th September 2014 we would still welcome users feedback into what comparisons would be useful to them.

To help us ensure that our publications are as useful and informative as possible, we welcome comments on this publication. We will consider these comments to inform the production of future reports.

The HSCIC welcomes feedback on the methodology and tables within this publication. Please contact us with your comments and suggestions, clearly stating ‘Data on Written Complaints, England’ as the subject heading, via:

Email: enquiries@hscic.gov.uk

Telephone: 0845 300 6016

Post: 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE.

Data Quality

Accuracy:

The complaints data forms (KO41a and KO41b) are sent to every NHS organisation with patient responsibilities. Prior to April 2011 Foundation Trusts (FTs) were only supplying data on a voluntary basis (although the majority did supply this information). In the last year (2010-11) of FTs supplying the data voluntary there were 29 who did not submit data. These FTs are included within the organisational tables as a 'nil' return for that year. Table 1 All NHS Written Complaints, 2003-04 to 2013-14, England' of the excel spread sheet accompanying this publication shows the number of FTs by year who did not supply any information.

The following key is used within all tables accompanying this publication

- ' nil ' refers to organisations that did not submit a return
- ' - ' denotes zero.
- ' .. ' refers to no data available
- ' . ' denotes not applicable

Prior to 2013-14, KO41b (Family Health Service – GP and Dental) data was collected from Primary Care Trusts (PCTs).

Last year (2012-13) saw considerably more PCTs indicating that a number of practices have not provided a return compared with previous years. Care is needed when comparing FHS data over time as during the 2012-13 collection, 65 PCTs (out of 150) indicated they were unable to provide complete returns for all practices within their area compared to 36 in 2011-12. We are unable to quantify how many additional written complaints these organisations have received. Three of the PCTs approached for data did not provide a return in 2012-13. Due to the large number of incomplete returns from PCTs for 2012-13 we are unable to provide any comparisons with this year and previous years.

This year (2013-14) KO41b data (FHS) was collected from NHS England Area Teams who in turn collected the information on-line from individual practices. This means that for the first time data was supplied by individual practices to the HSCIC. Thus for 2013-14 a return rate is known, (77% GP and 43% Dental practices).

The figures for the number of FHS written complaints indicate a rise between 2012-13 and 2013-14. It is not possible to distinguish if this is:

- Simply more complaints being raised i.e. the organisations responding last year are also those that responded this year or
- Higher return rate due to improved collection method i.e. more organisations supplied data
- Different collection methods used by the organisation responsible for providing the data to the HSCIC, which was previously by PCTs (for 2012-13 and years prior) and currently by NHS England Area Teams for 2013-14 collection

To reflect this, the publication has been amended as follows:

General practices complaints:-

- Inserted a time series break between 2012-13 and 2013-14

- Removal from ALL relevant tables year on year numeric differences and % change figures
- Comparison to previous years cannot be made

This also impacts on All NHS Written Complaints, therefore similar changes for overall totals made as follows:

- Inserted a time series break between 2012-13 and 2013-14 for All NHS Written Complaints
- Removal from tables any year on year numeric differences and % change figures
- Comparison to previous years cannot be made

NHS HCHS data on its own is unaffected and year on year comparisons are possible.

Relevance:

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. This survey collects data from all NHS organisations and also captures complaints about NHS Direct and Walk-in Centres. The data have been published annually since 1997-98.

This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2013 and 31 March 2014. These data relate to the complaints arrangements introduced in April 2009. Although the 2009 regulations apply to complaints about both adult social care and the NHS, these data cover only NHS complaints.

These are used by the Department of Health to answer Parliamentary Questions, press queries and are available for use by any NHS organisation or the general public.

The Francis report, which was an Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, recommendations included the requirement for NHS organisations to have a more open and transparent complaints process and that complaint information is required to inform patient choice.

Comparability and Coherence:

This publication has not changed much over the years however information on complaints resolved within a target time limit is no longer required by legislation and from 2009-10 was no longer part of the collection. In 2011-12 it was made compulsory for Foundation Trusts (FTs) to return their data (previous years were voluntary) therefore absolute totals and percentages are not strictly comparable prior to 2011-12.

As it is now compulsory for all organisations to supply data, those FTs who had previously chosen not to respond were given the opportunity to submit data. Of the 29 FTs who did not submit data in 2010-11 six chose to provide this data, thus the 2010-11 data has been revised with an increase of 1,594 (1.1% for all complaints or 1.6% for just HCHS) from the figure published in 2010-11.

For the 2011-12 collection an additional data item was added to the KO41 data returns, “Number of Complaints Upheld.” It is now possible to see how many complaints were upheld in addition to the number of complaints made to an organisation, which is not necessarily an accurate measure of performance. This was published as experimental statistics in 2011-12 and will continue to be classed as experimental statistics for now due to the wide variations and methods of collection

adopted by different organisations. The Experimental statistics can be found starting on page 32 of this publication

Over the past few years the NHS has gone through a series of changes which has affected the numbers of complaints received by organisations with responsibilities changing over time between commissioning and provider roles. Thus some organisations have seen large increases with others having large decreases due to changing roles and responsibilities and not necessarily a change to the complaint process. Where known these have been highlighted within the individual organisation tables.

At April 1st 2013 a re-organisation of the NHS meant that the SHAs and PCTs have been replaced with NHS England Area Teams (ATs) and Clinical Commissioning Groups (CCGs).

Data from 2013-14 onwards will be presented at Area Team level (2012-13 data was estimated at these levels where possible). We are unable to map the data to CCG level at present. Information at England level is unaffected by these changes.

Prior to 2013-14, KO41b (Family Health Service – GP and Dental) data was collected from Primary Care Trusts (PCTs).

2012-13 saw considerably more PCTs indicating that a number of practices have not provided a return compared with previous years. Care is needed when comparing FHS data over time as during last year's collection (2012-13) 65 PCTs (out of 150) indicated they were unable to provide complete returns for all practices within their area compared to 36 in 2011-12. We are unable to quantify how many additional written complaints these organisations have received. Three of the PCTs approached for data did not provide a return in 2012-13. Due to the large number of incomplete returns from PCTs for 2012-13 we are unable to provide any comparisons with this year and previous years.

2013-14 KO41b data (FHS) was collected from NHS England Area Teams who in turn collected the information on-line from individual practices. This means that for the first time data was supplied by individual practices to the HSCIC. Thus for 2013-14 a return rate is known, (77% GP and 43% Dental practices), however there are some issues (see below) that make 2013-14 data incomparable with previous years.

The figures for the number of FHS written complaints indicate a rise between 2012-13 and 2013-14. It is not possible to distinguish if this is:

- Simply more complaints being raised i.e. the organisations responding last year are also those that responded this year or
- Higher return rate due to improved collection method i.e. more organisations supplied data
- Different collection methods used by the organisation responsible for providing the data to the HSCIC, which was previously by PCTs (for 2012-13 and years prior) and currently by NHS England Area Teams for 2013-14 collection

This affects the way we have presented the data for both KO41b (FHS) data and total figures for All NHS Written complaints (KO41a and KO41b combined), changes are indicated below:

KO41b (FHS data)

- Insert time series break between 2012-13 and 2013-14 for Total general practice complaints
- Remove from ALL relevant tables year on year numeric differences and % change figures

- Comparison to previous years cannot be made

All NHS Written complaint

- Insert time series break between 2012-13 and 2013-14 for All NHS Written complaints
- Remove from tables any year on year numeric differences and % change figures
- Comparison to previous years cannot be made

Organisations have a statutory responsibility to adhere to the 2009 regulations (available here), which should ensure consistency on collection and reporting of written complaints. The HSCIC has no authority or responsibility to audit organisations to ensure that they are capturing and recording correctly all complaints. Each organisation monitors and audits their own collection process.

Upheld data:

Since the inclusion of the upheld collection in 2011-12, each year including the latest (2013-14), organisations have fed back a number of concerns over the collection and supply of the upheld figures. In summary the concerns are:

- A complaint can have a number of different aspects with no ability to distinguish within the monitoring system the various aspects, therefore a complaint is upheld if any element of the complaint is well founded.
- Comments show that there is and continues to be significant variation in recording practice across England with some organisations classifying all complaints as upheld upon receipt of a written complaint whilst others class all complaints as not upheld due to actively responding and resolving the written complaint.

Timeliness and punctuality:

The collection of the complaints information is taken during May following the end of the year in March to enable all the complaints for the previous year (April – March) to be assessed and included in the returns.

The complaints data is made available as soon as possible after it has been validated and compiled.

Accessibility:

All data areas are published and available in this publication, excel spread sheets and all data items collected in CSV files are available via HSCIC's own internet site and data.gov.uk. Further detailed analyses may be available on request, subject to resource limits and compliance with disclosure control requirements.

Performance cost and respondent burden

The KO41a and KO41b is a simple data collection and asks organisations to provide data that they already collect and is produced from existing administrative systems with minimal burden.

Confidentiality, Transparency and Security:

The standard HSCIC data security and confidentiality policies have been applied in the production of these statistics.

Analysis and Commentary

Introduction

The following sections (for All and Hospital and Community Health Services (HCHS) written complaints) are laid out to show information for every organisation. Since the collection became mandatory for all organisations (including FTs) in April 2011 figures for HCHS only for the last three years are directly comparable.

Due to FTs voluntary submission of data from 2007-08 to 2010-11, overall figures (numbers of complaints) are not directly comparable for these years.

Caution should be taken when interpreting the basic quantitative data. An organisation that has good publicity, that welcomes complaints as an opportunity to learn and to improve services, and that has a non-defensive approach in responding to complaints may be expected to receive a higher number of complaints than an organisation with poor publicity and a defensive approach in responding. Yet one might also expect its services to be of a higher quality. It is important that organisations are open about the number of complaints received, but these should not be read in isolation. The annual reports that organisations have to produce places a duty on them to provide further information which provides a more rounded view of complaints handling.

Officials are continuing to review and evaluate the effectiveness of the complaints data to ensure that it is both an accurate reflection of the number of complaints made to the NHS, how many are upheld and importantly is user friendly. To this end there is currently an open consultation, which closes on the 5th September 2014. Details of the proposed changes and how to respond to the consultation can be found at: http://www.hscic.gov.uk/complaintsconsultation

For 2013-14 there are no changes to the data.

This report concentrates on HCHS information, given the issues around the FHS data.

All NHS - Hospital and Community Health Services and Family Health Services: General Practice (including Dental)

Table 1a All NHS Written Complaints, 2007-08 to 2013-14, England

	2007-08	2008-09	2009-10	2010-11[R]	2011-12	2012-13[(1)]	2013-14 [(2)]
All NHS written complaints	**131,022**	**137,736**	**151,832**	**149,765**	**162,129**	**162,019**	**174,872**
Number of Foundation Trusts not returning data [(3)]	*17*	*23*	*18*	*23*	-	-	-

[(1)] We are unable to provide comparisons between 2012-13 and previous years for figures including FHS (GP data) due to the number of PCTs unable to submit complete returns this year . For more information see the Data Quality section of this publication.

[(2)] We are unable to provide comparisons between 2013-14 with previous years for figures including FHS (GP data) due to the change in collection methodology and return rates from practices in 2013-14. For more information see the Data Quality section of this publication.

[(3)] Up to 2010-11 data from FT was returned on a voluntary basis.

R = Revised, includes 6 FTs who provided data for 2010-11 since 2010-11 publication

Table 1a shows the total number of all reported written complaints in 2013-14 was 174,872, the equivalent of more than 3,300 written complaints a week.

The rise of over 10% seen between 2008-09 and 2009-10 was partly due to the changing emphasis placed on the complaint reporting and monitoring. It should also be noted that the drop in the number of FTs not responding may have contributed to the increase.

The 2009 changes were designed to simplify the complaints arrangements and to make them more accessible. There was also significant publicity around the reforms that will have led to increased awareness of the system.

Hospital and Community Health Services (HCHS)[3]

Tables 1 to 8 and Figures 1 to 3

Table 1b HCHS Written Complaints, 2007-08 to 2013-14, England

	2007-08	2008-09	2009-10	2010-11[R]	2011-12	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
HCHS Written Complaints	**87,080**	**89,139**	**101,077**	**99,057**	**107,259**	**109,316**	**114,308**	**4,992**	**4.6%**
Total organisations approached for data	*392*	*393*	*390*	*381*	*453*	*459*	*636*		
Number of foundation Trusts not returning data [(1)]	*17*	*23*	*18*	*23*	-	-	-		

(1) Up to 2010-11 data from FT returned on a voluntary basis.

R = Revised, includes 6 FTs who provided data for 2010-11 since 2010-11 publication

The number of reported written complaints about Hospital and Community Health Services has increased by 4.6% (4,992) from 109,316 in 2012-132 to 114,308 in 2013-14.

Factors which affect the numbers of written complaints an organisation receives include:

- Processes in place to resolve potential and verbal complaints before they escalate to written complaints. These include some organisations making staff available to discuss and resolve issues.
- Staff making patients aware of other helpful services such as the Patient Advice and Liaison Service, known as PALS, which has been introduced to ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. They provide information about the NHS complaints procedure and how to get independent help if you decide you may want to make a further complaint.
- Organisations have a responsibility to highlight the complaints procedures/processes and alternatives to patients, through a variety of methods including leaflets, poster adverts and through 1-2-1 discussions with patients. This better awareness of the written complaints process is leading to more patients complaining.

The large increase between 2008-09 and 2009-10 will be made up of:

[3] Up to 2010-11 data from FTs returned on a voluntary basis.

- Fewer non-respondent FTs, but predominantly due to
- Complaint regulation changes introduced April 2009 which made it easier for patients (or their representatives) to make a complaint.

From 2007-08 to 2010-11 it is difficult to state categorically that HCHS complaints have been increasing, decreasing or are static due to FTs voluntary response option. The HSCIC has been unable to estimate data for non-respondents due to the very different services offered by organisations across the NHS.

Hospital and Community Health Services (HCHS) by Service Area

Figure 1: 2013-14 Hospital and Community Health Services (HCHS) : Written Complaints by Service Area, England

Hospital acute services: Inpatient	**34,422**
Hospital acute services: Outpatient	**31,083**
Mental health services	**12,221**
Hospital acute services: A&E	**9,919**
Ambulance services	**6,873**
Other community health services	**6,292**
Areas with < 5%	**13,498**
Other	3,684
Maternity services	3,343
CCG, NHS England commissioning	2,547
Community hospital services	2,001
Elderly (geriatric) services	1,058
Walk in centres	503
NHS Direct	362
Total	**114,308**

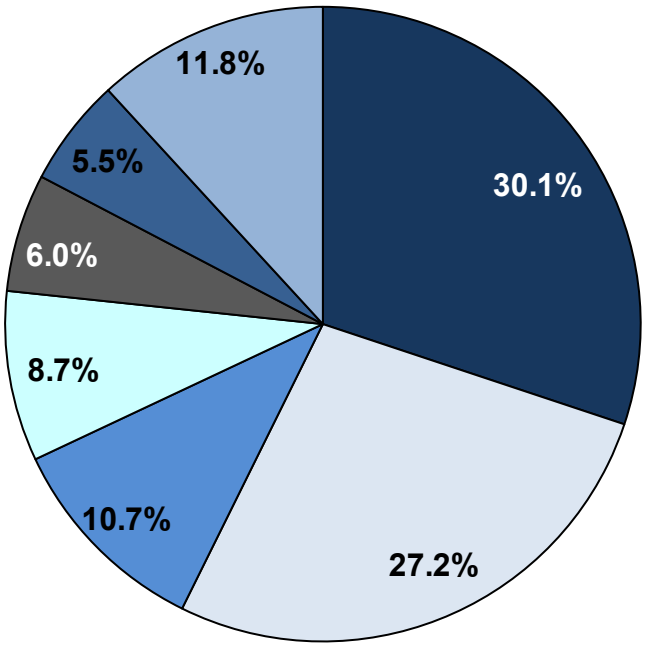


Figure 1 shows the number (table) and percentage (pie chart) of HCHS written complaints received by service area in England. It can be observed that *Inpatient -Hospital acute services* has the greatest percentage at 30.1% closely followed by *Outpatient – Hospital acute services* with 27.2%.

By Area Team *Inpatient -Hospital acute services* ranges from 23.7% in London to 44.5% in North Yorkshire and Humber. Almost all Area Teams have the majority (21 of 25) of complaints in the service area of Inpatient – Hospital acute services. The remaining four being Cumbria, Northumberland, Tyne and Wear Area Team, London Area Team, Leicestershire and Lincolnshire Area Team and the Essex Area Team which have their majority in Outpatient – Hospital acute services.

It should be noted that although Inpatient Hospital acute services has the greatest number of all written complaints by service area it is unknown if this is good or bad in relation to the other service areas, since we are unable (at present) to provide comparable statistics, such as number of complaints per 100,000 patients treated. The HSCIC, together with DH will investigate means of collecting patient number details to enable greater comparison across service areas. To this end there is currently an open consultation, which closes on the 5th September 2014. Details of the proposed changes and how to respond to the consultation can be found at: http://www.hscic.gov.uk/complaintsconsultation

HCHS by Service Area

Table 2a Hospital and Community Health Services (HCHS) : Written Complaints by Service Area, 2012-13 to 2013-14, England

	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All Service Areas	**109,316**	**114,308**	**4,992**	**4.6%**
Hospital acute services: Inpatient	34,872	34,422	**-450**	**-1.3%**
Hospital acute services: Outpatient	30,019	31,083	**1,064**	**3.5%**
Mental health services	11,749	12,221	**472**	**4.0%**
Hospital acute services: A&E	9,680	9,919	**239**	**2.5%**
Ambulance services	5,332	6,873	**1,541**	**28.9%**
Other community health services	6,840	6,292	**-548**	**-8.0%**
Other	2,045	3,684	**1,639**	**80.1%**
Maternity services	3,427	3,343	**-84**	**-2.5%**
CCG, NHS England commissioning	2,507	2,547	**40**	**1.6%**
Community hospital services	1,315	2,001	**686**	**52.2%**
Elderly (geriatric) services	880	1,058	**178**	**20.2%**
Walk in centres	457	503	**46**	**10.1%**
NHS Direct	193	362	**169**	**87.6%**

Table 2a shows that the largest percentage increase between 2012-13 and 2013-14 within service area, was in *NHS Direct* at 87.6% although this is based on small numbers and overall NHS Direct accounted for the lowest number of written complaints. *Other community health services* showed the largest fall at 8.0%.

Other community health services – is community based care, provided by a pharmacist, named nurse or multidisciplinary team. Further details are available in the aid to interpretation section of this document.

Ambulance services written complaints increased from 5,332 in 2012-13 to 6,873 in 2013-14 a 28.9% rise. During 2013-14 some ambulance trusts took over responsibility for 111 services, so the increase is a combination of the additional 111 service complaints plus a potential increase in the number of complaints against traditional ambulance services.

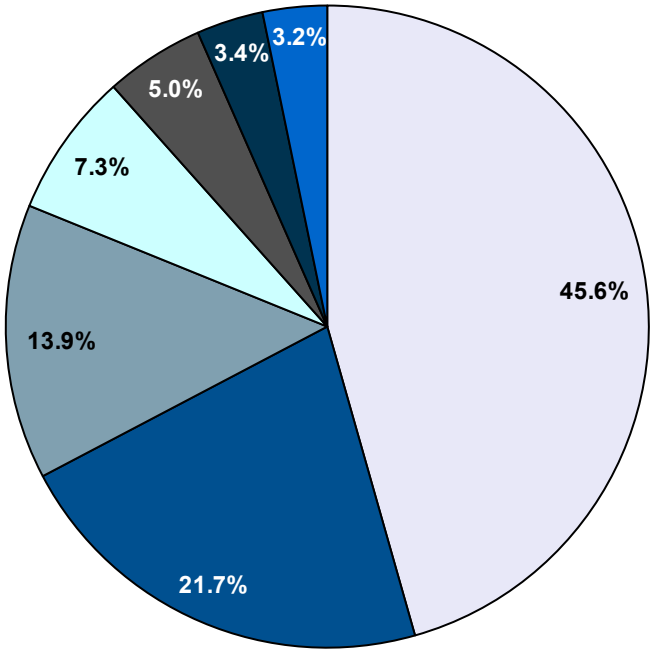
Over the past few years the NHS has gone through a series of changes with responsibilities changing over time between commissioning and provider roles, which has affected both the numbers and categorisation of complaints received by organisations.

Thus some service areas have seen large increases with others having large decreases due to changing roles and responsibilities and not necessarily a change to the quality of services. This will cease to be a factor going forward.

HCHS by Profession

Figure 2: 2013-14 Hospital and Community Health Services (HCHS): Written Complaints by Profession, England

Medical (including surgical)	**52,123**
Nursing, Midwifery and Health Visiting	**24,793**
Other	**15,835**
Trust Administrative staff / members	**8,323**
Ambulance crews (including paramedics)	**5,702**
Professions supplementary to medicine	**3,836**
Professions with < 2%	**3,696**
Administrative staff / members (exc GP admin)	1,196
Scientific, Technical and Professional	1,139
Dental (including surgical)	718
Maintenance and Ancillary staff	643
Total	**114,308**



The *Medical* profession had the highest percentage of written complaints at 45.6% (52,123), followed by *Nursing, Midwifery and Health Visiting* at 21.7% (24,793), both proportions are slightly lower than 2012-13 figures (47.1% and 22.1% respectively). *Trust Administrative staff* accounts for 7.3% (8,323) of written complaints, a slight rise (in the proportion of complaints by profession) from 7.2% in 2012-13.

By Area Team, Greater Manchester has the lowest percentage of *Medical (including surgical)* written complaints at 33.2%, with Leicestershire and Lincolnshire having the highest at 63.1%.
It should be noted that although Medical (including surgical) has the greatest number of all written complaints by profession, it is unknown if this is good or bad in relation to the other professions, since we are unable (at present) to provide comparable statistics, such as number of complaints per 100,000 patients treated.

HCHS by Profession

Table 3a Hospital and Community Health Services (HCHS) : Written Complaints by Profession, 2012-13 to 2013-14, England

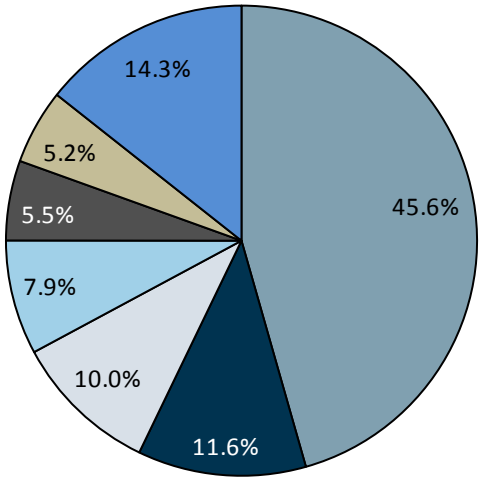
	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All Professions	**109,316**	**114,308**	**4,992**	**4.6%**
Medical (including surgical)	51,462	52,123	661	1.3%
Nursing, Midwifery and Health Visiting	24,146	24,793	647	2.7%
Other	13,812	15,835	2,023	14.6%
Trust Administrative staff / members	7,818	8,323	505	6.5%
Ambulance crews (including paramedics)	4,438	5,702	1,264	28.5%
Professions supplementary to medicine	3,926	3,836	-90	-2.3%
Administrative staff / members (exc GP admin)	1,077	1,196	119	11.0%
Scientific, Technical and Professional	1,051	1,139	88	8.4%
Dental (including surgical)	918	718	-200	-21.8%
Maintenance and Ancillary staff	668	643	-25	-3.7%

Table 3a shows that the largest percentage increase between 2012-13 and 2013-14 within professions, was in *Ambulance crews (including paramedics)* (28.5%) with *Dental (including surgical)* showing the largest fall (21.8%).

HCHS by Subject

Written Complaints by Subject [1], England

All aspects of clinical treatment	52,330
Attitude of staff	13,269
Communication / information to patients (written and oral)	11,472
Appointments, delay / cancellation (outpatient)	9,038
Other	6,303
Admissions, discharge and transfer arrangements	5,913
Subjects with < 5%	16,463
Total	**114,788**



(1) A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained w ithin the complaint letter received. Therefore the total number of complaints by subject (114,788) does not match the actual total number of complaints w hich is 114,308.

By subject[4] , the highest percentage of written complaints concerned the subject area *All aspects of clinical treatment* at 45.6% (52,330), compared to 46.2% (51,071) in 2012-13. This was followed by *Attitude of staff* at 11.6% (13,269), compared to 11.1% (12,303) in 2012-13. The third highest subject of complaint at 10.0% (11,472) concerned both *written and oral communication of information* to patients, last year this was 10.5% (11,606).

It should be noted that although *All aspects of clinical treatment* has the greatest number of all written complaints by subject it is unknown if this is good or bad in relation to the other subject areas, since we are unable (at present) to provide comparable statistics, such as number of complaints per 100,000 patients treated.

[4] A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained within the complaint letter received. Therefore the total number of complaints by subject (114,788) does not match the actual total number of complaints which is 114,308.

HCHS by Subject

Table 4a Hospital and Community Health Services (HCHS) : Written Complaints by Subject of Complaint [1], 2012-13 to 2013-14, England

	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All Subjects of Complaint [1]	**110,639**	**114,788**	**4,149**	**3.8%**
All aspects of clinical treatment	51,071	52,330	1,259	2.5%
Attitude of staff	12,303	13,269	966	7.9%
Communication / information to patients (written and oral)	11,606	11,472	-134	-1.2%
Appointments, delay / cancellation (outpatient)	8,886	9,038	152	1.7%
Other	5,809	6,303	494	8.5%
Admissions, discharge and transfer arrangements	6,227	5,913	-314	-5.0%
Transport (ambulances and other)	2,744	3,935	1,191	43.4%
Appointments, delay / cancellation (inpatient)	2,430	2,681	251	10.3%
Aids and appliances, equipment, premises (including access)	1,534	1,529	-5	-0.3%
CCG, NHS England commissioning (including waiting lists)	1,531	1,315	-216	-14.1%
Failure to follow agreed procedures	820	1,109	289	35.2%
Patients property and expenses	1,139	1,091	-48	-4.2%
Patients privacy and dignity	1,147	1,029	-118	-10.3%
Personal records (including medical and / or complaints)	987	1,017	30	3.0%
Policy and commercial decisions of trusts	883	734	-149	-16.9%
Hotel services (including food)	703	644	-59	-8.4%
Independent sector services commissioned by CCGs, NHS England	65	462	397	610.8%
Consent to treatment	201	229	28	13.9%
Patient's status, discrimination (e.g. racial, gender, age)	194	185	-9	-4.6%
Length of time waiting for a response, or to be seen: NHS Direct	50	168	118	236.0%
Complaints handling	111	120	9	8.1%
Length of time waiting for a response, or to be seen: Walk in centres	105	106	1	1.0%
Mortuary and post mortem arrangements	48	42	-6	-12.5%
Independent sector services commissioned by trusts	25	38	13	52.0%
Code of openness - complaints	20	29	9	45.0%

[1] A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained within the complaint letter received. Therefore the total number of complaints by subject does not match the actual total number of complaints.

Table 4a shows that the subject area *All aspects of clinical treatment* had the greatest number at 52,330 (45.6% of the total) of all complaints by subject an increase of 2.5% since 2012-13. The subject which received the fewest complaints during 2013-14 was *Code of openness – complaints* with just 29 (less than 0.1% of the total).

Care needs to be taken when considering just the percentage change year on year as the large percentage changes can be affected by the size of the numbers involved.

Family Health Services: General Practice (including Dental)

Tables 9 to 12 and Figures 4 & 5

Table 9a General Practice (including Dental) Health Services : Written Complaints, 2008-09 to 2013-14, England

	2008-09[1]	2009-10	2010-11	2011-12	2012-13[2][4]	2013-14[4][5]
Total general practice (including dental) health services Complaints	**48,597**	**50,755**	**50,708**	**54,870**	**52,703**	**60,564**
Total organisations approached for data	*152*	*152*	*151*	*154*	*150*	*25*
of which incomplete returns [3]	*36*	*18*	*29*	*36*	*65*	*25*

[1] Includes one PCT in 2008-09 which did not submit a return

[2] Three PCTs failed to submit a return for 2012-13

[3] Information from some PCTs state they did not receive returns for some practices within their area and so have submitted incomplete data.

[4] We are unable to provide comparisons between 2012-13 with previous years for figures including FHS (GP data) due to the number of PCTs unable to submit complete returns in 2012-13. For more information see the Data Quality section of this publication.

[5] We are unable to provide comparisons between 2013-14 with previous years for figures including FHS (GP data) due to the number of NHS England Area Teams unable to submit complete returns in 2013-14. For more information see the Data Quality section of this publication.

Data as at 1 April - 31 March each year

The total number of written complaints about general practice (including dental) health services in 2013-14 was 60,564. We are unable to provide comparisons with previous years due to:-

This year FHS (KO41b) data was collected from NHS England Area Teams who in turn collected the information on-line from individual practices. This means that, for the first time, data was supplied by individual practices to the HSCIC. Thus for 2013-14 a return rate is known, (77% GP and 43% Dental practices). Prior to 2013-14 Primary Care Trusts (PCT) provided an aggregated PCT return and in 2012-13 65 PCTs highlighted that at least 1 practice in their area failed to provide a response, which means the return rate was unknown.

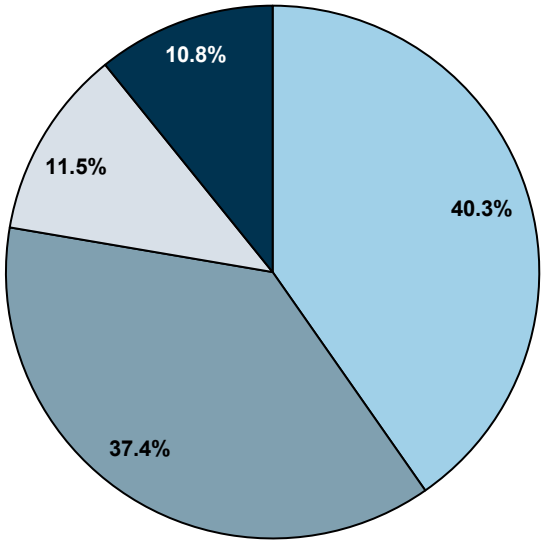
The figures for the number of FHS written complaints indicate a rise between 2012-13 and 2013-14. However, due to the unknown response rate for 2012-13 it is not possible to accurately establish if the increase is due to a genuine rise or due to a greater number of practices providing information in 2013-14. Therefore direct comparisons between 2013-14 data and previous years for FHS and any overall NHS written complaint totals (where HCHS and FHS figures are added together) are not possible.

Table 9 contained within the excel spread sheet accompanying this publication shows the number of PCTs for each year since 2008-09 who indicated that they have not had a response from at least 1 of their practices. Therefore comparisons of the numbers year on year could be misleading. Three PCTs did not provide any data for their areas for 2012-13.

FHS by Service Area

Figure 4: 2013-14 Family Health Services: Written Complaints by Service Area, England

Medical	24,405
General Practice administration	22,643
Dental	6,973
Other	6,543
Total	**60,564**



The highest percentage of written complaints concerned the *Medical* service area; 40.3% or 24,405 complaints. The service area with the second highest percentage of written complaints at 37.4% (22,643) concerned the *General Practice administration.*

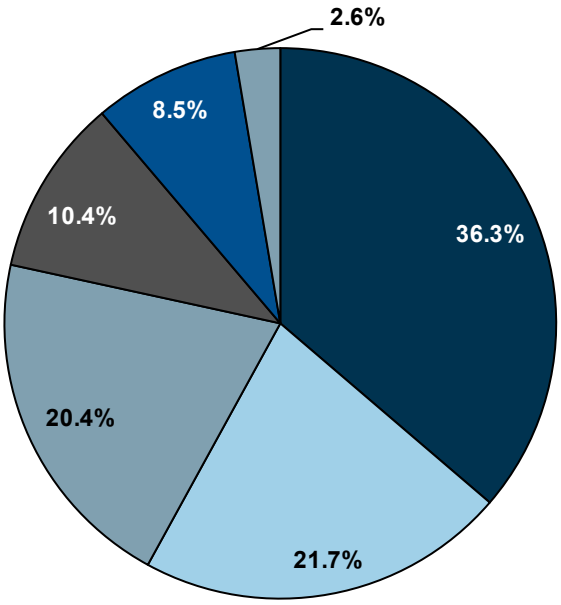
The percentage of service area complaints for *Medical* varies across Area Teams from 27.3% (Lancashire) to 86.9% (North Yorkshire and Humber). *Medical services* is not the highest proportion in every Area Team. This varies across many of the Area Teams.

It should be noted that although *Medical* has the greatest number of all written complaints by service area it is unknown if this is good or bad in relation to the other service areas, since we are unable (at present) to provide comparable statistics, such as number of complaints per 100,000 patients treated.

FHS by Subject

Figure 5: 2013-14 Family Health Services: Written Complaints by Subject [(1)], England

Clinical	22,202
Communications / attitude	13,275
General Practice administration	12,513
Practice / surgery management	6,360
Other	5,225
Premises	1,621
Total	**61,196**



[(1)] A complaint can be made concerning more than one subject area. Where this has occurred, the complaint is recorded under each subject area contained w ithin the complaint letter.

The highest percentage of written complaints by subject at 36.3% (22,202) concerned the subject[5] area *Clinical*.

Communications / attitude subject area was the second highest with 21.7% (13,275).

The percentage of *Clinical* subject area complaints ranged across Area Teams from 22.0% (Lancashire) to 43.2% (Wessex).

When a written complaint is received the subject area it is attributed to depends on the nature of the complaint. Organisations are provided with guidance which explains the subcategories for each service area to attribute the complaint. Briefly,

- 'communications/attitude' complaint falls into this category if it concerns a contact made either face to face or by telephone, facsimile, email or website and issues relating to verbal/non-verbal characteristics, or content
- 'practice/surgery management' complaint falls into this category if it concerns the Decisions made by the practice manager about the operation of the practice /service (e.g. access to individual practitioners, appointments, opening hours, locum cover)
- 'GP administration' complaint falls into this category if it concerns activities undertaken by the reception and administrative staff within the practice

5 A complaint can be made concerning more than one subject area. Where this has occurred, the complaint is recorded under each subject area contained within the complaint letter. Submitting data by subject of complaint is optional for the Family Health Services collection.

It should be noted that although *Clinical* has the greatest number of all written complaints by subject it is unknown if this is good or bad in relation to the other subject areas, since we are unable (at present) to provide comparable statistics, such as number of complaints per 100,000 patients treated. The HSCIC together with DH will investigate means of collecting patient number details to enable greater comparison across subject area. We welcome users feedback into what comparisons would be useful to them.

UK Home Country

Written complaints data for the other UK home countries is published however these are not directly comparable with the England data on written complaints contained within this bulletin. Factors which mean the different home country information is not comparable include:

- Wales – New regulations aimed at streamlining the handling of complaints about the NHS in Wales, referred to as Putting Things Right, came into force on 1 April 2011. Under these arrangements a new set of data will be collected. The new set of data is not comparable with the KO41 a or b.
- Scotland - There is a variation in recording practice across Scotland and some NHS Boards / organisations include telephone and other formal oral complaints. England contain only written complaints.
- Northern Ireland – Northern Ireland have an integrated health and social care system, which mean that Trusts figures would include complaints regarding social workers England's figures do not include social workers.

Related publications from other UK countries are available from the following links;

- Wales; http://wales.gov.uk/topics/statistics/headlines/health2011/110921/?lang=en
- Wales compliant online data: https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Performance/Complaints

- Scotland; http://www.isdscotland.org/Health-Topics/Quality-Improvement/NHS-Complaints-Statistics/statistics/

- Northern Ireland; http://www.hscboard.hscni.net/publications/Complaints/

Aid to Interpretation

i) Methods used to compile the statistics

Background

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. This survey collects data from all NHS organisations and also captures complaints about NHS Direct and Walk-in Centres. The data have been published annually since 1997-98.

This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2013 and 31 March 2014. The 2009 regulations provides details on what constitutes a complaint and the duties placed on organisations in responding to a written complaint. The 2009 regulations are available here

Data are collected via two forms; KO41a (NHS Hospital and Community Health Service) and KO41b (Family Health Service (GP)).

Organisations have a statutory responsibility to adhere to the 2009 regulations which should ensure consistency on collection and reporting of written complaints. The HSCIC has no authority or responsibility to audit that organisations are capturing and recording correctly all complaints. Each organisation monitors and audits their own collection process.

Note: Information on complaints resolved within a target time limit is no longer required by legislation and from 2009-10 was no longer part of the collection.

The statistics in the Data on Written Complaints publication have been assessed by the United Kingdom Statistics Authority (UKSA), the report is available **here.**

The 2009 regulations adopted a single approach for dealing with complaints about NHS and adult social care services, with organisations encouraged to ask people what they think of their care, to sort out problems more effectively and to use the opportunities to learn.

The new approach is designed to bring real benefits for health and care organisations and for the staff working in them.

From April 2009, health and social care managers have to show how they use feedback to learn and improve. Under the new complaints legislation, organisations need to produce an annual report detailing:

- the number of complaints they receive
- the issues that these complaints raise
- whether complaints have been upheld, and
- the number of cases referred to an Ombudsman.

Organisations will also need to record any significant issues raised by complaints, the lessons learnt and actions taken.

Improving the patient experience is a key priority for the government and it was recognised that simply counting the number of complaints made to an organisation did not indicate how an organisation was performing. From 2011-12 an additional data item was added to the KO41 data

returns, “Number of Complaints Upheld.” It will now be possible to see how many complaints were upheld in addition to the number of complaints made to an organisation, which is not necessarily an accurate measure of performance.

It should be noted that caution should be taken when interpreting the basic quantitative data. An organisation that has good publicity, that welcomes complaints as an opportunity to learn and to improve services, and that has a non-defensive approach in responding to complaints may be expected to receive a higher number of complaints than an organisation with poor publicity and a defensive approach in responding. Yet one might also expect its services to be of a higher quality. It is important that organisations are open about the number of complaints received, but these should not be read in isolation – the annual reports that organisations have to produce places a duty on them to provide further information that provides a more rounded view of complaints handling.

In 2010-11, 29 Foundation Trusts did not provide data on written complaints – a rise from 18 in 2009-10. From April 2011 In line with the Government’s Transparency Agenda, all Foundation Trusts must supply data on written complaints. This means that all NHS organisations must provide data on written complaints.

The information published annually by the HSCIC collects summary data from all NHS organisations, and also captures complaints about NHS Direct and Walk-in Centres.

A written complaint is one that is made in writing to any member of NHS staff, Trust, NHS England area team, GP and Dental practices, or is originally made orally and subsequently recorded in writing.

Officials are continuing to review and evaluate the effectiveness of the complaints data to ensure that it is both an accurate reflection of the number of complaints made to the NHS, how many are upheld and importantly is user friendly. To this end there is currently an open consultation, which closes on the 5th September 2014. Details of the proposed changes and how to respond to the consultation can be found at: http://www.hscic.gov.uk/complaintsconsultation

No additional changes have been made to the data this year (2013-14)

Collection

Under the new complaints legislation, responsible organisations are required to collect, respond to and maintain details of all written complaints received. Organisations maintain their own localised systems for recording these details which is used to complete the annual data submission to the Health and Social Care Information Centre (HSCIC).

The HSCIC uses two returns to collect the data and organisations complete one of these depending on the type of services provided.

The two written complaint collections are:

- the K041(a) written Hospital and Community Health Service complaints and
- the K041(b) written General Practice (including Dental) complaints

They each collect summary information by service area and type of written complaint received by the NHS each year. The data on written complaints is only collected or stored by responsible organisations; the only method available to the HSCIC to obtain this information is directly from each responsible organisation.

The information is collected annually for all written complaints made by, or on behalf of, patients in the period 1st April to 31st March. This falls in line with organisations own reporting time period.

K041(a) collection:

It is completed with information about written complaints, of those the number which were upheld, about hospital and community health services, made by, or on behalf of, patients in the period 1st April to 31st March. NHS organisations are required to complete and submit a return.

The collection form consists of 6 parts:

- number of written complaints by service area
- number of written complaints by category of profession
- number of written complaints by subject category
- number of written complaints received from patients by ethnic group of patient
- number of written complaints received against staff by ethnic group of staff
- section for comments

The same information is collected for the number of those written complaints which were upheld.

KO41(b) collection:

It is completed with information about written complaints, of those the number which were upheld, about family health services: general practice (including dental) health services; made by, or on behalf of, patients in the period 1st April to 31st March.

The collection form consists of 5 parts:

- number of written complaints by service area
- number of written complaints by subject of complaint
- number of written complaints received from patients by ethnic group of patient
- number of written complaints received against staff by ethnic group of staff
- section for comments

The same information is collected for the number of those written complaints which were upheld.

The two KO41 (a) and (b) forms are used to collect summary information from responsible organisations.

The KO41a is maintained on the Omnibus data collection system which has built-in data validation criteria that reduce errors in data entry and improve data quality at source. In order to successfully complete written complaints return on the Omnibus system the data has to pass the validation criteria.

Automatic validations via Omnibus system include:

- row and column values sum agree to totals.
- Year on year percentage change validation, users have to enter a reason for greater than 10% change.

In addition on receipt of the data the HSCIC check the data against previous year's information from data suppliers to ensure accuracy and perform additional internal validations.

For this year, due to technical problems in collecting the data via Omnibus for all of the practices (via Area teams) the KO41b was collected on a web based survey tool (Survey Monkey).

This does not have the facility to validate automatically. In this instance the HSCIC has validated the data and ensured totals match sums of components.

The collection of the complaints information is taken during May following the end of the year in March to enable all the complaints for the previous year (April – March) to be assessed and included in the returns. Information on time to resolve a complaint was collected prior to 2009, however, the new regulations dropped this requirement as it was deemed unfair to allocate a set period in which to respond to a complaint, as the time to respond is determined by the complexity of the complaint. Organisations are however required to acknowledge receipt of a complaint and set out the timescales for a formal response.

Aggregation (Analysis)

Every responsible organisation is required to publish an annual report which details

- the number of complaints received;
- the number of complaints which the organisation decided were well-founded;
- the number of complaints which have been referred to—
  (i) the Health Service Commissioner or
  (ii) the Local Commissioner
- and summarises—
  (i) the subject matter of complaints received;
  (ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
  (iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

The information sourced on the KO41 (a) and (b) is returned at an aggregated level. Each organisation provides totals by each category requested. From this, overall totals and percentages for England and NHS England area teams are calculated by the HSCIC. These are generated for numerous areas including type of complaint, area of complaint and subject of complaint.

Due to the nature of the NHS (not all organisations offer the same services and have equal catchments areas and as such similar population sizes) and patient choice, it is not possible to produce comparative information against population size.

A limitation of the report is that only totals are produced with no indication of scale of the number, i.e. two organisations with 100 complaints each do have the same number of complaints but if one organisation has only 100 patients all of which have complained against the second with a 1,000 patients of which 100 have complained, then clearly the first organisation got a higher percentage of complaints (100%) than the second (10%).

To enable some comparison between organisations from 2011-12 information on the number of complaints which were upheld has been collected. Total number of upheld and percentage of total number of written complaints at England, Regional and individual organisational level (KO41a only) has been provided as experimental statistics.

Sources of Error

The HSCIC collects from all responsible organisations the total number of written complaints received during the reported year, this gives 100% coverage of all written complaints for England. However it should be noted:

- Foundation Trusts (FTs) until 2011-12 only supplied data on a voluntary basis, however the majority did supply this information. In 2010-11 of the 137 FTs 29 did not submit data. These FTs are included within the organisational tables (table 8) as a 'nil' return. This means the totals are not a true reflection of all complaints within England for 2010-11. As it is now compulsory for all organisations to supply data, those FTs who had previously chosen not to respond in 2010-11 were given the opportunity to submit data in 2011-12. Of the 29 FTs who did not submit data in 2010-11 six chose to provide this data, thus the 2010-11 data has been revised with an increase of 1,594 (1.1% for all complaints or 1.6% for just HCHS) from the figure published in 2010-11.
- Responsible Organisations contact practices to collect the GP (including dental) data. In 2012-13 of the 150 Responsible Organisations 65 indicated that they were unable to provide complete returns for all practices within their area. In addition to these part submissions in 2012-13 three PCTs did not provide a return. This means the totals may not be a true reflection of all complaints within England.

These two factors mean that the total figures for England and (in previous years) some SHAs will be understated for those years where organisations either did not provide a return or indicated that not all organisations provided a return when requested, however the proportions of complaints by subject, area and type will be unaffected since the proportions across organisations follow similar patterns.

Other possible causes of error could be:

- Mis-allocation of the initial complaint. The complaint manager is responsible for allocating the complaint to the relevant categories and on occasion the subject and/or area of the compliant may be miscoded, however this should occur rarely as there are guidelines and training to ensure complaint handlers have relevant knowledge and training.
- Non-allocation of the complaint. The complaint manager having received a written letter does not deem it to be a valid complaint. Again this is minimised as the complaint handlers have specific knowledge and training.

- For 2013-14 the KO41b data was collected on an online collection tool via NHS England Area Teams. This is the first year that data has been collected through these teams (PCTs are no longer in existence). Because of this it is not possible to validate data against earlier years. Also, the online system did not allow for automatic validation which has led to some examples of poor data quality such as totals not matching sum of components.

During collection of the upheld data organisations fed back a number of concerns over the collection and supply of the upheld figures, in summary:

- Our system is not set up to enable the upheld figures to be provided
- A complaint can have a number of different aspects with no ability to distinguish within the monitoring system the various aspects, therefore a complaint is upheld if any element of the complaint is well founded.
- Comments show that there are significant variations in recording practice across England with some organisations classifying all complaints as upheld upon receipt of a written complaint whilst others class all complaints as not upheld due to actively responding and resolving the written complaint.
- The online system used for 2013-14 generated comments about the difficulty of completing the return – this was a one off method just for this year, a new system will be available next year.

Users and Uses

How are the statistics used?

Users and uses of the Report

i) Known Users of the Statistics

This section contains comments based on responses from the users listed. All these users have found the information in the report useful for the purposes set out.

Department of Health

"The annual collection of written complaints made by (or on behalf of) patients is used by the Department of Health and providers of NHS funded services to improve services; it also supports academics, researchers, regulators and policy makers in their work. Quantitative complaints data, whilst being acknowledged as a somewhat simplistic measure of organisational performance, are used in part to shape policy in the Department."

"The information is also used:

- to contribute to speeches and briefings for Ministers and senior officials.
- to answer PQs and Prime Minister's Questions.
- to respond to Media Enquiries and other correspondence."

Press, Journal Articles & Social media

Press – the data have been used to underpin articles in newspapers, journals, etc on matters of public interest.

- http://www.bbc.co.uk/news/health-11083236
- http://www.ft.com/cms/s/0/c433cdf6-b084-11df-8c04-00144feabdc0.html#axzz1qVu6Lv2O
- http://www.guardian.co.uk/society/2010/aug/25/nhs-record-complaints
- http://www.onmedica.com/newsarticle.aspx?id=fa868832-c7d7-4f07-b0d3-7b4738b41340

Health Service Journal - http://www.hsj.co.uk/news/acute-care/nhs-complaints-reach-record-high/5018630.article

Social media- The HSCIC corporate twitter account, which has over 4,000 followers, is used to publicise each statistical report on the morning of release. This complements more traditional media such as press releases (sent to bespoke lists according to specialism, with a combined total of more than 1,000 recipients), the press office section of the website, the publications calendar for journalists (sent to more than 1,000 contacts each month) and the press office contact programme, which targets key national and specialist media.

ii) Unknown Users of the Statistics

The survey report is free to access via the HSCIC website and therefore the majority of users will access the report without being known to the HSCIC.

It is therefore important to have in place mechanisms to understand how these additional users are using the statistics and to gain valuable feedback on how the HSCIC can make the data more useful to them.

On the webpage where the report is surfaced there is a link to offer feedback via email and also the telephone number of the general enquires desk.

Any responses received are passed to the team responsible for the report to consider. The HSCIC received four responses in 2009-10, zero responses on the 2010-11, 2011-12 and 2012-13 reports since publication.

Contact information is contained within the publication which can be used to provide feedback via post, telephone or email.

It is difficult to gather information about the use that is made of the report/tables published on the HSCIC website, unless we are informed by the user as to how they use the information.

These statistics could be used by:

- the general public to work out the areas where the highest numbers of complaints are made which could aid in the selection of an area to obtain NHS services.
- NHS organisations to compare level of complaints with other NHS organisations

Definitions

KO41 a: Is completed with information about written complaints about hospital and community health services (HCHS) made by, or on behalf of, patients in the period 1st April to 31st March. NHS HCHS organisations are required to complete and submit a return.

KO41 b: Is completed with information about written complaints about general practice (including dental) health services (formerly family health services) made by, or on behalf of, patients in the period 1st April to 31st March. Area Teams are required to complete and submit a return for their GP and Dental practices.

UPHELD: If any or all of a complaint is well founded then it should be recorded as "upheld locally."

Experimental Statistics

Tables 13 to 23

Improving the patient experience is a key priority for the government and it was recognised that simply counting the number of complaints made to an organisation did not indicate how an organisation was performing. From 2011-12 an additional data item was added to the KO41 data returns, “Number of Complaints Upheld.” It will now be possible to see how many complaints were upheld in addition to the number of complaints made to an organisation, which is not necessarily an accurate measure of performance.

It should be noted that caution should be taken when interpreting the basic quantitative data. An organisation that has good publicity, that welcomes complaints as an opportunity to learn and to improve services, and that has a non-defensive approach in responding to complaints may be expected to receive a higher number of complaints than an organisation with poor publicity and a defensive approach in responding. Yet one might also expect its services to be of a higher quality. It is important that organisations are open about the number of complaints received, but these should not be read in isolation – the annual reports that organisations have to produce places a duty on them to provide further information that provides a more rounded view of complaints handling.

Regulation 18 of the 2009 complaints regulations places a statutory obligation on all NHS organisations to collect the number of complaints upheld and make it available to any one requesting it. It was therefore expected all organisations would be in a position to provide the number of complaints upheld for the 2012-13 collection. During collection organisations fed back a number of concerns over the collection and supply of the upheld figures. In summary the concerns are:

- Our system is not set up to enable the upheld figures to be provided
- A complaint can have a number of different aspects with no ability to distinguish within the monitoring system the various aspects, therefore a complaint is upheld if any element of the complaint is well founded.
- Comments show that there is significant variation in recording practice across England with some organisations classifying all complaints as upheld upon receipt of a written complaint

whilst others class all complaints as not upheld due to actively responding and resolving the written complaint.

The above reasons mean that further work is required to enable direct organisational comparison on the various percentages that are shown in organisation tables 20 and 25.

Due to the highlighted factors the upheld statistics continue to be classified as 'Experimental Statistics'. This is in keeping with the UK Statistics Authority's Code of Practice.

Table 14a NHS Written Complaints, 2013-14, England experimental statistics

	Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
All NHS Written Complaints	174,872		87,691	50.1%
HCHS Written Complaints	114,308		57,072	49.9%
Family Health Services: General Practice (including Dental)	60,564		30,619	50.6%

Table 14a shows that the 50.1% (87,691) of all NHS Written Complaints (174,872) were fully or partially upheld. This varied by the two separate areas from 50.6% for Family Health Services to 49.9% for Hospital and Community Health Services.

It should be noted that these are experimental statistics and at an organisation level show a range from 0% to 100% of written complaints being upheld as shown in the organisation tables 19 for HCHS and the csv file accompanying this publication.

Experimental statistics are published in order to involve users and stakeholders in their development, and as a means to build-in quality at an early stage. The UK Statistics Code of Practice states that *"effective user engagement is fundamental to both trust in statistics and securing maximum public value…"* and that as suppliers of information, it is important that we involve users in the evaluation of experimental statistics.

The UK Statistics Code of Practice can be accessed via the following web-link: http://www.statisticsauthority.gov.uk/assessment/code-of-practice/code-of-practice-for-official-statistics.pdf.

To help us ensure that our publications are as useful and informative as possible, we welcome comments on this publication. We will consider these comments to inform the production of future reports. Please send comments to enquiries@hscic.gov.uk

FURTHER INFORMATION

Any enquiries about the data contained in this Bulletin or requests for further information should be addressed to:

Health and Social Care Information Centre

1 Trevelyan Square

Boar Lane

Leeds

LS1 6AE

Tel: 0845 300 6016

Email: enquires@hscic.gov.uk

This bulletin and previous editions of the publication can be found on the Health and Social Care Information Centre website patient experience section at:

http://www.hscic.gov.uk/searchcatalogue?q=written+complaints&topics=0%2fPatient+experience&sort=Relevance&size=10&page=1#top

August 2014

Index to Tables on Written Complaints

Table 1 All NHS Written Complaints, 2002-03 to 2013-14, England

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All NHS written complaints	**133,867**	**133,469**	**133,820**	**138,396**	**133,393**	**131,022**	**137,736**	**151,832**	**149,765**	**162,129**	**162019**[4]	**174872**[5]	**.** [5]	**.** [5]
Total HCHS Complaints	**91,023**	**90,122**	**90,413**	**95,047**	**90,801**	**87,080**	**89,139** [1]	**101,077**	**99,057** [2]	**107,259**	**109,316**	**114,308**	**4,992**	**4.6%**
Total organisations approached for data	*..*	*..*	*..*	*..*	*394*	*392*	*393*	*390*	*381*	*453*	*459*	*636*	**.**	**.**
of which Foundation Trusts not returning data [3]	*..*	*..*	*..*	*..*	*8*	*17*	*23*	*18*	*23* [2]	*-*	*-*	*-*	**.**	**.**
Organisations providing data for year and year before	*..*	*..*	*..*	*565*	*297*	*369*	*366*	*361*	*338*	*350*	*417*	*..*	**.**	**.**
Total general practice (including dental) health services Complaints	**42,844**	**43,347**	**43,407**	**43,349**	**42,592**	**43,942**	**48,597**	**50,755**	**50,708**	**54,870**	**52703**[4]	**60564**[5]	**.** [5]	**.** [5]

Notes:

[1] It has come to our attention that in 2008-09 a single organisation overstated the number of written complaints. The total number of written complaints for 2008-09 adjusted figure is 88,048.

[2] For 2011-12, Foundation Trusts (FT's) who did not supply data in 2010-11 were given the opportunity to submit data. Of the 29 FTs that did not submit data in 2010-11, six chose to provide this data which had led to a revision of 2010-11 data (total complaints and HCHS totals have increased by 1,594 from those previously published).

[3] Prior to 2011-2012 Foundation Trust participation was voluntary.

[4] We are unable to provide comparisons between 2012-13 with previous years for figures including FHS (GP data) due to the number of PCTs unable to submit complete returns in 2012-13. For more information see the Data Quality section of this publication.

[5] We are unable to provide comparisons between 2013-14 with previous years for figures including FHS (GP data) due to the number of NHS England Area Teams unable to submit complete returns in 2013-14. For more information see the Data Quality section of this publication.

'..' denotes not available
' - ' denotes zero
' . ' denotes not applicable

Data as at 1 April - 31 March each year

Source:

Table 2 Hospital and Community Health Services (HCHS) : Written Complaints by Service Area, 2008-09 to 2013-14, England

	2008-09	2009-10	2010-11 [1]	2011-12	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All Service Areas	**89,139**	**101,077**	**99,057**	**107,259**	**109,316**	**114,308**	**4,992**	**4.6%**
Ambulance services	2,661	3,729	4,168	5,173	5,332	6,873	1,541	28.9%
Community hospital services	1,416	1,550	1,638	1,328	1,315	2,001	686	52.2%
Elderly (geriatric) services	1,294	1,168	1,245	1,051	880	1,058	178	20.2%
Hospital acute services: A&E	6,872	7,667	7,888	9,362	9,680	9,919	239	2.5%
Hospital acute services: Inpatient	29,033	31,046	30,889	33,873	34,872	34,422	-450	-1.3%
Hospital acute services: Outpatient	26,793	28,576	27,644	29,559	30,019	31,083	1,064	3.5%
Maternity services	2,803	2,844	2,959	3,240	3,427	3,343	-84	-2.5%
Mental health services	7,214	9,587	9,180	10,439	11,749	12,221	472	4.0%
NHS Direct	407	487	303	163	193	362	169	87.6%
Other community health services	7,044	8,034	7,959	6,407	6,840	6,292	-548	-8.0%
CCG, NHS England commissioning	2,285	2,885	2,544	3,114	2,507	2,547	40	1.6%
Walk in centres	415	460	555	472	457	503	46	10.1%
Other	902	3,044	2,085	3,078	2,045	3,684	1,639	80.1%
Total organisations approached for data	*393*	*390*	*381*	*453*	*459*	*636*		
of which Foundation Trusts not returning data [2]	*23*	*18*	*23* [1]	*-*	*-*	*-*		

Notes:

[1] For 2011-12, Foundation Trusts (FT's) who did not supply data in 2010-11 were given the opportunity to submit data. Of the 29 FTs that did not submit data in 2010-11, six chose to provide this data which had led to a revision of 2010-11 data (total complaints and HCHS totals have increased by 1,594 from those previously published).

[2] Prior to 2011-2012 Foundation Trust participation was voluntary.

Data as at 1 April - 31 March each year

Source:

Table 3 Hospital and Community Health Services (HCHS) : Written Complaints by Profession, 2008-09 to 2013-14, England

	2008-09	2009-10	2010-11 [1]	2011-12	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All Professions	**89,139**	**101,077**	**99,057**	**107,259**	**109,316**	**114,308**	**4,992**	**4.6%**
Medical (including surgical)	39,981	44,682	44,269	49,264	51,462	52,123	661	1.3%
Dental (including surgical)	908	962	984	960	918	718	-200	-21.8%
Professions supplementary to medicine	4,056	4,878	4,411	4,365	3,926	3,836	-90	-2.3%
Nursing, Midwifery and Health Visiting	19,111	22,203	21,929	23,313	24,146	24,793	647	2.7%
Scientific, Technical and Professional	1,167	1,123	1,024	1,075	1,051	1,139	88	8.4%
Ambulance crews (including paramedics)	2,541	3,637	3,804	4,649	4,438	5,702	1,264	28.5%
Maintenance and Ancillary staff	1,014	799	707	756	668	643	-25	-3.7%
Administrative staff / members (exc GP admin)	1,314	1,312	1,679	1,305	1,077	1,196	119	11.0%
Trust Administrative staff / members	8,932	8,635	7,592	7,938	7,818	8,323	505	6.5%
Other	10,115	12,846	12,658	13,634	13,812	15,835	2,023	14.6%
Total organisations approached for data	*393*	*390*	*381*	*453*	*459*	*636*		
of which Foundation Trusts not returning data [2]	*23*	*18*	*23 [1]*	*-*	*-*	*-*		

Notes:

[1] For 2011-12, Foundation Trusts (FT's) who did not supply data in 2010-11 were given the opportunity to submit data. Of the 29 FTs that did not submit data in 2010-11, six chose to provide this data which had led to a revision of 2010-11 data (total complaints and HCHS totals have increased by 1,594 from those previously published).

[2] Prior to 2011-2012 Foundation Trust participation was voluntary.

Data as at 1 April - 31 March each year

Source:

Table 4 Hospital and Community Health Services (HCHS) : Written Complaints by Subject of Complaint [1], 2008-09 to 2013-14, England

	2008-09	2009-10	2010-11 [2]	2011-12	2012-13	2013-14	Change 2012-13 to 2013-14	Percentage Change 2012-13 to 2013-14
All Subjects of Complaint [1]	**89,698**	**101,308**	**99,444**	**108,250**	**110,639**	**114,788**	**4,149**	**3.8%**
Admissions, discharge and transfer arrangements	4,473	5,161	5,019	5,499	6,227	5,913	-314	-5.0%
Aids and appliances, equipment, premises (including access)	2,055	2,120	1,761	1,859	1,534	1,529	-5	-0.3%
Appointments, delay / cancellation (outpatient)	9,738	10,710	9,185	9,013	8,886	9,038	152	1.7%
Appointments, delay / cancellation (inpatient)	2,364	2,532	2,214	2,590	2,430	2,681	251	10.3%
Length of time waiting for a response, or to be seen: NHS Direct	134	73	34	297	50	168	118	236.0%
Length of time waiting for a response, or to be seen: Walk in centres	255	94	207	100	105	106	1	1.0%
Attitude of staff	11,332	12,331	12,166	12,571	12,303	13,269	966	7.9%
All aspects of clinical treatment	37,149	42,727	43,857	49,625	51,071	52,330	1,259	2.5%
Communication / information to patients (written and oral)	8,970	10,020	9,941	10,986	11,606	11,472	-134	-1.2%
Consent to treatment	238	163	206	195	201	229	28	13.9%
Complaints handling	104	105	105	105	111	120	9	8.1%
Patients privacy and dignity	1,351	1,258	1,129	1,190	1,147	1,029	-118	-10.3%
Patients property and expenses	930	1,037	1,080	1,113	1,139	1,091	-48	-4.2%
CCG, NHS England commissioning (including waiting lists)	1,038	1,247	1,204	965	1,531	1,315	-216	-14.1%
Independent sector services commissioned by CCG, NHS England	116	206	82	78	65	462	397	610.8%
Independent sector services commissioned by trusts	71	44	26	32	25	38	13	52.0%
Personal records (including medical and / or complaints)	1,047	1,032	999	976	987	1,017	30	3.0%
Failure to follow agreed procedures	820	1,024	943	1,100	820	1,109	289	35.2%
Patient's status, discrimination (e.g. racial, gender, age)	172	176	156	173	194	185	-9	-4.6%
Mortuary and post mortem arrangements	65	62	56	47	48	42	-6	-12.5%
Transport (ambulances and other)	1,450	1,925	2,135	2,507	2,744	3,935	1,191	43.4%
Policy and commercial decisions of trusts	883	970	1,006	1,158	883	734	-149	-16.9%
Code of openness - complaints	70	23	7	11	20	29	9	45.0%
Hotel services (including food)	1,001	821	696	706	703	644	-59	-8.4%
Other	3,872	5,447	5,230	5,354	5,809	6,303	494	8.5%
Total organisations approached for data	*393*	*390*	*381*	*453*	*459*	*636*		
of which Foundation Trusts not returning data [3]	*23*	*18*	*23 [2]*	-	-	-		

Notes:

[1] A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained within the complaint letter received. Therefore the total number of complaints by subject (114,788) does not match the actual total number of complaints which is 114,308.

[2] For 2011-12, Foundation Trusts (FT's) who did not supply data in 2010-11 were given the opportunity to submit data. Of the 29 FTs that did not submit data in 2010-11, six chose to provide this data which had led to a revision of 2010-11 data (total complaints and HCHS totals have increased by 1,594 from those previously published).

[3] Prior to 2011-2012 Foundation Trust participation was voluntary.

Data as at 1 April - 31 March each year

Source:

Table 5 Hospital and Community Health Services (HCHS) : Written Complaints by Service Area within each NHS England Area Team, 2013 -14, England

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55
Total HCHS Complaints	**114,308**	**2,110**	**1,438**	**8,151**	**2,364**	**2,556**	**4,261**	**2,477**	**2,790**	**5,026**	**2,352**	**5,080**	**4,727**
Hospital acute services: Inpatient	34,422	767	600	2,119	903	919	1,171	1,102	977	1,602	769	1,880	1,391
Hospital acute services: Outpatient	31,083	449	365	1,828	485	742	1,252	584	890	1,436	585	1,146	1,073
Hospital acute services: A&E	9,919	207	146	527	221	170	428	255	280	387	300	483	299
Elderly (geriatric) services	1,058	61	10	27	9	5	125	38	23	56	6	37	17
Mental health services	12,221	325	151	486	320	385	415	126	252	517	159	491	723
Maternity services	3,343	48	50	201	33	20	143	72	108	168	117	229	83
Ambulance services	6,873	2	1	2,087	1	1	446	1	8	364	-	417	184
Community hospital services	2,001	5	5	45	6	23	11	31	6	32	40	18	123
NHS Direct	362	-	-	-	-	-	18	1	-	119	-	5	-
Walk in centres	503	14	35	45	-	9	11	-	9	3	-	14	6
Other community health services	6,292	149	51	324	298	189	154	152	131	296	235	217	157
CCG, NHS England commissioning	2,547	50	24	123	79	37	48	83	94	30	83	111	138
Other	3,684	33	-	339	9	56	39	32	12	16	58	32	533

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55
Total HCHS Complaints	**100.0%**	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
Hospital acute services: Inpatient	30.1%	*36.4%*	*41.7%*	*26.0%*	*38.2%*	*36.0%*	*27.5%*	*44.5%*	*35.0%*	*31.9%*	*32.7%*	*37.0%*	*29.4%*
Hospital acute services: Outpatient	27.2%	*21.3%*	*25.4%*	*22.4%*	*20.5%*	*29.0%*	*29.4%*	*23.6%*	*31.9%*	*28.6%*	*24.9%*	*22.6%*	*22.7%*
Hospital acute services: A&E	8.7%	*9.8%*	*10.2%*	*6.5%*	*9.3%*	*6.7%*	*10.0%*	*10.3%*	*10.0%*	*7.7%*	*12.8%*	*9.5%*	*6.3%*
Elderly (geriatric) services	0.9%	*2.9%*	*0.7%*	*0.3%*	*0.4%*	*0.2%*	*2.9%*	*1.5%*	*0.8%*	*1.1%*	*0.3%*	*0.7%*	*0.4%*
Mental health services	10.7%	*15.4%*	*10.5%*	*6.0%*	*13.5%*	*15.1%*	*9.7%*	*5.1%*	*9.0%*	*10.3%*	*6.8%*	*9.7%*	*15.3%*
Maternity services	2.9%	*2.3%*	*3.5%*	*2.5%*	*1.4%*	*0.8%*	*3.4%*	*2.9%*	*3.9%*	*3.3%*	*5.0%*	*4.5%*	*1.8%*
Ambulance services	6.0%	*0.1%*	*0.1%*	*25.6%*	*0.0%*	*0.0%*	*10.5%*	*0.0%*	*0.3%*	*7.2%*	-	*8.2%*	*3.9%*
Community hospital services	1.8%	*0.2%*	*0.3%*	*0.6%*	*0.3%*	*0.9%*	*0.3%*	*1.3%*	*0.2%*	*0.6%*	*1.7%*	*0.4%*	*2.6%*
NHS Direct	0.3%	-	-	-	-	-	*0.4%*	*0.0%*	-	*2.4%*	-	*0.1%*	-
Walk in centres	0.4%	*0.7%*	*2.4%*	*0.6%*	-	*0.4%*	*0.3%*	-	*0.3%*	*0.1%*	-	*0.3%*	*0.1%*
Other community health services	5.5%	*7.1%*	*3.5%*	*4.0%*	*12.6%*	*7.4%*	*3.6%*	*6.1%*	*4.7%*	*5.9%*	*10.0%*	*4.3%*	*3.3%*
CCG, NHS England commissioning	2.2%	*2.4%*	*1.7%*	*1.5%*	*3.3%*	*1.4%*	*1.1%*	*3.4%*	*3.4%*	*0.6%*	*3.5%*	*2.2%*	*2.9%*
Other	3.2%	*1.6%*	-	*4.2%*	*0.4%*	*2.2%*	*0.9%*	*1.3%*	*0.4%*	*0.3%*	*2.5%*	*0.6%*	*11.3%*

Notes:

' - ' denotes zero

Data as at 1 April 2013 - 31 March 2014

Source:

East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q56	Q57	Q58	Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
6,436	**5,118**	**4,118**	**3,662**	**2,756**	**2,644**	**2,515**	**4,123**	**3,479**	**6,103**	**3,546**	**4,935**	**20,646**	**895**
1,840	1,617	1,337	1,154	875	904	1,004	1,185	1,075	1,738	1,187	1,420	4,884	2
1,585	1,662	1,209	1,271	789	703	797	884	918	1,690	894	1,280	6,565	1
553	597	407	255	261	204	264	216	393	580	273	417	1,796	-
43	110	29	5	44	4	8	12	26	47	22	84	210	-
703	425	390	419	155	428	55	528	371	862	296	441	2,797	1
148	197	118	97	80	62	79	77	133	90	97	176	717	-
803	9	6	1	10	-	8	547	1	440	385	11	1,140	-
251	58	28	85	123	63	39	357	28	190	25	182	225	2
-	4	7	3	2	-	10	1	-	16	5	42	129	-
22	2	15	8	14	3	11	33	6	25	17	32	145	24
245	310	315	250	220	128	104	166	369	154	134	465	804	275
113	68	176	71	106	108	43	91	33	149	140	206	319	24
130	59	81	43	77	37	93	26	126	122	71	179	915	566

Percentage (%)

East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q56	Q57	Q58	Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
100.0%	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
28.6%	*31.6%*	*32.5%*	*31.5%*	*31.7%*	*34.2%*	*39.9%*	*28.7%*	*30.9%*	*28.5%*	*33.5%*	*28.8%*	*23.7%*	*0.2%*
24.6%	*32.5%*	*29.4%*	*34.7%*	*28.6%*	*26.6%*	*31.7%*	*21.4%*	*26.4%*	*27.7%*	*25.2%*	*25.9%*	*31.8%*	*0.1%*
8.6%	*11.7%*	*9.9%*	*7.0%*	*9.5%*	*7.7%*	*10.5%*	*5.2%*	*11.3%*	*9.5%*	*7.7%*	*8.4%*	*8.7%*	-
0.7%	*2.1%*	*0.7%*	*0.1%*	*1.6%*	*0.2%*	*0.3%*	*0.3%*	*0.7%*	*0.8%*	*0.6%*	*1.7%*	*1.0%*	-
10.9%	*8.3%*	*9.5%*	*11.4%*	*5.6%*	*16.2%*	*2.2%*	*12.8%*	*10.7%*	*14.1%*	*8.3%*	*8.9%*	*13.5%*	*0.1%*
2.3%	*3.8%*	*2.9%*	*2.6%*	*2.9%*	*2.3%*	*3.1%*	*1.9%*	*3.8%*	*1.5%*	*2.7%*	*3.6%*	*3.5%*	-
12.5%	*0.2%*	*0.1%*	*0.0%*	*0.4%*	-	*0.3%*	*13.3%*	*0.0%*	*7.2%*	*10.9%*	*0.2%*	*5.5%*	-
3.9%	*1.1%*	*0.7%*	*2.3%*	*4.5%*	*2.4%*	*1.6%*	*8.7%*	*0.8%*	*3.1%*	*0.7%*	*3.7%*	*1.1%*	*0.2%*
-	*0.1%*	*0.2%*	*0.1%*	*0.1%*	-	*0.4%*	*0.0%*	-	*0.3%*	*0.1%*	*0.9%*	*0.6%*	-
0.3%	*0.0%*	*0.4%*	*0.2%*	*0.5%*	*0.1%*	*0.4%*	*0.8%*	*0.2%*	*0.4%*	*0.5%*	*0.6%*	*0.7%*	*2.7%*
3.8%	*6.1%*	*7.6%*	*6.8%*	*8.0%*	*4.8%*	*4.1%*	*4.0%*	*10.6%*	*2.5%*	*3.8%*	*9.4%*	*3.9%*	*30.7%*
1.8%	*1.3%*	*4.3%*	*1.9%*	*3.8%*	*4.1%*	*1.7%*	*2.2%*	*0.9%*	*2.4%*	*3.9%*	*4.2%*	*1.5%*	*2.7%*
2.0%	*1.2%*	*2.0%*	*1.2%*	*2.8%*	*1.4%*	*3.7%*	*0.6%*	*3.6%*	*2.0%*	*2.0%*	*3.6%*	*4.4%*	*63.2%*

Table 6 Hospital and Community Health Services (HCHS) : Written Complaints by Profession within each NHS England Area Team, 2013-14, England

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54
Total HCHS Complaints	**114,308**	**2,110**	**1,438**	**8,151**	**2,364**	**2,556**	**4,261**	**2,477**	**2,790**	**5,026**	**2,352**	**5,080**
Medical (including surgical)	52,123	1,190	785	2,710	1,122	1,365	2,055	1,439	1,359	2,301	1,187	2,561
Dental (including surgical)	718	5	2	22	34	6	15	8	23	22	5	36
Professions supplementary to medicine	3,836	79	35	144	167	104	85	58	101	262	64	124
Nursing, Midwifery and Health Visiting	24,793	514	451	1,397	537	706	1,068	592	819	983	517	1,325
Scientific, Technical and Professional	1,139	12	25	36	43	11	39	12	38	46	53	43
Ambulance crews (including paramedics)	5,702	3	1	1,928	1	1	125	2	9	365	1	428
Maintenance and Ancillary staff	643	5	2	23	8	33	19	5	16	37	8	9
Administrative staff / members (exc GP admin)	1,196	41	22	74	-	19	51	95	23	14	4	47
Trust Administrative staff / members	8,323	111	48	387	69	126	382	50	171	675	172	291
Other	15,835	150	67	1,430	383	185	422	216	231	321	341	216

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54
Total HCHS Complaints	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
Medical (including surgical)	*45.6%*	*56.4%*	*54.6%*	*33.2%*	*47.5%*	*53.4%*	*48.2%*	*58.1%*	*48.7%*	*45.8%*	*50.5%*	*50.4%*
Dental (including surgical)	*0.6%*	*0.2%*	*0.1%*	*0.3%*	*1.4%*	*0.2%*	*0.4%*	*0.3%*	*0.8%*	*0.4%*	*0.2%*	*0.7%*
Professions supplementary to medicine	*3.4%*	*3.7%*	*2.4%*	*1.8%*	*7.1%*	*4.1%*	*2.0%*	*2.3%*	*3.6%*	*5.2%*	*2.7%*	*2.4%*
Nursing, Midwifery and Health Visiting	*21.7%*	*24.4%*	*31.4%*	*17.1%*	*22.7%*	*27.6%*	*25.1%*	*23.9%*	*29.4%*	*19.6%*	*22.0%*	*26.1%*
Scientific, Technical and Professional	*1.0%*	*0.6%*	*1.7%*	*0.4%*	*1.8%*	*0.4%*	*0.9%*	*0.5%*	*1.4%*	*0.9%*	*2.3%*	*0.8%*
Ambulance crews (including paramedics)	*5.0%*	*0.1%*	*0.1%*	*23.7%*	*0.0%*	*0.0%*	*2.9%*	*0.1%*	*0.3%*	*7.3%*	*0.0%*	*8.4%*
Maintenance and Ancillary staff	*0.6%*	*0.2%*	*0.1%*	*0.3%*	*0.3%*	*1.3%*	*0.4%*	*0.2%*	*0.6%*	*0.7%*	*0.3%*	*0.2%*
Administrative staff / members (exc GP admin)	*1.0%*	*1.9%*	*1.5%*	*0.9%*	-	*0.7%*	*1.2%*	*3.8%*	*0.8%*	*0.3%*	*0.2%*	*0.9%*
Trust Administrative staff / members	*7.3%*	*5.3%*	*3.3%*	*4.7%*	*2.9%*	*4.9%*	*9.0%*	*2.0%*	*6.1%*	*13.4%*	*7.3%*	*5.7%*
Other	*13.9%*	*7.1%*	*4.7%*	*17.5%*	*16.2%*	*7.2%*	*9.9%*	*8.7%*	*8.3%*	*6.4%*	*14.5%*	*4.3%*

Notes:

' - ' denotes zero

Data as at 1 April 2013 - 31 March 2014

Source:

Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
4,727	**6,436**	**5,118**	**4,118**	**3,662**	**2,756**	**2,644**	**2,515**	**4,123**	**3,479**	**6,103**	**3,546**	**4,935**	**20,646**	**895**
2,078	2,520	2,205	2,308	2,312	1,062	1,242	1,402	1,845	2,065	2,738	1,376	1,987	8,630	279
36	26	5	25	5	16	11	61	39	29	21	29	28	206	3
246	386	60	133	91	127	65	66	157	184	220	172	222	473	11
1,177	1,817	1,240	689	560	782	529	586	734	574	1,234	649	1,489	3,798	26
27	54	63	22	8	32	14	31	34	98	38	22	193	144	1
108	664	13	16	1	14	7	1	393	2	433	269	15	902	-
49	35	34	14	12	43	26	44	15	14	44	19	15	114	-
26	61	63	47	6	40	86	28	8	9	65	10	145	209	3
233	386	344	234	45	178	134	157	162	170	659	333	313	2,460	33
747	487	1,091	630	622	462	530	139	736	334	651	667	528	3,710	539

Percentage (%)

Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Bristol, North Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
100%	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
44.0%	*39.2%*	*43.1%*	*56.0%*	*63.1%*	*38.5%*	*47.0%*	*55.7%*	*44.7%*	*59.4%*	*44.9%*	*38.8%*	*40.3%*	*41.8%*	*31.2%*
0.8%	*0.4%*	*0.1%*	*0.6%*	*0.1%*	*0.6%*	*0.4%*	*2.4%*	*0.9%*	*0.8%*	*0.3%*	*0.8%*	*0.6%*	*1.0%*	*0.3%*
5.2%	*6.0%*	*1.2%*	*3.2%*	*2.5%*	*4.6%*	*2.5%*	*2.6%*	*3.8%*	*5.3%*	*3.6%*	*4.9%*	*4.5%*	*2.3%*	*1.2%*
24.9%	*28.2%*	*24.2%*	*16.7%*	*15.3%*	*28.4%*	*20.0%*	*23.3%*	*17.8%*	*16.5%*	*20.2%*	*18.3%*	*30.2%*	*18.4%*	*2.9%*
0.6%	*0.8%*	*1.2%*	*0.5%*	*0.2%*	*1.2%*	*0.5%*	*1.2%*	*0.8%*	*2.8%*	*0.6%*	*0.6%*	*3.9%*	*0.7%*	*0.1%*
2.3%	*10.3%*	*0.3%*	*0.4%*	*0.0%*	*0.5%*	*0.3%*	*0.0%*	*9.5%*	*0.1%*	*7.1%*	*7.6%*	*0.3%*	*4.4%*	*-*
1.0%	*0.5%*	*0.7%*	*0.3%*	*0.3%*	*1.6%*	*1.0%*	*1.7%*	*0.4%*	*0.4%*	*0.7%*	*0.5%*	*0.3%*	*0.6%*	*-*
0.6%	*0.9%*	*1.2%*	*1.1%*	*0.2%*	*1.5%*	*3.3%*	*1.1%*	*0.2%*	*0.3%*	*1.1%*	*0.3%*	*2.9%*	*1.0%*	*0.3%*
4.9%	*6.0%*	*6.7%*	*5.7%*	*1.2%*	*6.5%*	*5.1%*	*6.2%*	*3.9%*	*4.9%*	*10.8%*	*9.4%*	*6.3%*	*11.9%*	*3.7%*
15.8%	*7.6%*	*21.3%*	*15.3%*	*17.0%*	*16.8%*	*20.0%*	*5.5%*	*17.9%*	*9.6%*	*10.7%*	*18.8%*	*10.7%*	*18.0%*	*60.2%*

Table 7 Hospital and Community Health Services (HCHS) : Written Complaints by Subject(1) within each NHS England Area Team, 2013-14, England

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54
Total HCHS Complaints	**114,788**	**2,110**	**1,438**	**8,242**	**2,364**	**2,556**	**4,261**	**2,477**	**2,790**	**5,026**	**2,352**	**5,083**
Admissions, discharge and transfer arrangements	5,913	114	86	387	144	100	223	105	149	214	142	229
Aids and appliances, equipment, premises (including access)	1,529	24	20	38	35	26	40	7	53	49	27	59
Appointments, delay / cancellation (outpatient)	9,038	135	69	534	107	154	308	114	221	454	170	333
Appointments, delay / cancellation (inpatient)	2,681	36	44	66	84	34	114	20	55	103	64	159
Length of time waiting for a response, or to be seen: NHS Direct	168	1	-	-	-	1	-	-	-	32	-	4
Length of time waiting for a response, or to be seen: Walk in centres	106	4	-	-	1	-	15	-	1	-	-	-
Attitude of staff	13,269	293	99	946	298	351	420	205	311	504	193	562
All aspects of clinical treatment	52,330	842	923	3,188	1,208	1,333	2,185	1,611	1,474	2,669	1,231	2,662
Communication / information to patients (written and oral)	11,472	246	77	842	131	231	363	190	268	455	189	429
Consent to treatment	229	7	5	11	4	5	6	3	5	2	3	13
Complaints handling	120	1	1	14	2	2	6	2	-	5	-	8
Patients privacy and dignity	1,029	19	47	70	28	43	37	17	21	29	39	39
Patients property and expenses	1,091	16	10	67	24	74	23	8	18	26	22	25
CCG, NHS England commissioning (including waiting lists)	1,315	11	22	56	15	29	34	93	38	21	32	23
Independent sector services commissioned by PCTs	462	1	-	3	-	2	4	-	11	-	-	4
Independent sector services commissioned by trusts	38	1	-	-	-	-	10	-	-	1	1	-
Personal records (including medical and / or complaints)	1,017	29	6	78	31	33	48	12	15	50	16	30
Failure to follow agreed procedures	1,109	28	6	80	10	11	21	11	50	34	35	25
Patient's status, discrimination (e.g. racial, gender, age)	185	2	4	25	3	7	19	1	2	4	1	2
Mortuary and post mortem arrangements	42	1	1	2	1	1	-	1	1	2	-	2
Transport (ambulances and other)	3,935	3	1	1,457	1	3	230	3	14	251	3	18
Policy and commercial decisions of trusts	734	6	5	17	8	12	22	7	18	38	7	65
Code of openness - complaints	29	-	-	-	-	-	-	-	-	-	-	1
Hotel services (including food)	644	4	3	37	13	25	52	8	15	18	11	22
Other	6,303	286	9	324	216	79	81	59	50	65	166	369

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54
Total HCHS Complaints	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Admissions, discharge and transfer arrangements	5.2%	5.4%	6.0%	4.7%	6.1%	3.9%	5.2%	4.2%	5.3%	4.3%	6.0%	4.5%
Aids and appliances, equipment, premises (including access)	1.3%	1.1%	1.4%	0.5%	1.5%	1.0%	0.9%	0.3%	1.9%	1.0%	1.1%	1.2%
Appointments, delay / cancellation (outpatient)	7.9%	6.4%	4.8%	6.5%	4.5%	6.0%	7.2%	4.6%	7.9%	9.0%	7.2%	6.6%
Appointments, delay / cancellation (inpatient)	2.3%	1.7%	3.1%	0.8%	3.6%	1.3%	2.7%	0.8%	2.0%	2.0%	2.7%	3.1%
Length of time waiting for a response, or to be seen: NHS Direct	0.1%	0.0%	-	-	-	0.0%	-	-	-	0.6%	-	0.1%
Length of time waiting for a response, or to be seen: Walk in centres	0.1%	0.2%	-	-	0.0%	-	0.4%	-	0.0%	-	-	-
Attitude of staff	11.6%	13.9%	6.9%	11.5%	12.6%	13.7%	9.9%	8.3%	11.1%	10.0%	8.2%	11.1%
All aspects of clinical treatment	45.6%	39.9%	64.2%	38.7%	51.1%	52.2%	51.3%	65.0%	52.8%	53.1%	52.3%	52.4%
Communication / information to patients (written and oral)	10.0%	11.7%	5.4%	10.2%	5.5%	9.0%	8.5%	7.7%	9.6%	9.1%	8.0%	8.4%
Consent to treatment	0.2%	0.3%	0.3%	0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.0%	0.1%	0.3%
Complaints handling	0.1%	0.0%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	-	0.1%	-	0.2%
Patients privacy and dignity	0.9%	0.9%	3.3%	0.8%	1.2%	1.7%	0.9%	0.7%	0.8%	0.6%	1.7%	0.8%
Patients property and expenses	1.0%	0.8%	0.7%	0.8%	1.0%	2.9%	0.5%	0.3%	0.6%	0.5%	0.9%	0.5%
CCG, NHS England commissioning (including waiting lists)	1.1%	0.5%	1.5%	0.7%	0.6%	1.1%	0.8%	3.8%	1.4%	0.4%	1.4%	0.5%
Independent sector services commissioned by PCTs	0.4%	0.0%	-	0.0%	-	0.1%	0.1%	-	0.4%	-	-	0.1%
Independent sector services commissioned by trusts	0.0%	0.0%	-	-	-	-	0.2%	-	-	0.0%	0.0%	-
Personal records (including medical and / or complaints)	0.9%	1.4%	0.4%	0.9%	1.3%	1.3%	1.1%	0.5%	0.5%	1.0%	0.7%	0.6%
Failure to follow agreed procedures	1.0%	1.3%	0.4%	1.0%	0.4%	0.4%	0.5%	0.4%	1.8%	0.7%	1.5%	0.5%
Patient's status, discrimination (e.g. racial, gender, age)	0.2%	0.1%	0.3%	0.3%	0.1%	0.3%	0.4%	0.0%	0.1%	0.1%	0.0%	0.0%
Mortuary and post mortem arrangements	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	-	0.0%	0.0%	0.0%	-	0.0%
Transport (ambulances and other)	3.4%	0.1%	0.1%	17.7%	0.0%	0.1%	5.4%	0.1%	0.5%	5.0%	0.1%	0.4%
Policy and commercial decisions of trusts	0.6%	0.3%	0.3%	0.2%	0.3%	0.5%	0.5%	0.3%	0.6%	0.8%	0.3%	1.3%
Code of openness - complaints	0.0%	-	-	-	-	-	-	-	-	-	-	0.0%
Hotel services (including food)	0.6%	0.2%	0.2%	0.4%	0.5%	1.0%	1.2%	0.3%	0.5%	0.4%	0.5%	0.4%
Other	5.5%	13.6%	0.6%	3.9%	9.1%	3.1%	1.9%	2.4%	1.8%	1.3%	7.1%	7.3%

Notes:

(1) A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained within the complaint letter received. Therefore the total number of complaints by subject (114,788) does not match the actual total number of complaints which is 114,308.

' - ' denotes zero

Data as at 1 April 2013 - 31 March 2014

Source:

Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
4,727	**6,436**	**5,118**	**4,122**	**3,695**	**2,756**	**2,644**	**2,624**	**4,123**	**3,479**	**6,103**	**3,641**	**4,936**	**20,671**	**1,014**
206	349	277	261	212	157	193	123	213	229	398	276	317	800	9
72	150	114	62	25	113	51	22	61	88	82	51	48	199	13
311	540	532	461	563	260	206	118	277	202	551	369	396	1,609	44
59	104	125	75	95	86	50	173	73	108	108	62	106	678	-
-	-	1	6	5	3	-	-	1	-	6	-	15	82	11
18	3	-	2	-	-	-	3	-	1	18	3	-	26	11
530	862	494	360	353	271	320	313	578	418	730	507	510	2,754	87
2,148	2,764	2,462	1,900	1,685	1,335	1,285	1,114	1,919	1,780	2,537	1,424	2,235	8,209	207
365	697	658	505	392	283	267	429	293	365	650	341	639	2,098	69
4	6	2	17	3	3	2	7	3	8	19	4	8	79	-
6	4	4	2	1	4	2	4	7	5	7	8	-	21	4
32	46	30	24	26	21	18	24	46	32	67	18	44	211	1
107	53	55	23	19	12	20	18	18	27	106	20	47	243	10
26	23	51	122	47	5	86	11	29	29	130	19	107	254	2
4	-	2	24	1	1	-	-	3	-	7	1	21	14	359
1	-	-	6	2	-	2	-	3	1	1	-	-	9	-
33	48	41	38	36	20	19	16	23	34	41	36	48	236	-
72	31	28	18	54	19	26	23	32	5	29	10	93	314	44
10	3	6	-	1	3	5	7	2	8	14	8	6	40	2
2	2	6	-	-	-	1	1	-	4	2	-	3	9	-
127	449	12	28	8	27	15	19	13	4	163	199	17	870	-
92	34	12	41	12	39	16	3	15	13	24	91	16	120	1
-	-	-	-	-	9	1	-	-	-	-	-	4	14	-
32	30	22	9	30	5	15	7	19	10	33	56	12	155	1
470	238	184	138	125	80	44	189	495	108	380	138	244	1,627	139

Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4.4%	5.4%	5.4%	6.3%	5.7%	5.7%	7.3%	4.7%	5.2%	6.6%	6.5%	7.6%	6.4%	3.9%	0.9%
1.5%	2.3%	2.2%	1.5%	0.7%	4.1%	1.9%	0.8%	1.5%	2.5%	1.3%	1.4%	1.0%	1.0%	1.3%
6.6%	8.4%	10.4%	11.2%	15.2%	9.4%	7.8%	4.5%	6.7%	5.8%	9.0%	10.1%	8.0%	7.8%	4.3%
1.2%	1.6%	2.4%	1.8%	2.6%	3.1%	1.9%	6.6%	1.8%	3.1%	1.8%	1.7%	2.1%	3.3%	-
-	-	0.0%	0.1%	0.1%	0.1%	-	-	0.0%	-	0.1%	-	0.3%	0.4%	1.1%
0.4%	0.0%	-	0.0%	-	-	-	0.1%	-	0.0%	0.3%	0.1%	-	0.1%	1.1%
11.2%	13.4%	9.7%	8.7%	9.6%	9.8%	12.1%	11.9%	14.0%	12.0%	12.0%	13.9%	10.3%	13.3%	8.6%
45.4%	42.9%	48.1%	46.1%	45.6%	48.4%	48.6%	42.5%	46.5%	51.2%	41.6%	39.1%	45.3%	39.7%	20.4%
7.7%	10.8%	12.9%	12.3%	10.6%	10.3%	10.1%	16.3%	7.1%	10.5%	10.7%	9.4%	12.9%	10.1%	6.8%
0.1%	0.1%	0.0%	0.4%	0.1%	0.1%	0.1%	0.3%	0.1%	0.2%	0.3%	0.1%	0.2%	0.4%	-
0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	-	0.1%	0.4%
0.7%	0.7%	0.6%	0.6%	0.7%	0.8%	0.7%	0.9%	1.1%	0.9%	1.1%	0.5%	0.9%	1.0%	0.1%
2.3%	0.8%	1.1%	0.6%	0.5%	0.4%	0.8%	0.7%	0.4%	0.8%	1.7%	0.5%	1.0%	1.2%	1.0%
0.6%	0.4%	1.0%	3.0%	1.3%	0.2%	3.3%	0.4%	0.7%	0.8%	2.1%	0.5%	2.2%	1.2%	0.2%
0.1%	-	0.0%	0.6%	0.0%	0.0%	-	-	0.1%	-	0.1%	0.0%	0.4%	0.1%	35.4%
0.0%	-	-	0.1%	0.1%	-	0.1%	-	0.1%	0.0%	0.0%	-	-	0.0%	-
0.7%	0.7%	0.8%	0.9%	1.0%	0.7%	0.7%	0.6%	0.6%	1.0%	0.7%	1.0%	1.0%	1.1%	-
1.5%	0.5%	0.5%	0.4%	1.5%	0.7%	1.0%	0.9%	0.8%	0.1%	0.5%	0.3%	1.9%	1.5%	4.3%
0.2%	0.0%	0.1%	-	0.0%	0.1%	0.2%	0.3%	0.0%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%
0.0%	0.0%	0.1%	-	-	-	0.0%	0.0%		0.1%	0.0%	-	0.1%	0.0%	-
2.7%	7.0%	0.2%	0.7%	0.2%	1.0%	0.6%	0.7%	0.3%	0.1%	2.7%	5.5%	0.3%	4.2%	-
1.9%	0.5%	0.2%	1.0%	0.3%	1.4%	0.6%	0.1%	0.4%	0.4%	0.4%	2.5%	0.3%	0.6%	0.1%
-	-	-	-	-	0.3%	0.0%	-	-	-	-	-	0.1%	0.1%	-
0.7%	0.5%	0.4%	0.2%	0.8%	0.2%	0.6%	0.3%	0.5%	0.3%	0.5%	1.5%	0.2%	0.7%	0.1%
9.9%	3.7%	3.6%	3.3%	3.4%	2.9%	1.7%	7.2%	12.0%	3.1%	6.2%	3.8%	4.9%	7.9%	13.7%

Table 8 Hospital and Community Health Services (HCHS) : Written Complaints by NHS England Area Team and Organisation, 2013-14, England

England		**114,308**
Q44	**Cheshire, Warrington and Wirral**	**2,110**
01C	Eastern Cheshire CCG	20
01R	South Cheshire CCG	19
02D	Vale Royal CCG	9
02E	Warrington CCG	13
02F	West Cheshire CCG	22
12F	Wirral CCG	38
RBL	Wirral University Teaching Hospital NHS Foundation Trust	463
RBT	Mid Cheshire Hospitals NHS Foundation Trust	228
REN	The Clatterbridge Cancer Centre NHS Foundation Trust	19
RJN	East Cheshire NHS Trust	184
RJR	Countess of Chester Hospital NHS Foundation Trust	228
RTV	5 Boroughs Partnership NHS Foundation Trust	244
RWW	Warrington and Halton Hospitals NHS Foundation Trust	422
RXA	Cheshire and Wirral Partnership NHS Foundation Trust	161
RY7	Wirral Community NHS Trust	40
Q45	**Durham, Darlington and Tees**	**1,438**
00C	Darlington CCG	2
00D	Durham Dales, Easington and Sedgefield CCG	3
00J	North Durham CCG	3
00K	Hartlepool and Stockton-on-Tees CCG	11
00M	South Tees CCG	11
RTR	South Tees Hospitals NHS Foundation Trust	391
RVW	North Tees and Hartlepool NHS Foundation Trust	319
RX3	Tees, Esk and Wear Valleys NHS Foundation Trust	151
RXP	County Durham and Darlington NHS Foundation Trust	547
Q46	**Greater Manchester**	**8,151**
00T	Bolton CCG	24
00V	Bury CCG	14
00W	Central Manchester CCG	10
00Y	Oldham CCG	17
01D	Heywood, Middleton and Rochdale CCG	22
01G	Salford CCG	10
01M	North Manchester CCG	3
01N	South Manchester CCG	3
01W	Stockport CCG	38
01Y	Tameside and Glossop CCG	8
02A	Trafford CCG	10
02H	Wigan Borough CCG	6
NCE	Mastercall Healthcare	14
NCM	Six Degrees Social Enterprise CIC	1
NJH	Future Directions CIC	13
RBV	The Christie NHS Foundation Trust	66
RM2	University Hospital of South Manchester NHS Foundation Trust	622
RM3	Salford Royal NHS Foundation Trust	383
RMC	Bolton NHS Foundation Trust	564
RMP	Tameside Hospital NHS Foundation Trust	412
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	391
RT2	Pennine Care NHS Foundation Trust	324
RW3	Central Manchester University Hospitals NHS Foundation Trust	1,192
RW6	Pennine Acute Hospitals NHS Trust	813
RWJ	Stockport NHS Foundation Trust	708
RX7	North West Ambulance Service NHS Trust	2,078
RXV	Greater Manchester West Mental Health NHS Foundation Trust	121
RY2	Bridgewater Community Healthcare NHS Trust	88
TAE	Manchester Mental Health and Social Care Trust	196
Q47	**Lancashire**	**2,364**
00Q	Blackburn With Darwen CCG	16
00R	Blackpool CCG	6
00X	Chorley and South Ribble CCG	6
01A	East Lancashire CCG	24
01E	Greater Preston CCG	4
01K	Lancashire North CCG	3
02G	West Lancashire CCG	12
02M	Fylde & Wyre CCG	9
RJX	Calderstones Partnership NHS Foundation Trust	97
RW5	Lancashire Care NHS Foundation Trust	471
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	434
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	582
RXR	East Lancashire Hospitals NHS Trust	700
Q48	**Merseyside**	**2,556**
01F	Halton CCG	19
01J	Knowsley CCG	7
01T	South Sefton CCG	19
01V	Southport and Formby CCG	10
01X	St Helens CCG	18
99A	Liverpool CCG	115
RBN	St Helens and Knowsley Hospitals NHS Trust	325
RBQ	Liverpool Heart and Chest Hospital NHS Foundation Trust	59
RBS	Alder Hey Children's NHS Foundation Trust	166
REM	Aintree University Hospital NHS Foundation Trust	307
REP	Liverpool Women's NHS Foundation Trust	213
RET	The Walton Centre NHS Foundation Trust	180
RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust	277
RVY	Southport and Ormskirk Hospital NHS Trust	330

RW4	Mersey Care NHS Trust	371
RY1	Liverpool Community Health NHS Trust	140
Q49	**Cumbria, Northumberland, Tyne and Wear**	**4,261**
00F	Gateshead CCG	3
00G	Newcastle North and East CCG	2
00H	Newcastle West CCG	nil
00L	Northumberland CCG	3
00N	South Tyneside CCG	2
00P	Sunderland CCG	1
01H	Cumbria CCG	31
99C	North Tyneside CCG	3
NLM	Teeside Urgent Care	23
RE9	South Tyneside NHS Foundation Trust	221
RLN	City Hospitals Sunderland NHS Foundation Trust	721
RNL	North Cumbria University Hospitals NHS Trust	365
RNN	Cumbria Partnership NHS Foundation Trust	161
RR7	Gateshead Health NHS Foundation Trust	234
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	702
RTF	Northumbria Healthcare NHS Foundation Trust	510
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	489
RX4	Northumberland, Tyne and Wear NHS Foundation Trust	346
RX6	North East Ambulance Service NHS Foundation Trust	444
Q50	**North Yorkshire and Humber**	**2,477**
02Y	East Riding of Yorkshire CCG	18
03D	Hambleton, Richmondshire and Whitby CCG	10
03E	Harrogate and Rural District CCG	16
03F	Hull CCG	2
03H	North East Lincolnshire CCG	nil
03K	North Lincolnshire CCG	9
03M	Scarborough and Ryedale CCG	19
03Q	Vale of York CCG	20
NL3	Care Plus Group	28
NNF	City Health Care Partnership CIC	59
NQL	Navigo	24
RCB	York Teaching Hospital NHS Foundation Trust	564
RCD	Harrogate and District NHS Foundation Trust	215
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	537
RV9	Humber NHS Foundation Trust	167
RWA	Hull and East Yorkshire Hospitals NHS Trust	789
Q51	**South Yorkshire and Bassetlaw**	**2,790**
02P	Barnsley CCG	10
02Q	Bassetlaw CCG	15
02X	Doncaster CCG	15
03L	Rotherham CCG	10
03N	Sheffield CCG	82
RCU	Sheffield Children's NHS Foundation Trust	116
RFF	Barnsley Hospital NHS Foundation Trust	279
RFR	The Rotherham NHS Foundation Trust	595
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	949
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	417
RXE	Rotherham Doncaster and South Humber NHS Foundation Trust	155
TAH	Sheffield Health & Social Care NHS Foundation Trust	147
Q52	**West Yorkshire**	**5,026**
02N	Airedale, Wharfdale and Craven CCG	13
02R	Bradford Districts CCG	5
02T	Calderdale CCG	23
02V	Leeds North CCG	3
02W	Bradford City CCG	1
03A	Greater Huddersfield CCG	14
03C	Leeds West CCG	6
03G	Leeds South and East CCG	7
03J	North Kirklees CCG	9
03R	Wakefield CCG	10
NL1	Spectrum Community Health - CIC	22
NL8	Locala Community Partnerships	30
RAE	Bradford Teaching Hospitals NHS Foundation Trust	553
RCF	Airedale NHS Foundation Trust	73
RGD	Leeds and York Partnership NHS Foundation Trust	147
RR8	Leeds Teaching Hospitals NHS Trust	1,066
RWY	Calderdale and Huddersfield NHS Foundation Trust	564
RX8	Yorkshire Ambulance Service NHS Trust	481
RXF	Mid Yorkshire Hospitals NHS Trust	1,405
RXG	South West Yorkshire Partnership NHS Foundation Trust	338
RY6	Leeds Community Healthcare NHS Trust	176
TAD	Bradford District Care Trust	80
Q53	**Arden, Herefordshire and Worcestershire**	**2,352**
05A	Coventry and Rugby CCG	29
05F	Herefordshire CCG	21
05H	Warwickshire North CCG	22
05J	Redditch and Bromsgrove CCG	7
05R	South Warwickshire CCG	31
05T	South Worcestershire CCG	19
06D	Wyre Forest CCG	8
R1A	Worcestershire Health and Care NHS Trust	258
RJC	South Warwickshire NHS Foundation Trust	190
RKB	University Hospitals Coventry and Warwickshire NHS Trust	490
RLQ	Wye Valley NHS Trust	242
RLT	George Eliot Hospital NHS Trust	326
RWP	Worcestershire Acute Hospitals NHS Trust	600
RYG	Coventry and Warwickshire Partnership NHS Trust	109
Q54	**Birmingham and the Black Country**	**5,080**
04X	Birmingham South and Central CCG	26

05C	Dudley CCG	60
05L	Sandwell and West Birmingham CCG	22
05P	Solihull CCG	20
05Y	Walsall CCG	22
06A	Wolverhampton CCG	23
13P	Birmingham Crosscity CCG	16
NR9	John Taylor Hospice Community Interest Company	1
RBK	Walsall Healthcare NHS Trust	354
RL4	The Royal Wolverhampton NHS Trust	402
RLU	Birmingham Women'S NHS Foundation Trust	146
RNA	The Dudley Group NHS Foundation Trust	330
RQ3	Birmingham Children's Hospital NHS Foundation Trust	110
RR1	Heart of England NHS Foundation Trust	958
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	146
RRK	University Hospitals Birmingham NHS Foundation Trust	664
RXK	Sandwell and West Birmingham Hospitals NHS Trust	663
RXT	Birmingham and Solihull Mental Health NHS Foundation Trust	272
RYA	West Midlands Ambulance Service NHS Foundation Trust	417
RYK	Dudley and Walsall Mental Health Partnership NHS Trust	90
RYW	Birmingham Community Healthcare NHS Trust	177
TAJ	Black Country Partnership NHS Foundation Trust	161
Q55	**Derbyshire and Nottinghamshire**	**4,727**
03X	Erewash CCG	10
03Y	Hardwick CCG	12
04E	Mansfield and Ashfield CCG	33
04H	Newark & Sherwood CCG	24
04J	North Derbyshire CCG	14
04L	Nottingham North and East CCG	24
04M	Nottingham West CCG	8
04N	Rushcliffe CCG	12
04R	Southern Derbyshire CCG	37
NDW	Ripplez CIC	4
NNJ	Derbyshire Health United Ltd	311
RFS	Chesterfield Royal Hospital NHS Foundation Trust	805
RHA	Nottinghamshire Healthcare NHS Trust	864
RK5	Sherwood Forest Hospitals NHS Foundation Trust	699
RTG	Derby Hospitals NHS Foundation Trust	681
RX1	Nottingham University Hospitals NHS Trust	693
RX9	East Midlands Ambulance Service NHS Trust	177
RXM	Derbyshire Healthcare NHS Foundation Trust	127
RY8	Derbyshire Community Health Services NHS Trust	192
Q56	**East Anglia**	**6,436**
06H	Cambridgeshire and Peterborough CCG	40
06L	Ipswich and East Suffolk CCG	53
06M	Great Yarmouth and Waveney CCG	14
06V	North Norfolk CCG	20
06W	Norwich CCG	11
06Y	South Norfolk CCG	11
07J	West Norfolk CCG	9
07K	West Suffolk CCG	20
NAX	East Coast Community Healthcare CIC	175
NHM	Suffolk Community Healthcare	65
RCX	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	569
RGM	Papworth Hospital NHS Foundation Trust	48
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust	502
RGP	James Paget University Hospitals NHS Foundation Trust	266
RGQ	Ipswich Hospital NHS Trust	709
RGR	West Suffolk NHS Foundation Trust	356
RGT	Cambridge University Hospitals NHS Foundation Trust	465
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	986
RMY	Norfolk and Suffolk NHS Foundation Trust	544
RQQ	Hinchingbrooke Health Care NHS Trust	242
RT1	Cambridgeshire and Peterborough NHS Foundation Trust	151
RY3	Norfolk Community Health and Care NHS Trust	207
RYC	East of England Ambulance Service NHS Trust	798
RYV	Cambridgeshire Community Services NHS Trust	175
Q57	**Essex**	**5,118**
06Q	Mid Essex CCG	2
06T	North East Essex CCG	21
07G	Thurrock CCG	11
07H	West Essex CCG	16
99E	Basildon and Brentwood CCG	45
99F	Castle Point and Rochford CCG	20
99G	Southend CCG	45
NQ1	Anglian Community Enterprise Community Interest Company (Ace CIC)	67
NQA	Provide	163
RAJ	Southend University Hospital NHS Foundation Trust	883
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust	833
RDE	Colchester Hospital University NHS Foundation Trust	1,257
RQ8	Mid Essex Hospital Services NHS Trust	839
RQW	The Princess Alexandra Hospital NHS Trust	389
RRD	North Essex Partnership University NHS Foundation Trust	138
RWN	South Essex Partnership University NHS Foundation Trust	389
Q58	**Hertfordshire and the South Midlands**	**4,118**
03V	Corby CCG	7
04F	Milton Keynes CCG	15
04G	Nene CCG	40
06F	Bedfordshire CCG	101
06K	East and North Hertfordshire CCG	51
06N	Herts Valleys CCG	41
06P	Luton CCG	27
NPH	Milton Keynes Urgent Care Services CIC	17
NRG	Baby Ways Community Interest Company	nil
NRR	Community Dental Services CIC	7
RC1	Bedford Hospital NHS Trust	285
RC9	Luton and Dunstable University Hospital NHS Foundation Trust	624

RD8	Milton Keynes Hospital NHS Foundation Trust	395
RNQ	Kettering General Hospital NHS Foundation Trust	369
RNS	Northampton General Hospital NHS Trust	526
RP1	Northamptonshire Healthcare NHS Foundation Trust	328
RWH	East and North Hertfordshire NHS Trust	868
RWR	Hertfordshire Partnership University NHS Foundation Trust	232
RY4	Hertfordshire Community NHS Trust	185
Q59	**Leicestershire and Lincolnshire**	**3,662**
03T	Lincolnshire East CCG	32
03W	East Leicestershire and Rutland CCG	6
04C	Leicester City CCG	25
04D	Lincolnshire West CCG	13
04Q	South West Lincolnshire CCG	9
04V	West Leicestershire CCG	109
99D	South Lincolnshire CCG	5
RP7	Lincolnshire Partnership NHS Foundation Trust	194
RT5	Leicestershire Partnership NHS Trust	330
RWD	United Lincolnshire Hospitals NHS Trust	712
RWE	University Hospitals of Leicester NHS Trust	2,034
RY5	Lincolnshire Community Health Services NHS Trust	193
Q60	**Shropshire and Staffordshire**	**2,756**
04Y	Cannock Chase CCG	nil
05D	East Staffordshire CCG	16
05G	North Staffordshire CCG	29
05N	Shropshire CCG	20
05Q	South East Staffs and Seisdon Peninsular CCG	18
05V	Stafford and Surrounds CCG	18
05W	Stoke on Trent CCG	60
05X	Telford and Wrekin CCG	22
NRX	Midlands Psychology CIC	1
R1D	Shropshire Community Health NHS Trust	77
R1E	Staffordshire and Stoke on Trent Partnership NHS Trust	263
RJD	Mid Staffordshire NHS Foundation Trust	268
RJE	University Hospital of North Staffordshire NHS Trust	809
RJF	Burton Hospitals NHS Foundation Trust	475
RL1	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trus	87
RLY	North Staffordshire Combined Healthcare NHS Trust	57
RRE	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	92
RXW	Shrewsbury and Telford Hospital NHS Trust	444
Q64	**Bath, Gloucestershire, Swindon and Wiltshire**	**2,644**
11E	Bath and North East Somerset CCG	27
11M	Gloucestershire CCG	23
12D	Swindon CCG	33
99N	Wiltshire CCG	114
NLX	Sirona Care & Health	49
R1J	Gloucestershire Care Services NHS Trust	77
RBB	Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	12
RD1	Royal United Hospital Bath NHS Trust	365
RN3	Great Western Hospitals NHS Foundation Trust	360
RNZ	Salisbury NHS Foundation Trust	330
RTE	Gloucestershire Hospitals NHS Foundation Trust	836
RTQ	2Gether NHS Foundation Trust	146
RVN	Avon and Wiltshire Mental Health Partnership NHS Trust	272
Q65	**Bristol, North Somerset, Somerset and South Gloucestershire**	**2,515**
11H	Bristol CCG	44
11T	North Somerset CCG	24
11X	Somerset CCG	62
12A	South Gloucestershire CCG	12
NLT	North Somerset Community Partnership Community Interest Company	26
NLW	Bristol Community Health	31
RA3	Weston Area Health NHS Trust	225
RA4	Yeovil District Hospital NHS Foundation Trust	266
RA7	University Hospitals Bristol NHS Foundation Trust	775
RBA	Taunton and Somerset NHS Foundation Trust	182
RH5	Somerset Partnership NHS Foundation Trust	113
RVJ	North Bristol NHS Trust	755
Q66	**Devon, Cornwall and Isles of Scilly**	**4,123**
11N	Kernow CCG	19
99P	North, East, West Devon CCG	95
99Q	South Devon and Torbay CCG	9
NLL	Peninsula Community Health CIC	120
NR5	Plymouth Community Healthcare (CIC)	160
NX0	Chime Social Enterprise	7
R1G	Torbay and Southern Devon Health and Care NHS Trust	67
RA9	South Devon Healthcare NHS Foundation Trust	241
RBZ	Northern Devon Healthcare NHS Trust	324
REF	Royal Cornwall Hospitals NHS Trust	491
RH8	Royal Devon and Exeter NHS Foundation Trust	497
RJ8	Cornwall Partnership NHS Foundation Trust	111
RK9	Plymouth Hospitals NHS Trust	860
RWV	Devon Partnership NHS Trust	336
RYF	South Western Ambulance Service NHS Foundation Trust	786
Q67	**Kent and Medway**	**3,479**
09C	Ashford CCG	9
09E	Canterbury and Coastal CCG	18
09J	Dartford, Gravesham and Swanley CCG	14
09W	Medway CCG	4
10A	South Kent Coast CCG	12
10D	Swale CCG	6
10E	Thanet CCG	17
99J	West Kent CCG	43
NQ7	Medway Community Healthcare	143

RN7	Dartford and Gravesham NHS Trust	451
RPA	Medway NHS Foundation Trust	628
RVV	East Kent Hospitals University NHS Foundation Trust	895
RWF	Maidstone and Tunbridge Wells NHS Trust	574
RXY	Kent and Medway NHS and Social Care Partnership Trust	376
RYY	Kent Community Health NHS Trust	289
Q68	**Surrey and Sussex**	**6,103**
09D	Brighton and Hove CCG	49
09F	Eastbourne, Hailsham and Seaford CCG	33
09G	Coastal West Sussex CCG	67
09H	Crawley CCG	15
09L	East Surrey CCG	4
09N	Guildford and Waverley CCG	37
09P	Hastings and Rother CCG	32
09X	Horsham and Mid Sussex CCG	10
09Y	North West Surrey CCG	1
10C	Surrey Heath CCG	3
99H	Surrey Downs CCG	34
99K	High Weald Lewes Havens CCG	23
RA2	Royal Surrey County Hospital NHS Foundation Trust	430
RDR	Sussex Community NHS Trust	204
RDU	Frimley Park Hospital NHS Foundation Trust	382
RPC	Queen Victoria Hospital NHS Foundation Trust	80
RTK	Ashford and St Peter'S Hospitals NHS Foundation Trust	548
RTP	Surrey and Sussex Healthcare NHS Trust	482
RX2	Sussex Partnership NHS Foundation Trust	765
RXC	East Sussex Healthcare NHS Trust	521
RXH	Brighton and Sussex University Hospitals NHS Trust	1,126
RXX	Surrey and Borders Partnership NHS Foundation Trust	130
RYD	South East Coast Ambulance Service NHS Foundation Trust	605
RYR	Western Sussex Hospitals NHS Foundation Trust	522
Q69	**Thames Valley**	**3,546**
10G	Bracknell and Ascot CCG	26
10H	Chiltern CCG	60
10M	Newbury and District CCG	18
10N	North & West Reading CCG	10
10Q	Oxfordshire CCG	40
10T	Slough CCG	11
10W	South Reading CCG	14
10Y	Aylesbury Vale CCG	39
11C	Windsor, Ascot and Maidenhead CCG	35
11D	Wokingham CCG	14
RD7	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	548
RHW	Royal Berkshire NHS Foundation Trust	411
RNU	Oxford Health NHS Foundation Trust	225
RTH	Oxford University Hospitals NHS Trust	890
RWX	Berkshire Healthcare NHS Foundation Trust	210
RXQ	Buckinghamshire Healthcare NHS Trust	613
RYE	South Central Ambulance Service NHS Foundation Trust	382
Q70	**Wessex**	**4,935**
10J	North Hampshire CCG	26
10K	Fareham and Gosport CCG	40
10L	Isle of Wight CCG	9
10R	Portsmouth CCG	11
10V	South Eastern Hampshire CCG	35
10X	Southampton CCG	31
11A	West Hampshire CCG	174
11J	Dorset CCG	61
99M	North East Hampshire and Farnham CCG	11
NCH	Talkplus	nil
NWA	Echotech Ltd	nil
R1C	Solent NHS Trust	295
R1F	Isle of Wight NHS Trust	194
RBD	Dorset County Hospital NHS Foundation Trust	428
RD3	Poole Hospital NHS Foundation Trust	467
RDY	Dorset Healthcare University NHS Foundation Trust	452
RDZ	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	370
RHM	University Hospital Southampton NHS Foundation Trust	563
RHU	Portsmouth Hospitals NHS Trust	692
RN5	Hampshire Hospitals NHS Foundation Trust	606
RW1	Southern Health NHS Foundation Trust	470
Q71	**London**	**20,646**
07L	Barking and Dagenham CCG	3
07M	Barnet CCG	4
07N	Bexley CCG	25
07P	Brent CCG	35
07Q	Bromley CCG	28
07R	Camden CCG	3
07T	City and Hackney CCG	1
07V	Croydon CCG	31
07W	Ealing CCG	15
07X	Enfield CCG	12
07Y	Hounslow CCG	39
08A	Greenwich CCG	47
08C	Hammersmith and Fulham CCG	7
08D	Haringey CCG	4
08E	Harrow CCG	26
08F	Havering CCG	1
08G	Hillingdon CCG	14
08H	Islington CCG	nil
08J	Kingston CCG	8
08K	Lambeth CCG	12
08L	Lewisham CCG	19
08M	Newham CCG	nil
08N	Redbridge CCG	10
08P	Richmond CCG	13

08Q	Southwark CCG	2
08R	Merton CCG	19
08T	Sutton CCG	34
08V	Tower Hamlets CCG	nil
08W	Waltham Forest CCG	3
08X	Wandsworth CCG	18
08Y	West London (K&C & Qpp) CCG	28
09A	Central London (Westminster) CCG	23
NAL	Patientfirst Social Enterprise	nil
NDA	Virgin Care Services Ltd	138
NNV	Your Healthcare	22
NQV	Bromley Healthcare	118
R1H	Barts Health NHS Trust	2,451
RAL	Royal Free London NHS Foundation Trust	652
RAN	Royal National Orthopaedic Hospital NHS Trust	91
RAP	North Middlesex University Hospital NHS Trust	497
RAS	The Hillingdon Hospitals NHS Foundation Trust	423
RAT	North East London NHS Foundation Trust	215
RAX	Kingston Hospital NHS Foundation Trust	401
RC3	Ealing Hospital NHS Trust	223
RF4	Barking, Havering and Redbridge University Hospitals NHS Trust	771
RFW	West Middlesex University Hospital NHS Trust	384
RJ1	Guy's and St Thomas' NHS Foundation Trust	926
RJ2	Lewisham and Greenwich NHS Trust	807
RJ6	Croydon Health Services NHS Trust	705
RJ7	St George's Healthcare NHS Trust	1,083
RJZ	King's College Hospital NHS Foundation Trust	980
RKE	The Whittington Hospital NHS Trust	460
RKL	West London Mental Health NHS Trust	444
RNK	Tavistock and Portman NHS Foundation Trust	12
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	123
RP6	Moorfields Eye Hospital NHS Foundation Trust	249
RPG	Oxleas NHS Foundation Trust	204
RPY	The Royal Marsden NHS Foundation Trust	175
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	356
RQX	Homerton University Hospital NHS Foundation Trust	271
RQY	South West London and St George's Mental Health NHS Trust	359
RRP	Barnet, Enfield and Haringey Mental Health NHS Trust	293
RRU	London Ambulance Service NHS Trust	1,060
RRV	University College London Hospitals NHS Foundation Trust	788
RT3	Royal Brompton & Harefield NHS Foundation Trust	65
RV3	Central and North West London NHS Foundation Trust	538
RV5	South London and Maudsley NHS Foundation Trust	561
RV8	North West London Hospitals NHS Trust	784
RVL	Barnet and Chase Farm Hospitals NHS Trust	336
RVR	Epsom and St Helier University Hospitals NHS Trust	480
RWK	East London NHS Foundation Trust	375
RY9	Hounslow and Richmond Community Healthcare NHS Trust	82
RYH	NHS Direct NHS Trust	68
RYJ	Imperial College Healthcare NHS Trust	884
RYX	Central London Community Healthcare NHS Trust	92
TAF	Camden and Islington NHS Foundation Trust	216
Other		**895**
KO41aSE01	First Contact Clinical	3
KO41aSE02	Bevan Healthcare CIC	nil
KO41aSE05	Health First ALW Community Interest Company	nil
KO41aSE06	St Pauls Way Medical Centre (MEEBBB Health CIC)	7
KO41aSE08	First Community Health and Care	16
KO41aSE102	City & Hackney Urgent Healthcare Social Enterprise	1
KO41aSE125	Allied Healthcare Group Limited	214
KO41aSE16	Herts Urgent Care	29
KO41aSE19	East Lancashire Medical Services	108
KO41aSE20	Accelerate Health CIC	1
KO41aSE23	Urgent Care 24	73
KO41aSE25	Integrated Care 24 (formerly South East Health Limited)	263
KO41aSE28	Willow Bank Partnership Community Interest Company(Willow Bank Surgery)	13
KO41aSE34	Annie's Healthcare Services CIC	nil
KO41aSE39	Care & Support Partnership Community Interest Company Limited	131
KO41aSE40	Carers' Break - Community Interest Company	nil
KO41aSE44	Connections (West Yorkshire) Health and Social Care CIC	nil
KO41aSE52	Falcare CIC Ltd	nil
KO41aSE66	Inclusion Healthcare Social Enterprise CIC	nil
KO41aSE74	Positive Support in Tees Community Interest Company	nil
KO41aSE80	SCIL Continuing Care Community Interest Company	nil
KO41aSE88	Support Horizons CIC	nil
KO41aSE93	Vernova Healthcare Community Interest Company	2
NWL	My General Practice Limited	1
X24	NHS England	33

Total organisations approached for data	636
of which Foundation Trusts not returning data [(2)]	-

Notes:

' nil ' refers to organisations that did not submit a return

' - ' denotes zero.

Data as at 1 April 2013 - 31 March 2014

Source:

Table 9 General Practice (including Dental) Health Services : Written Complaints by Service Area, 2008-09 to 2013-14, England

	2008-09[1]	2009-10	2010-11	2011-12	2012-13[2][4]	2013-14[4][5]
All Service Areas	**48,597**	**50,755**	**50,708**	**54,870**	**52,703**	**60,564**
Medical	29,411	30,623	30,784	29,897	27,711	24,405
Dental	8,909	8,100	8,321	8,167	6,729	6,973
General Practice administration	9,042	9,889	9,745	13,298	13,933	22,643
Other	1,235	2,143	1,858	3,508	4,330	6,543
Total organisations approached for data	*152*	*152*	*151*	*154*	*150*	*25*[5]
of which incomplete returns [3]	*36*	*18*	*29*	*36*	*65*	*25*[5]

Notes:

[1] Includes one PCT in 2008-09 which did not submit a return

[2] Three PCTs failed to submit a return for 2012-13

[3] Information from some PCTs state they did not receive returns for some practices within their area and so have submitted incomplete data.

[4] We are unable to provide comparisons between 2012-13 with previous years for figures including FHS (GP data) due to the number of PCTs unable to submit complete returns in 2012-13. For more information see the Data Quality section of this publication.

[5] We are unable to provide comparisons between 2013-14 with previous years for figures including FHS (GP data) due to the number of NHS England Area Teams unable to submit complete returns in 2013-14. For more information see the Data Quality section of this publication.

Data as at 1 April - 31 March each year

Source:

Table 10 General Practice (including Dental) Health Services : Written Complaints by Subject of Complaint [1], 2008-09 to 2013-14, England

	2008-09[3]	2009-10	2010-11	2011-12	2012-13[4][5]	2013-14[5][6]
All Subjects of Complaint [1]	**46,248**	**48,271**	**49,275**	**53,590**	**48,637**	**61,196**
Communications / attitude	11,003	11,677	11,360	11,650	10,110	13,275
Premises	1,083	773	681	650	602	1,621
Practice / surgery management	6,045	5,766	5,050	5,210	4,889	6,360
General Practice administration	7,448	7,673	8,055	9,924	9,461	12,513
Clinical	14,866	16,300	17,465	19,336	17,184	22,202
Other	5,803	6,082	6,664	6,820	6,391	5,225
Total organisations approached for data	*152*	*152*	*151*	*154*	*150*	*25 [6]*
of which incomplete returns [2]	*36*	*18*	*29*	*36*	*65*	*25 [6]*

Notes:

[1] A complaint can be made concerning more than one subject area. Where this has occurred, some Practices have recorded a complaint under each subject area contained within the complaint letter received.

[2] Information from some PCTs state they did not receive returns for some practices within their area and so have submitted incomplete data.

[3] Includes one PCT in 2008-09 which did not submit a return

[4] Three PCTs failed to submit a return for 2012-13

[5] We are unable to provide comparisons between 2012-13 with previous years for figures including FHS (GP data) due to the number of PCTs unable to submit complete returns in 2012-13. For more information see the Data Quality section of this publication.

[6] We are unable to provide comparisons between 2013-14 with previous years for figures including FHS (GP data) due to the number of NHS England Area Teams unable to submit complete returns in 2013-14. For more information see the Data Quality section of this publication.

Data as at 1 April - 31 March each year

Source:

Table 11 General Practice (including Dental) Health Services : Written Complaints by Service Area within each NHS England Area Team, 2013-14, England

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54
Total general practice (including dental) health services Complaints[1]	**60,564**	**1,287**	**1,075**	**2,742**	**4,323**	**1,403**	**1,548**	**2,548**	**1,654**	**2,884**	**1,960**	**2,082**
Medical	24,405	476	505	1,097	1,182	548	727	2,213	643	1,035	815	856
Dental	6,973	121	107	341	1,141	154	194	335	140	271	249	129
General Practice administration	22,643	615	346	1,072	1,157	561	487	-	708	1,319	694	916
Other	6,543	75	117	232	843	140	140	-	163	259	202	181

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54
Total general practice (including dental) health services Complaints	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
Medical	*40.3%*	*37.0%*	*47.0%*	*40.0%*	*27.3%*	*39.1%*	*47.0%*	*86.9%*	*38.9%*	*35.9%*	*41.6%*	*41.1%*
Dental	*11.5%*	*9.4%*	*10.0%*	*12.4%*	*26.4%*	*11.0%*	*12.5%*	*13.1%*	*8.5%*	*9.4%*	*12.7%*	*6.2%*
General Practice administration	*37.4%*	*47.8%*	*32.2%*	*39.1%*	*26.8%*	*40.0%*	*31.5%*	-	*42.8%*	*45.7%*	*35.4%*	*44.0%*
Other	*10.8%*	*5.8%*	*10.9%*	*8.5%*	*19.5%*	*10.0%*	*9.0%*	-	*9.9%*	*9.0%*	*10.3%*	*8.7%*

Data as at 1 April 2013 - 31 March 2014

' - ' denotes zero

Source:

Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
574	**3,222**	**2,190**	**3,552**	**1,450**	**1,855**	**1,683**	**2,081**	**2,550**	**1,942**	**3,260**	**1,886**	**3,644**	**7,019**	**150**
224	1,209	981	1,312	645	860	597	819	992	798	1,310	681	1,317	2,525	38
149	307	142	239	168	161	136	164	282	250	244	155	640	710	44
139	1,369	755	1,709	531	621	808	835	978	662	1,459	829	1,215	2,799	59
62	337	312	292	106	213	142	263	298	232	247	221	472	985	9

Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
100%	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
39.0%	*37.5%*	*44.8%*	*36.9%*	*44.5%*	*46.4%*	*35.5%*	*39.4%*	*38.9%*	*41.1%*	*40.2%*	*36.1%*	*36.1%*	*36.0%*	*25.3%*
26.0%	*9.5%*	*6.5%*	*6.7%*	*11.6%*	*8.7%*	*8.1%*	*7.9%*	*11.1%*	*12.9%*	*7.5%*	*8.2%*	*17.6%*	*10.1%*	*29.3%*
24.2%	*42.5%*	*34.5%*	*48.1%*	*36.6%*	*33.5%*	*48.0%*	*40.1%*	*38.4%*	*34.1%*	*44.8%*	*44.0%*	*33.3%*	*39.9%*	*39.3%*
10.8%	*10.5%*	*14.2%*	*8.2%*	*7.3%*	*11.5%*	*8.4%*	*12.6%*	*11.7%*	*11.9%*	*7.6%*	*11.7%*	*13.0%*	*14.0%*	*6.0%*

Table 12 General Practice (including Dental) Health Services : Written Complaints by Subject(1) within each NHS England Area Team, 2013 -14, England

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55
dental) health services Complaints [1]	**61,196**	**1,305**	**1,097**	**2,537**	**6,749**	**1,202**	**1,427**	**2,548**	**1,640**	**2,933**	**1,703**	**2,101**	**519**
Communications / attitude	13,275	223	311	629	1,333	320	297	589	337	580	417	435	137
Premises	1,621	14	8	26	1,054	6	21	28	12	28	16	17	1
Practice / surgery management	6,360	176	118	199	1,120	151	170	172	138	318	146	231	32
General Practice administration	12,513	326	158	524	927	219	257	460	340	682	338	442	94
Clinical	22,202	468	420	980	1,483	439	565	1,064	637	1,099	682	785	211
Other	5,225	98	82	179	832	67	117	235	176	226	104	191	44

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55
Total general practice (including dental) health services Complaints	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
Communications / attitude	*21.7%*	*17.1%*	*28.4%*	*24.8%*	*19.8%*	*26.6%*	*20.8%*	*23.1%*	*20.5%*	*19.8%*	*24.5%*	*20.7%*	*26.4%*
Premises	*2.6%*	*1.1%*	*0.7%*	*1.0%*	*15.6%*	*0.5%*	*1.5%*	*1.1%*	*0.7%*	*1.0%*	*0.9%*	*0.8%*	*0.2%*
Practice / surgery management	*10.4%*	*13.5%*	*10.8%*	*7.8%*	*16.6%*	*12.6%*	*11.9%*	*6.8%*	*8.4%*	*10.8%*	*8.6%*	*11.0%*	*6.2%*
General Practice administration	*20.4%*	*25.0%*	*14.4%*	*20.7%*	*13.7%*	*18.2%*	*18.0%*	*18.1%*	*20.7%*	*23.3%*	*19.8%*	*21.0%*	*18.1%*
Clinical	*36.3%*	*35.9%*	*38.3%*	*38.6%*	*22.0%*	*36.5%*	*39.6%*	*41.8%*	*38.8%*	*37.5%*	*40.0%*	*37.4%*	*40.7%*
Other	*8.5%*	*7.5%*	*7.5%*	*7.1%*	*12.3%*	*5.6%*	*8.2%*	*9.2%*	*10.7%*	*7.7%*	*6.1%*	*9.1%*	*8.5%*

[1] A complaint can be made concerning more than one subject area. Where this has occurred, some Practices have recorded a complaint under each subject area contained within the complaint letter received.

Data as at 1 April 2013 - 31 March 2014

Source:

East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
3,195	**1,783**	**3,582**	**1,516**	**1,920**	**1,595**	**2,129**	**2,321**	**1,875**	**3,207**	**1,898**	**3,506**	**6,767**	**141**
608	365	660	334	441	329	449	505	390	696	406	747	1,699	38
35	9	41	23	18	23	33	23	10	39	17	41	74	4
433	153	409	130	170	125	216	198	173	303	186	241	638	14
616	344	865	308	407	416	483	548	407	768	419	668	1,473	24
1,220	711	1,329	620	701	593	779	868	776	1,192	734	1,513	2,282	51
283	201	278	101	183	109	169	179	119	209	136	296	601	10

East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
100%	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
19.0%	*20.5%*	*18.4%*	*22.0%*	*23.0%*	*20.6%*	*21.1%*	*21.8%*	*20.8%*	*21.7%*	*21.4%*	*21.3%*	*25.1%*	27.0%
1.1%	*0.5%*	*1.1%*	*1.5%*	*0.9%*	*1.4%*	*1.6%*	*1.0%*	*0.5%*	*1.2%*	*0.9%*	*1.2%*	*1.1%*	2.8%
13.6%	*8.6%*	*11.4%*	*8.6%*	*8.9%*	*7.8%*	*10.1%*	*8.5%*	*9.2%*	*9.4%*	*9.8%*	*6.9%*	*9.4%*	9.9%
19.3%	*19.3%*	*24.1%*	*20.3%*	*21.2%*	*26.1%*	*22.7%*	*23.6%*	*21.7%*	*23.9%*	*22.1%*	*19.1%*	*21.8%*	17.0%
38.2%	*39.9%*	*37.1%*	*40.9%*	*36.5%*	*37.2%*	*36.6%*	*37.4%*	*41.4%*	*37.2%*	*38.7%*	*43.2%*	*33.7%*	36.2%
8.9%	*11.3%*	*7.8%*	*6.7%*	*9.5%*	*6.8%*	*7.9%*	*7.7%*	*6.3%*	*6.5%*	*7.2%*	*8.4%*	*8.9%*	7.1%

Index to Tables on Written Complaints; Experimental statistics

Table 13 Hospital and Community Health Services (HCHS): Written Complaints and Complaints Upheld by Service Area 2013-14, England, experimental statistics

	Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
All Service Areas	**114,308**		**57,072**	**49.9%**
Ambulance services	6,873		2,451	35.7%
Community hospital services	2,001		1,059	52.9%
Elderly (geriatric) services	1,058		575	54.3%
Hospital acute services: A&E	9,919		5,155	52.0%
Hospital acute services: Inpatient	34,422		18,500	53.7%
Hospital acute services: Outpatient	31,083		17,647	56.8%
Maternity services	3,343		1,878	56.2%
Mental health services	12,221		4,614	37.8%
NHS Direct	362		204	56.4%
Other community health services	6,292		2,847	45.2%
CCG, NHS England commissioning	2,547		863	33.9%
Walk in centres	503		220	43.7%
Other	3,684		1,059	28.7%

Data as at 1 April 2013 - 31 March 2014

Source:

Table 14 Hospital and Community Health Services (HCHS): Written Complaints and Complaints Upheld by Profession 2013-14, England, experimental statistics

	Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
All Professions	**114,308**		**57,072**	**49.9%**
Medical (including surgical)	52,123		26,157	50.2%
Dental (including surgical)	718		348	48.5%
Professions supplementary to medicine	3,836		1,992	51.9%
Nursing, Midwifery and Health Visiting	24,793		13,213	53.3%
Scientific, Technical and Professional	1,139		634	55.7%
Ambulance crews (including paramedics)	5,702		1,961	34.4%
Maintenance and Ancillary staff	643		384	59.7%
Administrative staff / members (exc GP admin)	1,196		445	37.2%
Trust Administrative staff / members	8,323		4,934	59.3%
Other	15,835		7,004	44.2%

Data as at 1 April 2013 - 31 March 2014

Source:

Table 15 Hospital and Community Health Services (HCHS): Written Complaints and Complaints Upheld by Subject of Complaint[1] 2013-14, England, experimental statistics

	Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
All Subjects of Complaint [1]	**114,788**		**57,312**	**49.9%**
Admissions, discharge and transfer arrangements	5,913		3,104	52.5%
Aids and appliances, equipment, premises (including access)	1,529		849	55.5%
Appointments, delay / cancellation (outpatient)	9,038		5,932	65.6%
Appointments, delay / cancellation (inpatient)	2,681		1,420	53.0%
Length of time waiting for a response, or to be seen: NHS Direct	168		74	44.0%
Length of time waiting for a response, or to be seen: Walk in centres	106		49	46.2%
Attitude of staff	13,269		6,763	51.0%
All aspects of clinical treatment	52,330		25,363	48.5%
Communication / information to patients (written and oral)	11,472		6,389	55.7%
Consent to treatment	229		87	38.0%
Complaints handling	120		61	50.8%
Patients privacy and dignity	1,029		528	51.3%
Patients property and expenses	1,091		517	47.4%
CCG, NHS England commissioning (including waiting lists)	1,315		329	25.0%
Independent sector services commissioned by CCGs, NHS England	462		150	32.5%
Independent sector services commissioned by trusts	38		8	21.1%
Personal records (including medical and / or complaints)	1,017		563	55.4%
Failure to follow agreed procedures	1,109		552	49.8%
Patient's status, discrimination (e.g. racial, gender, age)	185		74	40.0%
Mortuary and post mortem arrangements	42		19	45.2%
Transport (ambulances and other)	3,935		1,498	38.1%
Policy and commercial decisions of trusts	734		213	29.0%
Code of openness - complaints	29		5	17.2%
Hotel services (including food)	644		383	59.5%
Other	6,303		2,382	37.8%

Notes:

[1] A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained within the complaint letter received. Therefore the total number of complaints by subject (114,788) does not match the actual total number of complaints which is 114,308.

Data as at 1 April 2013 - 31 March 2014

Source:

Table 16 Hospital and Community Health Services (HCHS): Written Complaints and Complaints Upheld by Service Area within each NHS England Area Team, 2013-14, England, experimental statistics

Total Complaints Received

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58	Q59	Q60	Q64
Total HCHS Complaints	**114,308**	**2,110**	**1,438**	**8,151**	**2,364**	**2,556**	**4,261**	**2,477**	**2,790**	**5,026**	**2,352**	**5,080**	**4,727**	**6,436**	**5,118**	**4,118**	**3,662**	**2,756**	**2,644**
Hospital acute services: Inpatient	34,422	767	600	2,119	903	919	1,171	1,102	977	1,602	769	1,880	1,391	1,840	1,617	1,337	1,154	875	904
Hospital acute services: Outpatient	31,083	449	365	1,828	485	742	1,252	584	890	1,436	585	1,146	1,073	1,585	1,662	1,209	1,271	789	703
Hospital acute services: A&E	9,919	207	146	527	221	170	428	255	280	387	300	483	299	553	597	407	255	261	204
Elderly (geriatric) services	1,058	61	10	27	9	5	125	38	23	56	6	37	17	43	110	29	5	44	4
Mental health services	12,221	325	151	486	320	385	415	126	252	517	159	491	723	703	425	390	419	155	428
Maternity services	3,343	48	50	201	33	20	143	72	108	168	117	229	83	148	197	118	97	80	62
Ambulance services	6,873	2	1	2,087	1	1	446	1	8	364	-	417	184	803	9	6	1	10	-
Community hospital services	2,001	5	5	45	6	23	11	31	6	32	40	18	123	251	58	28	85	123	63
NHS Direct	362	-	-	-	-	-	18	1	-	119	-	5	-	-	4	7	3	2	-
Walk in centres	503	14	35	45	-	9	11	-	9	3	-	14	6	22	2	15	8	14	3
Other community health services	6,292	149	51	324	298	189	154	152	131	296	235	217	157	245	310	315	250	220	128
CCG, NHS England commissioning	2,547	50	24	123	79	37	48	83	94	30	83	111	138	113	68	176	71	106	108
Other	3,684	33	-	339	9	56	39	32	12	16	58	32	533	130	59	81	43	77	37

Written Complaints Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58	Q59	Q60	Q64
Total HCHS Complaints	**57,072**	**762**	**647**	**3,253**	**847**	**1,191**	**2,306**	**1,197**	**1,794**	**3,069**	**1,429**	**2,108**	**1,986**	**4,415**	**2,211**	**2,088**	**2,534**	**1,073**	**1,117**
Hospital acute services: Inpatient	18,500	320	275	1,111	302	488	653	537	717	1,031	548	791	602	1,421	677	668	863	312	395
Hospital acute services: Outpatient	17,647	176	144	856	194	434	647	255	628	964	401	448	469	1,279	762	653	1,138	325	300
Hospital acute services: A&E	5,155	66	66	256	92	86	230	132	180	201	204	177	106	414	221	235	156	107	81
Elderly (geriatric) services	575	24	9	15	4	1	62	29	17	31	5	21	-	36	45	20	1	18	2
Mental health services	4,614	95	85	133	75	94	219	43	42	400	56	251	229	313	187	185	120	69	222
Maternity services	1,878	13	22	103	15	14	76	44	88	81	78	97	28	104	116	78	90	24	17
Ambulance services	2,451	-	1	425	-	-	272	-	6	105	-	159	101	503	1	5	-	4	-
Community hospital services	1,059	-	2	26	1	9	8	19	3	29	20	6	70	59	29	10	27	52	30
NHS Direct	204	-	-	-	-	-	17	-	-	53	-	3	-	-	1	2	-	1	-
Walk in centres	220	6	10	30	-	-	5	-	5	2	-	3	3	10	1	-	2	5	1
Other community health services	2,847	56	24	165	92	62	82	79	53	157	86	101	101	156	135	177	102	112	42
CCG, NHS England commissioning	863	1	9	40	66	2	15	40	52	11	17	37	78	59	18	42	8	16	21
Other	1,059	5	-	93	6	1	20	19	3	4	14	14	199	61	18	13	27	28	6

Percentage Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58	Q59	Q60	Q64
Total HCHS Complaints	***50%***	***36%***	***45%***	***40%***	***36%***	***47%***	***54%***	***48%***	***64%***	***61%***	***61%***	***41%***	***42%***	***69%***	***43%***	***51%***	***69%***	***39%***	***42%***
Hospital acute services: Inpatient	*54%*	*42%*	*46%*	*52%*	*33%*	*53%*	*56%*	*49%*	*73%*	*64%*	*71%*	*42%*	*43%*	*77%*	*42%*	*50%*	*75%*	*36%*	*44%*
Hospital acute services: Outpatient	*57%*	*39%*	*39%*	*47%*	*40%*	*58%*	*52%*	*44%*	*71%*	*67%*	*69%*	*39%*	*44%*	*81%*	*46%*	*54%*	*90%*	*41%*	*43%*
Hospital acute services: A&E	*52%*	*32%*	*45%*	*49%*	*42%*	*51%*	*54%*	*52%*	*64%*	*52%*	*68%*	*37%*	*35%*	*75%*	*37%*	*58%*	*61%*	*41%*	*40%*
Elderly (geriatric) services	*54%*	*39%*	*90%*	*56%*	*44%*	*20%*	*50%*	*76%*	*74%*	*55%*	*83%*	*57%*	*0%*	*84%*	*41%*	*69%*	*20%*	*41%*	*50%*
Mental health services	*38%*	*29%*	*56%*	*27%*	*23%*	*24%*	*53%*	*34%*	*17%*	*77%*	*35%*	*51%*	*32%*	*45%*	*44%*	*47%*	*29%*	*45%*	*52%*
Maternity services	*56%*	*27%*	*44%*	*51%*	*45%*	*70%*	*53%*	*61%*	*81%*	*48%*	*67%*	*42%*	*34%*	*70%*	*59%*	*66%*	*93%*	*30%*	*27%*
Ambulance services	*36%*	*0%*	*100%*	*20%*	*0%*	*0%*	*61%*	*0%*	*75%*	*29%*	.	*38%*	*55%*	*63%*	*11%*	*83%*	*0%*	*40%*	.
Community hospital services	*53%*	*0%*	*40%*	*58%*	*17%*	*39%*	*73%*	*61%*	*50%*	*91%*	*50%*	*33%*	*57%*	*24%*	*50%*	*36%*	*32%*	*42%*	*48%*
NHS Direct	*56%*	.	.	.	.	.	*94%*	*0%*	.	*45%*	.	*60%*	.	.	*25%*	*29%*	*0%*	*50%*	.
Walk in centres	*44%*	*43%*	*29%*	*67%*	.	*0%*	*45%*	.	*56%*	*67%*	.	*21%*	*50%*	*45%*	*50%*	*0%*	*25%*	*36%*	*33%*
Other community health services	*45%*	*38%*	*47%*	*51%*	*31%*	*33%*	*53%*	*52%*	*40%*	*53%*	*37%*	*47%*	*64%*	*64%*	*44%*	*56%*	*41%*	*51%*	*33%*
CCG, NHS England commissioning	*34%*	*2%*	*38%*	*33%*	*84%*	*5%*	*31%*	*48%*	*55%*	*37%*	*20%*	*33%*	*57%*	*52%*	*26%*	*24%*	*11%*	*15%*	*19%*
Other	*29%*	*15%*	.	*27%*	*67%*	*2%*	*51%*	*59%*	*25%*	*25%*	*24%*	*44%*	*37%*	*47%*	*31%*	*16%*	*63%*	*36%*	*16%*

Notes:

It should be noted that these are experimental statistics and at an organisation level show a range from 0% to 100% of written complaints being upheld as shown in the organisation tables 20 and 25.

' - ' denotes zero

' . ' denotes not applicable

Data as at 1 April 2013 - 31 March 2014

Source:

Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
2,515	**4,123**	**3,479**	**6,103**	**3,546**	**4,935**	**20,646**	**895**
1,004	1,185	1,075	1,738	1,187	1,420	4,884	2
797	884	918	1,690	894	1,280	6,565	1
264	216	393	580	273	417	1,796	-
8	12	26	47	22	84	210	-
55	528	371	862	296	441	2,797	1
79	77	133	90	97	176	717	-
8	547	1	440	385	11	1,140	-
39	357	28	190	25	182	225	2
10	1	-	16	5	42	129	-
11	33	6	25	17	32	145	24
104	166	369	154	134	465	804	275
43	91	33	149	140	206	319	24
93	26	126	122	71	179	915	566

Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
1,538	**1,770**	**1,554**	**3,271**	**2,195**	**2,620**	**9,832**	**265**
566	472	527	956	912	764	2,591	1
522	406	470	1,073	579	765	3,759	-
176	66	199	349	198	260	897	-
8	1	12	23	6	35	150	-
39	149	168	174	107	159	1,000	-
40	21	75	53	62	94	445	-
3	296	-	292	214	9	55	-
28	214	5	134	14	107	156	1
1	-	-	10	3	37	76	-
6	13	-	8	6	16	74	14
60	94	62	92	58	240	447	12
13	26	10	55	26	84	116	1
76	12	26	52	10	50	66	236

Percentage (%)

Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
61%	***43%***	***45%***	***54%***	***62%***	***53%***	***48%***	***30%***
56%	*40%*	*49%*	*55%*	*77%*	*54%*	*53%*	*50%*
65%	*46%*	*51%*	*63%*	*65%*	*60%*	*57%*	*0%*
67%	*31%*	*51%*	*60%*	*73%*	*62%*	*50%*	.
100%	*8%*	*46%*	*49%*	*27%*	*42%*	*71%*	.
71%	*28%*	*45%*	*20%*	*36%*	*36%*	*36%*	*0%*
51%	*27%*	*56%*	*59%*	*64%*	*53%*	*62%*	.
38%	*54%*	*0%*	*66%*	*56%*	*82%*	*5%*	.
72%	*60%*	*18%*	*71%*	*56%*	*59%*	*69%*	*50%*
10%	*0%*	.	*63%*	*60%*	*88%*	*59%*	.
55%	*39%*	*0%*	*32%*	*35%*	*50%*	*51%*	*58%*
58%	*57%*	*17%*	*60%*	*43%*	*52%*	*56%*	*4%*
30%	*29%*	*30%*	*37%*	*19%*	*41%*	*36%*	*4%*
82%	*46%*	*21%*	*43%*	*14%*	*28%*	*7%*	*42%*

Table 17 Hospital and Community Health Services (HCHS): Written Complaints and Complaints Upheld by Profession within each NHS England Area Team, 2013-14, England, experimental statistics

Written Complaints Received

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58
Total HCHS Complaints	**114,308**	**2,110**	**1,438**	**8,151**	**2,364**	**2,556**	**4,261**	**2,477**	**2,790**	**5,026**	**2,352**	**5,080**	**4,727**	**6,436**	**5,118**	**4,118**
Medical (including surgical)	52,123	1,190	785	2,710	1,122	1,365	2,055	1,439	1,359	2,301	1,187	2,561	2,078	2,520	2,205	2,308
Dental (including surgical)	718	5	2	22	34	6	15	8	23	22	5	36	36	26	5	25
Professions supplementary to medicine	3,836	79	35	144	167	104	85	58	101	262	64	124	246	386	60	133
Nursing, Midwifery and Health Visiting	24,793	514	451	1,397	537	706	1,068	592	819	983	517	1,325	1,177	1,817	1,240	689
Scientific, Technical and Professional	1,139	12	25	36	43	11	39	12	38	46	53	43	27	54	63	22
Ambulance crews (including paramedics)	5,702	3	1	1,928	1	1	125	2	9	365	1	428	108	664	13	16
Maintenance and Ancillary staff	643	5	2	23	8	33	19	5	16	37	8	9	49	35	34	14
Administrative staff / members (exc GP admin)	1,196	41	22	74	-	19	51	95	23	14	4	47	26	61	63	47
Trust Administrative staff / members	8,323	111	48	387	69	126	382	50	171	675	172	291	233	386	344	234
Other	15,835	150	67	1,430	383	185	422	216	231	321	341	216	747	487	1,091	630

Written Complaints Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58
Total HCHS Complaints	**57,072**	**762**	**647**	**3,253**	**847**	**1,191**	**2,306**	**1,197**	**1,794**	**3,069**	**1,429**	**2,108**	**1,986**	**4,415**	**2,211**	**2,088**
Medical (including surgical)	26,157	362	322	1,270	389	659	1,135	618	872	1,363	724	994	736	1,872	744	1,199
Dental (including surgical)	348	2	-	10	9	2	9	3	11	15	1	20	12	16	1	13
Professions supplementary to medicine	1,992	35	19	68	46	30	44	31	55	206	32	55	157	223	24	64
Nursing, Midwifery and Health Visiting	13,213	254	229	718	184	315	561	378	538	644	369	609	544	1,196	525	405
Scientific, Technical and Professional	634	3	11	21	11	6	14	1	27	30	47	21	18	37	26	7
Ambulance crews (including paramedics)	1,961	-	1	389	-	-	43	-	7	106	-	164	42	408	-	10
Maintenance and Ancillary staff	384	1	1	11	5	16	13	1	12	31	7	2	26	30	15	10
Administrative staff / members (exc GP admin)	445	1	7	17	-	6	13	47	9	9	-	17	12	51	20	10
Trust Administrative staff / members	4,934	67	29	198	34	80	181	19	137	523	134	141	164	310	145	126
Other	7,004	37	28	551	169	77	293	99	126	142	115	85	275	272	711	244

Percentage Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58
Total HCHS Complaints	***50%***	***36%***	***45%***	***40%***	***36%***	***47%***	***54%***	***48%***	***64%***	***61%***	***61%***	***41%***	***42%***	***69%***	***43%***	***51%***
Medical (including surgical)	*50%*	*30%*	*41%*	*47%*	*35%*	*48%*	*55%*	*43%*	*64%*	*59%*	*61%*	*39%*	*35%*	*74%*	*34%*	*52%*
Dental (including surgical)	*48%*	*40%*	*0%*	*45%*	*26%*	*33%*	*60%*	*38%*	*48%*	*68%*	*20%*	*56%*	*33%*	*62%*	*20%*	*52%*
Professions supplementary to medicine	*52%*	*44%*	*54%*	*47%*	*28%*	*29%*	*52%*	*53%*	*54%*	*79%*	*50%*	*44%*	*64%*	*58%*	*40%*	*48%*
Nursing, Midwifery and Health Visiting	*53%*	*49%*	*51%*	*51%*	*34%*	*45%*	*53%*	*64%*	*66%*	*66%*	*71%*	*46%*	*46%*	*66%*	*42%*	*59%*
Scientific, Technical and Professional	*56%*	*25%*	*44%*	*58%*	*26%*	*55%*	*36%*	*8%*	*71%*	*65%*	*89%*	*49%*	*67%*	*69%*	*41%*	*32%*
Ambulance crews (including paramedics)	*34%*	*0%*	*100%*	*20%*	*0%*	*0%*	*34%*	*0%*	*78%*	*29%*	*0%*	*38%*	*39%*	*61%*	*0%*	*63%*
Maintenance and Ancillary staff	*60%*	*20%*	*50%*	*48%*	*63%*	*48%*	*68%*	*20%*	*75%*	*84%*	*88%*	*22%*	*53%*	*86%*	*44%*	*71%*
Administrative staff / members (exc GP admin)	*37%*	*2%*	*32%*	*23%*	.	*32%*	*25%*	*49%*	*39%*	*64%*	*0%*	*36%*	*46%*	*84%*	*32%*	*21%*
Trust Administrative staff / members	*59%*	*60%*	*60%*	*51%*	*49%*	*63%*	*47%*	*38%*	*80%*	*77%*	*78%*	*48%*	*70%*	*80%*	*42%*	*54%*
Other	*44%*	*25%*	*42%*	*39%*	*44%*	*42%*	*69%*	*46%*	*55%*	*44%*	*34%*	*39%*	*37%*	*56%*	*65%*	*39%*

' - ' denotes zero
' . ' denotes not applicable

Data as at 1 April 2013 - 31 March 2014

Source:

Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
3,662	**2,756**	**2,644**	**2,515**	**4,123**	**3,479**	**6,103**	**3,546**	**4,935**	**20,646**	**895**
2,312	1,062	1,242	1,402	1,845	2,065	2,738	1,376	1,987	8,630	279
5	16	11	61	39	29	21	29	28	206	3
91	127	65	66	157	184	220	172	222	473	11
560	782	529	586	734	574	1,234	649	1,489	3,798	26
8	32	14	31	34	98	38	22	193	144	1
1	14	7	1	393	2	433	269	15	902	-
12	43	26	44	15	14	44	19	15	114	-
6	40	86	28	8	9	65	10	145	209	3
45	178	134	157	162	170	659	333	313	2,460	33
622	462	530	139	736	334	651	667	528	3,710	539

Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
2,534	**1,073**	**1,117**	**1,538**	**1,770**	**1,554**	**3,271**	**2,195**	**2,620**	**9,832**	**265**
1,662	327	600	895	686	989	1,405	806	1,111	4,375	42
3	4	6	58	19	6	12	10	22	81	3
57	71	35	52	63	38	115	71	123	274	4
246	332	247	344	330	239	645	365	805	2,185	6
3	17	4	18	17	28	26	15	122	103	1
-	3	3	1	184	2	290	155	11	142	-
10	12	6	33	5	7	32	13	10	75	-
1	1	8	13	6	4	40	7	51	93	2
25	96	81	65	86	98	452	201	213	1,314	15
527	210	127	59	374	143	254	552	152	1,190	192

Percentage (%)

Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
69%	***39%***	***42%***	***61%***	***43%***	***45%***	***54%***	***62%***	***53%***	***48%***	***30%***
72%	*31%*	*48%*	*64%*	*37%*	*48%*	*51%*	*59%*	*56%*	*51%*	*15%*
60%	*25%*	*55%*	*95%*	*49%*	*21%*	*57%*	*34%*	*79%*	*39%*	*100%*
63%	*56%*	*54%*	*79%*	*40%*	*21%*	*52%*	*41%*	*55%*	*58%*	*36%*
44%	*42%*	*47%*	*59%*	*45%*	*42%*	*52%*	*56%*	*54%*	*58%*	*23%*
38%	*53%*	*29%*	*58%*	*50%*	*29%*	*68%*	*68%*	*63%*	*72%*	*100%*
0%	*21%*	*43%*	*100%*	*47%*	*100%*	*67%*	*58%*	*73%*	*16%*	.
83%	*28%*	*23%*	*75%*	*33%*	*50%*	*73%*	*68%*	*67%*	*66%*	.
17%	*3%*	*9%*	*46%*	*75%*	*44%*	*62%*	*70%*	*35%*	*44%*	*67%*
56%	*54%*	*60%*	*41%*	*53%*	*58%*	*69%*	*60%*	*68%*	*53%*	*45%*
85%	*45%*	*24%*	*42%*	*51%*	*43%*	*39%*	*83%*	*29%*	*32%*	*36%*

Table 18 Hospital and Community Health Services (HCHS) : Written Complaints and Complaints Upheld by Subject(1) within each NHS England Area Team, 2013-14, England, experimental statistics

Written Complaints Received

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Bristol, North Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
Total HCHS Complaints	**114,788**	**2,110**	**1,438**	**8,242**	**2,364**	**2,556**	**4,261**	**2,477**	**2,790**	**5,026**	**2,352**	**5,083**	**4,727**	**6,436**	**5,118**	**4,122**	**3,695**	**2,756**	**2,644**	**2,624**	**4,123**	**3,479**	**6,103**	**3,641**	**4,936**	**20,671**	**1,014**
Admissions, discharge and transfer arrangements	5,913	114	86	387	144	100	223	105	149	214	142	229	206	349	277	261	212	157	193	123	213	229	398	276	317	800	9
Aids and appliances, equipment, premises (including access)	1,529	24	20	38	35	26	40	7	53	49	27	59	72	150	114	62	25	113	51	22	61	88	82	51	48	199	13
Appointments, delay / cancellation (outpatient)	9,038	135	69	534	107	154	308	114	221	454	170	333	311	540	532	461	563	260	206	118	277	202	551	369	396	1,609	44
Appointments, delay / cancellation (inpatient)	2,681	36	44	66	84	34	114	20	55	103	64	159	59	104	125	75	95	86	50	173	73	108	108	62	106	678	-
Length of time waiting for a response, or to be seen: NHS Direct	168	1	-	-	-	1	-	-	-	32	-	4	-	-	1	6	5	3	-	-	1	-	6	-	15	82	11
Length of time waiting for a response, or to be seen: Walk in centres	106	4	-	-	1	-	15	-	1	-	-	-	18	3	-	2	-	-	-	3	-	1	18	3	-	26	11
Attitude of staff	13,269	293	99	946	298	351	420	205	311	504	193	562	530	862	494	360	353	271	320	313	578	418	730	507	510	2,754	87
All aspects of clinical treatment	52,330	842	923	3,188	1,208	1,333	2,185	1,611	1,474	2,669	1,231	2,662	2,148	2,764	2,462	1,900	1,685	1,335	1,285	1,114	1,919	1,780	2,537	1,424	2,235	8,209	207
Communication / information to patients (written and oral)	11,472	246	77	842	131	231	363	190	268	455	189	429	365	697	658	505	392	283	267	429	293	365	650	341	639	2,098	69
Consent to treatment	229	7	5	11	4	5	6	3	5	2	3	13	4	6	2	17	3	3	2	7	3	8	19	4	8	79	-
Complaints handling	120	1	1	14	2	2	6	2	-	5	-	8	6	4	4	2	1	4	2	4	7	5	7	8	-	21	4
Patients privacy and dignity	1,029	19	47	70	28	43	37	17	21	29	39	39	32	46	30	24	26	21	18	24	46	32	67	18	44	211	1
Patients property and expenses	1,091	16	10	67	24	74	23	8	18	26	22	25	107	53	55	23	19	12	20	18	18	27	106	20	47	243	10
CCG, NHS England commissioning (including waiting lists)	1,315	11	22	56	15	29	34	93	38	21	32	23	26	23	51	122	47	5	86	11	29	29	130	19	107	254	2
Independent sector services commissioned by CCGs, NHS England	462	1	-	3	-	2	4	-	11	-	-	4	4	-	2	24	1	1	-	-	3	-	7	1	21	14	359
Independent sector services commissioned by trusts	38	1	-	-	-	-	10	-	-	1	1	-	1	-	-	6	2	-	2	-	3	1	1	-	-	9	-
Personal records (including medical and / or complaints)	1,017	29	6	78	31	33	48	12	15	50	16	30	33	48	41	38	36	20	19	16	23	34	41	36	48	236	-
Failure to follow agreed procedures	1,109	28	6	80	10	11	21	11	50	34	35	25	72	31	28	18	54	19	26	23	32	5	29	10	93	314	44
Patient's status, discrimination (e.g. racial, gender, age)	185	2	4	25	3	7	19	1	2	4	1	2	10	3	6	-	1	3	5	7	2	8	14	8	6	40	2
Mortuary and post mortem arrangements	42	1	1	2	1	1	-	1	1	2	-	2	2	2	6	-	-	-	1	1	-	4	2	-	3	9	-
Transport (ambulances and other)	3,935	3	1	1,457	1	3	230	3	14	251	3	18	127	449	12	28	8	27	15	19	13	4	163	199	17	870	-
Policy and commercial decisions of trusts	734	6	5	17	8	12	22	7	18	38	7	65	92	34	12	41	12	39	16	3	15	13	24	91	16	120	1
Code of openness - complaints	29	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	9	1	-	-	-	-	-	4	14	-
Hotel services (including food)	644	4	3	37	13	25	52	8	15	18	11	22	32	30	22	9	30	5	15	7	19	10	33	56	12	155	1
Other	6,303	286	9	324	216	79	81	59	50	65	166	369	470	238	184	138	125	80	44	189	495	108	380	138	244	1,627	139

Written Complaints Upheld

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Bristol, North Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
Total HCHS Complaints	**57,312**	**762**	**647**	**3,320**	**847**	**1,191**	**2,306**	**1,199**	**1,794**	**3,069**	**1,431**	**2,096**	**1,986**	**4,415**	**2,211**	**2,089**	**2,534**	**1,073**	**1,117**	**1,576**	**1,770**	**1,570**	**3,271**	**2,290**	**2,620**	**9,863**	**265**
Admissions, discharge and transfer arrangements	3,104	40	45	170	50	43	93	62	107	134	92	91	86	256	140	108	130	63	87	68	97	116	209	214	169	434	-
Aids and appliances, equipment, premises (including access)	849	16	11	20	16	10	24	4	39	37	19	28	50	103	53	32	14	47	18	11	31	25	55	32	29	124	1
Appointments, delay / cancellation (outpatient)	5,932	59	35	316	53	109	178	51	173	360	113	167	168	413	242	290	533	133	99	79	166	82	395	276	264	1,176	2
Appointments, delay / cancellation (inpatient)	1,420	9	23	48	32	20	35	10	41	88	56	78	37	83	76	39	89	32	31	118	39	68	78	44	52	194	-
Length of time waiting for a response, or to be seen: NHS Direct	74	-	-	-	-	-	-	-	-	19	-	2	-	-	-	1	1	1	-	-	1	-	5	-	12	32	-
Length of time waiting for a response, or to be seen: Walk in centres	49	-	-	1	-	-	11	-	-	-	-	-	6	3	-	-	-	-	-	2	-	-	9	3	-	14	-
Attitude of staff	6,783	125	41	379	104	170	219	114	203	292	136	243	193	584	226	192	228	116	143	224	224	221	353	320	273	1,422	18
All aspects of clinical treatment	25,363	247	405	1,366	357	613	1,200	765	919	1,579	767	1,033	776	1,887	1,014	939	1,009	455	531	640	723	762	1,372	844	1,135	3,977	48
Communication / information to patients (written and oral)	6,389	97	43	469	52	116	203	89	173	305	110	209	212	506	288	291	291	138	121	193	138	181	342	215	378	1,220	9
Consent to treatment	87	-	1	5	-	3	2	1	4	2	2	6	1	4	-	5	2	-	1	3	-	3	10	3	5	24	-
Complaints handling	61	-	1	4	1	-	3	1	-	3	-	5	3	2	2	1	1	1	-	4	2	3	5	5	-	14	-
Patients privacy and dignity	528	8	17	35	14	24	21	9	8	17	14	9	11	37	12	16	20	9	11	10	19	16	27	11	34	119	-
Patients property and expenses	517	8	3	35	10	26	12	5	9	20	13	10	72	22	23	9	13	6	12	12	8	9	48	13	9	110	-
CCG, NHS England commissioning (including waiting lists)	329	-	7	7	5	1	5	45	15	4	7	4	16	3	11	31	4	2	8	1	6	9	46	2	19	70	1
Independent sector services commissioned by CCGs, NHS England	150	-	-	3	-	-	-	-	6	-	-	3	1	-	-	8	-	-	-	-	1	-	4	-	20	6	98
Independent sector services commissioned by trusts	8	-	-	-	-	-	3	-	-	1	-	-	-	-	-	-	2	-	-	-	-	1	-	-	-	1	-
Personal records (including medical and / or complaints)	563	17	4	38	10	16	26	5	11	35	8	10	17	38	21	27	24	10	6	7	10	20	27	21	19	136	-
Failure to follow agreed procedures	552	14	2	45	7	6	13	9	32	21	28	14	30	18	11	12	28	6	11	17	8	2	14	5	56	143	-
Patient's status, discrimination (e.g. racial, gender, age)	74	1	1	7	1	2	6	1	2	4	-	2	3	3	3	-	-	2	1	5	-	4	6	4	2	14	-
Mortuary and post mortem arrangements	19	-	1	1	-	-	-	-	-	1	-	-	-	2	2	-	-	-	-	1	-	2	1	-	3	5	-
Transport (ambulances and other)	1,498	-	-	297	1	3	183	1	11	84	2	9	86	303	4	20	6	8	7	14	3	3	114	126	15	198	-
Policy and commercial decisions of trusts	213	-	3	4	-	1	8	-	7	17	4	17	34	17	10	7	1	1	4	2	6	4	7	18	7	34	-
Code of openness - complaints	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1	-	-	-	-	-	1	1	-
Hotel services (including food)	383	2	2	14	8	10	25	2	8	11	7	9	13	24	15	3	28	5	8	4	4	6	22	50	6	96	1
Other	2,382	119	2	57	125	18	36	25	26	35	53	147	171	107	58	58	110	36	17	161	284	33	122	84	112	299	87

Percentage Upheld

Percentage (%)

	England	Cheshire, Warrington and Wirral Q44	Durham, Darlington and Tees Q45	Greater Manchester Q46	Lancashire Q47	Merseyside Q48	Cumbria, Northumberland, Tyne and Wear Q49	North Yorkshire and Humber Q50	South Yorkshire and Bassetlaw Q51	West Yorkshire Q52	Arden, Herefordshire and Worcestershire Q53	Birmingham and the Black Country Q54	Derbyshire and Nottinghamshire Q55	East Anglia Q56	Essex Q57	Hertfordshire and the South Midlands Q58	Leicestershire and Lincolnshire Q59	Shropshire and Staffordshire Q60	Bath, Gloucestershire, Swindon and Wiltshire Q64	Bristol, North Somerset, Somerset and South Gloucestershire Q65	Devon, Cornwall and Isles of Scilly Q66	Kent and Medway Q67	Surrey and Sussex Q68	Thames Valley Q69	Wessex Q70	London Q71	Other Q99
Total HCHS Complaints	***50%***	***36%***	***45%***	***40%***	***36%***	***47%***	***54%***	***48%***	***64%***	***61%***	***61%***	***41%***	***42%***	***69%***	***43%***	***51%***	***69%***	***39%***	***42%***	***60%***	***43%***	***45%***	***54%***	***63%***	***53%***	***48%***	***26%***
Admissions, discharge and transfer arrangements	*52%*	*35%*	*52%*	*44%*	*35%*	*43%*	*42%*	*59%*	*72%*	*63%*	*65%*	*40%*	*42%*	*73%*	*51%*	*41%*	*61%*	*40%*	*45%*	*55%*	*46%*	*51%*	*53%*	*78%*	*53%*	*54%*	*0%*
Aids and appliances, equipment, premises (including access)	*56%*	*67%*	*55%*	*53%*	*46%*	*38%*	*60%*	*57%*	*74%*	*76%*	*70%*	*47%*	*69%*	*69%*	*46%*	*52%*	*56%*	*42%*	*35%*	*50%*	*51%*	*28%*	*67%*	*63%*	*60%*	*62%*	*8%*
Appointments, delay / cancellation (outpatient)	*66%*	*44%*	*51%*	*59%*	*50%*	*71%*	*58%*	*45%*	*78%*	*79%*	*66%*	*50%*	*54%*	*76%*	*45%*	*63%*	*95%*	*51%*	*48%*	*67%*	*60%*	*41%*	*72%*	*75%*	*67%*	*73%*	*5%*
Appointments, delay / cancellation (inpatient)	*53%*	*25%*	*52%*	*73%*	*38%*	*59%*	*31%*	*50%*	*75%*	*85%*	*88%*	*49%*	*63%*	*80%*	*61%*	*52%*	*94%*	*37%*	*62%*	*68%*	*53%*	*63%*	*72%*	*71%*	*49%*	*29%*	.
Length of time waiting for a response, or to be seen: NHS Direct	*44%*	*0%*	.	.	.	*0%*	.	.	.	*59%*	.	*50%*	.	.	*0%*	*17%*	*20%*	*33%*	.	.	*100%*	.	*83%*	.	*80%*	*39%*	*0%*
Length of time waiting for a response, or to be seen: Walk in centres	*46%*	*0%*	.	.	*100%*	.	*73%*	.	*0%*	.	.	.	*33%*	*100%*	.	*0%*	.	.	.	*67%*	.	*0%*	*50%*	*100%*	.	*54%*	*0%*
Attitude of staff	*51%*	*43%*	*41%*	*40%*	*35%*	*48%*	*52%*	*56%*	*65%*	*58%*	*70%*	*43%*	*36%*	*68%*	*46%*	*53%*	*65%*	*43%*	*45%*	*72%*	*39%*	*53%*	*48%*	*63%*	*54%*	*52%*	*21%*
All aspects of clinical treatment	*48%*	*29%*	*44%*	*43%*	*30%*	*46%*	*55%*	*47%*	*62%*	*59%*	*62%*	*39%*	*36%*	*68%*	*41%*	*49%*	*60%*	*34%*	*41%*	*57%*	*38%*	*43%*	*54%*	*59%*	*51%*	*48%*	*23%*
Communication / information to patients (written and oral)	*56%*	*39%*	*56%*	*56%*	*40%*	*50%*	*56%*	*47%*	*65%*	*67%*	*58%*	*49%*	*58%*	*73%*	*44%*	*58%*	*74%*	*49%*	*45%*	*45%*	*47%*	*50%*	*53%*	*63%*	*59%*	*58%*	*13%*
Consent to treatment	*38%*	*0%*	*20%*	*45%*	*0%*	*60%*	*33%*	*33%*	*80%*	*100%*	*67%*	*46%*	*25%*	*67%*	*0%*	*29%*	*67%*	*0%*	*50%*	*43%*	*0%*	*38%*	*53%*	*75%*	*63%*	*30%*	.
Complaints handling	*51%*	*0%*	*100%*	*29%*	*50%*	*0%*	*50%*	*50%*	.	*60%*	.	*63%*	*50%*	*50%*	*50%*	*50%*	*100%*	*25%*	*0%*	*100%*	*29%*	*60%*	*71%*	*63%*	.	*67%*	*0%*
Patients privacy and dignity	*51%*	*42%*	*36%*	*50%*	*50%*	*56%*	*57%*	*53%*	*38%*	*59%*	*36%*	*23%*	*34%*	*80%*	*40%*	*67%*	*77%*	*43%*	*61%*	*42%*	*41%*	*50%*	*40%*	*61%*	*77%*	*56%*	*0%*
Patients property and expenses	*47%*	*50%*	*30%*	*52%*	*42%*	*35%*	*52%*	*63%*	*50%*	*77%*	*59%*	*40%*	*67%*	*42%*	*42%*	*39%*	*68%*	*50%*	*60%*	*67%*	*44%*	*33%*	*45%*	*65%*	*19%*	*45%*	*0%*
CCG, NHS England commissioning (including waiting lists)	*25%*	*0%*	*32%*	*13%*	*33%*	*3%*	*15%*	*48%*	*39%*	*19%*	*22%*	*17%*	*62%*	*13%*	*22%*	*25%*	*9%*	*40%*	*9%*	*9%*	*21%*	*31%*	*35%*	*11%*	*18%*	*28%*	*50%*
Independent sector services commissioned by CCGs, NHS England	*32%*	*0%*	.	*100%*	.	*0%*	*0%*	.	*55%*	.	.	*75%*	*25%*	.	*0%*	*33%*	*0%*	*0%*	.	*33%*	.	*57%*	*0%*	*95%*	*43%*	*27%*
Independent sector services commissioned by trusts	*21%*	*0%*	.	.	.	.	*30%*	.	.	*100%*	*0%*	.	*0%*	.	.	*0%*	*100%*	.	*0%*	.	*0%*	*100%*	*0%*	.	.	*11%*	.
Personal records (including medical and / or complaints)	*55%*	*59%*	*67%*	*49%*	*32%*	*48%*	*54%*	*42%*	*73%*	*70%*	*50%*	*33%*	*52%*	*79%*	*51%*	*71%*	*67%*	*50%*	*32%*	*44%*	*43%*	*59%*	*66%*	*58%*	*40%*	*58%*	.
Failure to follow agreed procedures	*50%*	*50%*	*33%*	*56%*	*70%*	*55%*	*62%*	*82%*	*64%*	*62%*	*80%*	*56%*	*42%*	*58%*	*39%*	*67%*	*52%*	*32%*	*42%*	*74%*	*25%*	*40%*	*48%*	*50%*	*60%*	*46%*	*0%*
Patient's status, discrimination (e.g. racial, gender, age)	*40%*	*50%*	*25%*	*28%*	*33%*	*29%*	*32%*	*100%*	*100%*	*100%*	*0%*	*100%*	*30%*	*100%*	*50%*	.	*0%*	*67%*	*20%*	*71%*	*0%*	*50%*	*43%*	*50%*	*33%*	*35%*	*0%*
Mortuary and post mortem arrangements	*45%*	*0%*	*100%*	*50%*	*0%*	*0%*	.	*0%*	*0%*	*50%*	.	*0%*	*0%*	*100%*	*33%*	.	.	.	*0%*	*100%*	.	*50%*	*50%*	.	*100%*	*56%*	.
Transport (ambulances and other)	*38%*	*0%*	*0%*	*20%*	*100%*	*100%*	*80%*	*33%*	*79%*	*33%*	*67%*	*50%*	*68%*	*67%*	*33%*	*71%*	*75%*	*30%*	*47%*	*74%*	*23%*	*75%*	*70%*	*63%*	*88%*	*23%*	.
Policy and commercial decisions of trusts	*29%*	*0%*	*60%*	*24%*	*0%*	*8%*	*36%*	*0%*	*39%*	*45%*	*57%*	*26%*	*37%*	*50%*	*83%*	*17%*	*8%*	*3%*	*25%*	*67%*	*40%*	*31%*	*29%*	*20%*	*44%*	*28%*	*0%*
Code of openness - complaints	*17%*	.	.	.	.	.	.	.	.	.	.	*0%*	.	.	.	.	.	*22%*	*100%*	.	.	.	.	.	*25%*	*7%*	.
Hotel services (including food)	*59%*	*50%*	*67%*	*38%*	*62%*	*40%*	*48%*	*25%*	*53%*	*61%*	*64%*	*41%*	*41%*	*80%*	*68%*	*33%*	*93%*	*100%*	*53%*	*57%*	*21%*	*60%*	*67%*	*89%*	*50%*	*62%*	*100%*
Other	*38%*	*42%*	*22%*	*18%*	*58%*	*23%*	*44%*	*42%*	*52%*	*54%*	*32%*	*40%*	*36%*	*45%*	*32%*	*42%*	*88%*	*45%*	*39%*	*85%*	*57%*	*31%*	*32%*	*61%*	*46%*	*18%*	*63%*

Notes:

(1) A complaint can be made concerning more than one subject area. Where this has occurred, some organisations have recorded a complaint under each subject area contained within the complaint letter received. Therefore the total number of complaints by subject (114,788) does not match the actual total number of complaints which is 114,308.

' - ' denotes zero

' . ' denotes not applicable

Data as at 1 April 2013 - 31 March 2014

Source:

Table 19 Hospital and Community Health Services (HCHS): Written Complaints and Complaints Upheld by NHS England Area Team and Organisation, 2013-14, England, experimental statistics

		Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
England		**114,308**		**57,072**	**49.9%**
Q44	**Cheshire, Warrington and Wirral**	**2,110**		**762**	36.1%
01C	Eastern Cheshire CCG	20		-	0.0%
01R	South Cheshire CCG	19		-	0.0%
02D	Vale Royal CCG	9		-	0.0%
02E	Warrington CCG	13		-	0.0%
02F	West Cheshire CCG	22		-	0.0%
12F	Wirral CCG	38		-	0.0%
RBL	Wirral University Teaching Hospital NHS Foundation Trust	463		249	53.8%
RBT	Mid Cheshire Hospitals NHS Foundation Trust	228		135	59.2%
REN	The Clatterbridge Cancer Centre NHS Foundation Trust	19		8	42.1%
RJN	East Cheshire NHS Trust	184		126	68.5%
RJR	Countess of Chester Hospital NHS Foundation Trust	228		48	21.1%
RTV	5 Boroughs Partnership NHS Foundation Trust	244		104	42.6%
RWW	Warrington and Halton Hospitals NHS Foundation Trust	422		52	12.3%
RXA	Cheshire and Wirral Partnership NHS Foundation Trust	161		19	11.8%
RY7	Wirral Community NHS Trust	40		21	52.5%
Q45	**Durham, Darlington and Tees**	**1,438**		**647**	**45.0%**
00C	Darlington CCG	2		1	50.0%
00D	Durham Dales, Easington and Sedgefield CCG	3		1	33.3%
00J	North Durham CCG	3		2	66.7%
00K	Hartlepool and Stockton-on-Tees CCG	11		2	18.2%
00M	South Tees CCG	11		4	36.4%
RTR	South Tees Hospitals NHS Foundation Trust	391		217	55.5%
RVW	North Tees and Hartlepool NHS Foundation Trust	319		207	64.9%
RX3	Tees, Esk and Wear Valleys NHS Foundation Trust	151		85	56.3%
RXP	County Durham and Darlington NHS Foundation Trust	547		128	23.4%
Q46	**Greater Manchester**	**8,151**		**3,253**	**39.9%**
00T	Bolton CCG	24		11	45.8%
00V	Bury CCG	14		2	14.3%
00W	Central Manchester CCG	10		1	10.0%
00Y	Oldham CCG	17		4	23.5%
01D	Heywood, Middleton and Rochdale CCG	22		6	27.3%
01G	Salford CCG	10		2	20.0%
01M	North Manchester CCG	3		-	0.0%
01N	South Manchester CCG	3		1	33.3%
01W	Stockport CCG	38		20	52.6%
01Y	Tameside and Glossop CCG	8		7	87.5%
02A	Trafford CCG	10		6	60.0%
02H	Wigan Borough CCG	6		-	0.0%
NCE	Mastercall Healthcare	14		12	85.7%
NCM	Six Degrees Social Enterprise CIC	1		1	100.0%
NJH	Future Directions CIC	13		11	84.6%
RBV	The Christie NHS Foundation Trust	66		48	72.7%
RM2	University Hospital of South Manchester NHS Foundation Trust	622		362	58.2%
RM3	Salford Royal NHS Foundation Trust	383		262	68.4%
RMC	Bolton NHS Foundation Trust	564		262	46.5%
RMP	Tameside Hospital NHS Foundation Trust	412		365	88.6%
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	391		391	100.0%
RT2	Pennine Care NHS Foundation Trust	324		137	42.3%
RW3	Central Manchester University Hospitals NHS Foundation Trust	1,192		90	7.6%
RW6	Pennine Acute Hospitals NHS Trust	813		345	42.4%
RWJ	Stockport NHS Foundation Trust	708		374	52.8%
RX7	North West Ambulance Service NHS Trust	2,078		419	20.2%
RXV	Greater Manchester West Mental Health NHS Foundation Trust	121		36	29.8%
RY2	Bridgewater Community Healthcare NHS Trust	88		54	61.4%
TAE	Manchester Mental Health and Social Care Trust	196		24	12.2%
Q47	**Lancashire**	**2,364**		**847**	**35.8%**
00Q	Blackburn With Darwen CCG	16		16	100.0%
00R	Blackpool CCG	6		1	16.7%
00X	Chorley and South Ribble CCG	6		6	100.0%
01A	East Lancashire CCG	24		24	100.0%
01E	Greater Preston CCG	4		4	100.0%
01K	Lancashire North CCG	3		1	33.3%
02G	West Lancashire CCG	12		10	83.3%
02M	Fylde & Wyre CCG	9		5	55.6%
RJX	Calderstones Partnership NHS Foundation Trust	97		31	32.0%
RW5	Lancashire Care NHS Foundation Trust	471		118	25.1%
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	434		153	35.3%
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	582		280	48.1%
RXR	East Lancashire Hospitals NHS Trust	700		198	28.3%
Q48	**Merseyside**	**2,556**		**1,191**	**46.6%**
01F	Halton CCG	19		-	0.0%
01J	Knowsley CCG	7		-	0.0%
01T	South Sefton CCG	19		-	0.0%
01V	Southport and Formby CCG	10		-	0.0%
01X	St Helens CCG	18		-	0.0%
99A	Liverpool CCG	115		10	8.7%
RBN	St Helens and Knowsley Hospitals NHS Trust	325		325	100.0%
RBQ	Liverpool Heart and Chest Hospital NHS Foundation Trust	59		21	35.6%
RBS	Alder Hey Children's NHS Foundation Trust	166		96	57.8%
REM	Aintree University Hospital NHS Foundation Trust	307		165	53.7%
REP	Liverpool Women's NHS Foundation Trust	213		108	50.7%
RET	The Walton Centre NHS Foundation Trust	180		129	71.7%
RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust	277		-	0.0%
RVY	Southport and Ormskirk Hospital NHS Trust	330		200	60.6%

RW4	Mersey Care NHS Trust	371	89	24.0%
RY1	Liverpool Community Health NHS Trust	140	48	34.3%
Q49	**Cumbria, Northumberland, Tyne and Wear**	**4,261**	**2,306**	**54.1%**
00F	Gateshead CCG	3	1	33.3%
00G	Newcastle North and East CCG	2	1	50.0%
00H	Newcastle West CCG	nil	nil	.
00L	Northumberland CCG	3	1	33.3%
00N	South Tyneside CCG	2	1	50.0%
00P	Sunderland CCG	1	-	0.0%
01H	Cumbria CCG	31	8	25.8%
99C	North Tyneside CCG	3	1	33.3%
NLM	Teeside Urgent Care	23	12	52.2%
RE9	South Tyneside NHS Foundation Trust	221	159	71.9%
RLN	City Hospitals Sunderland NHS Foundation Trust	721	324	44.9%
RNL	North Cumbria University Hospitals NHS Trust	365	280	76.7%
RNN	Cumbria Partnership NHS Foundation Trust	161	71	44.1%
RR7	Gateshead Health NHS Foundation Trust	234	60	25.6%
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	702	631	89.9%
RTF	Northumbria Healthcare NHS Foundation Trust	510	298	58.4%
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	489	10	2.0%
RX4	Northumberland, Tyne and Wear NHS Foundation Trust	346	177	51.2%
RX6	North East Ambulance Service NHS Foundation Trust	444	271	61.0%
Q50	**North Yorkshire and Humber**	**2,477**	**1,197**	**48.3%**
02Y	East Riding of Yorkshire CCG	18	1	5.6%
03D	Hambleton, Richmondshire and Whitby CCG	10	5	50.0%
03E	Harrogate and Rural District CCG	16	12	75.0%
03F	Hull CCG	2	1	50.0%
03H	North East Lincolnshire CCG	nil	nil	.
03K	North Lincolnshire CCG	9	-	0.0%
03M	Scarborough and Ryedale CCG	19	13	68.4%
03Q	Vale of York CCG	20	14	70.0%
NL3	Care Plus Group	28	17	60.7%
NNF	City Health Care Partnership CIC	59	34	57.6%
NQL	Navigo	24	4	16.7%
RCB	York Teaching Hospital NHS Foundation Trust	564	451	80.0%
RCD	Harrogate and District NHS Foundation Trust	215	128	59.5%
RJL	Northern Lincolnshire and Goole NHS Foundation Trust	537	82	15.3%
RV9	Humber NHS Foundation Trust	167	76	45.5%
RWA	Hull and East Yorkshire Hospitals NHS Trust	789	359	45.5%
Q51	**South Yorkshire and Bassetlaw**	**2,790**	**1,794**	**64.3%**
02P	Barnsley CCG	10	-	0.0%
02Q	Bassetlaw CCG	15	15	100.0%
02X	Doncaster CCG	15	12	80.0%
03L	Rotherham CCG	10	6	60.0%
03N	Sheffield CCG	82	41	50.0%
RCU	Sheffield Children's NHS Foundation Trust	116	49	42.2%
RFF	Barnsley Hospital NHS Foundation Trust	279	169	60.6%
RFR	The Rotherham NHS Foundation Trust	595	386	64.9%
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	949	646	68.1%
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	417	417	100.0%
RXE	Rotherham Doncaster and South Humber NHS Foundation Trust	155	26	16.8%
TAH	Sheffield Health & Social Care NHS Foundation Trust	147	27	18.4%
Q52	**West Yorkshire**	**5,026**	**3,069**	**61.1%**
02N	Airedale, Wharfdale and Craven CCG	13	-	0.0%
02R	Bradford Districts CCG	5	-	0.0%
02T	Calderdale CCG	23	9	39.1%
02V	Leeds North CCG	3	3	100.0%
02W	Bradford City CCG	1	-	0.0%
03A	Greater Huddersfield CCG	14	8	57.1%
03C	Leeds West CCG	6	6	100.0%
03G	Leeds South and East CCG	7	7	100.0%
03J	North Kirklees CCG	9	-	0.0%
03R	Wakefield CCG	10	3	30.0%
NL1	Spectrum Community Health - CIC	22	2	9.1%
NL8	Locala Community Partnerships	30	20	66.7%
RAE	Bradford Teaching Hospitals NHS Foundation Trust	553	271	49.0%
RCF	Airedale NHS Foundation Trust	73	-	0.0%
RGD	Leeds and York Partnership NHS Foundation Trust	147	71	48.3%
RR8	Leeds Teaching Hospitals NHS Trust	1,066	1066	100.0%
RWY	Calderdale and Huddersfield NHS Foundation Trust	564	-	0.0%
RX8	Yorkshire Ambulance Service NHS Trust	481	156	32.4%
RXF	Mid Yorkshire Hospitals NHS Trust	1,405	977	69.5%
RXG	South West Yorkshire Partnership NHS Foundation Trust	338	338	100.0%
RY6	Leeds Community Healthcare NHS Trust	176	99	56.3%
TAD	Bradford District Care Trust	80	33	41.3%
Q53	**Arden, Herefordshire and Worcestershire**	**2,352**	**1,429**	**60.8%**
05A	Coventry and Rugby CCG	29	8	27.6%
05F	Herefordshire CCG	21	1	4.8%
05H	Warwickshire North CCG	22	2	9.1%
05J	Redditch and Bromsgrove CCG	7	-	0.0%
05R	South Warwickshire CCG	31	9	29.0%
05T	South Worcestershire CCG	19	2	10.5%
06D	Wyre Forest CCG	8	-	0.0%
R1A	Worcestershire Health and Care NHS Trust	258	93	36.0%
RJC	South Warwickshire NHS Foundation Trust	190	43	22.6%
RKB	University Hospitals Coventry and Warwickshire NHS Trust	490	355	72.4%
RLQ	Wye Valley NHS Trust	242	129	53.3%
RLT	George Eliot Hospital NHS Trust	326	155	47.5%
RWP	Worcestershire Acute Hospitals NHS Trust	600	591	98.5%
RYG	Coventry and Warwickshire Partnership NHS Trust	109	41	37.6%
Q54	**Birmingham and the Black Country**	**5,080**	**2,108**	**41.5%**

04X	Birmingham South and Central CCG	26	3	11.5%
05C	Dudley CCG	60	14	23.3%
05L	Sandwell and West Birmingham CCG	22	14	63.6%
05P	Solihull CCG	20	10	50.0%
05Y	Walsall CCG	22	2	9.1%
06A	Wolverhampton CCG	23	12	52.2%
13P	Birmingham Crosscity CCG	16	5	31.3%
NR9	John Taylor Hospice Community Interest Company	1	1	100.0%
RBK	Walsall Healthcare NHS Trust	354	58	16.4%
RL4	The Royal Wolverhampton NHS Trust	402	-	0.0%
RLU	Birmingham Women'S NHS Foundation Trust	146	70	47.9%
RNA	The Dudley Group NHS Foundation Trust	330	217	65.8%
RQ3	Birmingham Children's Hospital NHS Foundation Trust	110	24	21.8%
RR1	Heart of England NHS Foundation Trust	958	574	59.9%
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	146	83	56.8%
RRK	University Hospitals Birmingham NHS Foundation Trust	664	344	51.8%
RXK	Sandwell and West Birmingham Hospitals NHS Trust	663	145	21.9%
RXT	Birmingham and Solihull Mental Health NHS Foundation Trust	272	132	48.5%
RYA	West Midlands Ambulance Service NHS Foundation Trust	417	159	38.1%
RYK	Dudley and Walsall Mental Health Partnership NHS Trust	90	56	62.2%
RYW	Birmingham Community Healthcare NHS Trust	177	100	56.5%
TAJ	Black Country Partnership NHS Foundation Trust	161	85	52.8%
Q55	**Derbyshire and Nottinghamshire**	**4,727**	**1,986**	**42.0%**
03X	Erewash CCG	10	8	80.0%
03Y	Hardwick CCG	12	8	66.7%
04E	Mansfield and Ashfield CCG	33	12	36.4%
04H	Newark & Sherwood CCG	24	18	75.0%
04J	North Derbyshire CCG	14	9	64.3%
04L	Nottingham North and East CCG	24	12	50.0%
04M	Nottingham West CCG	8	4	50.0%
04N	Rushcliffe CCG	12	7	58.3%
04R	Southern Derbyshire CCG	37	20	54.1%
NDW	Ripplez CIC	4	-	0.0%
NNJ	Derbyshire Health United Ltd	311	137	44.1%
RFS	Chesterfield Royal Hospital NHS Foundation Trust	805	805	100.0%
RHA	Nottinghamshire Healthcare NHS Trust	864	271	31.4%
RK5	Sherwood Forest Hospitals NHS Foundation Trust	699	-	0.0%
RTG	Derby Hospitals NHS Foundation Trust	681	139	20.4%
RX1	Nottingham University Hospitals NHS Trust	693	261	37.7%
RX9	East Midlands Ambulance Service NHS Trust	177	97	54.8%
RXM	Derbyshire Healthcare NHS Foundation Trust	127	60	47.2%
RY8	Derbyshire Community Health Services NHS Trust	192	118	61.5%
Q56	**East Anglia**	**6,436**	**4,415**	**68.6%**
06H	Cambridgeshire and Peterborough CCG	40	3	7.5%
06L	Ipswich and East Suffolk CCG	53	42	79.2%
06M	Great Yarmouth and Waveney CCG	14	5	35.7%
06V	North Norfolk CCG	20	10	50.0%
06W	Norwich CCG	11	3	27.3%
06Y	South Norfolk CCG	11	1	9.1%
07J	West Norfolk CCG	9	3	33.3%
07K	West Suffolk CCG	20	16	80.0%
NAX	East Coast Community Healthcare CIC	175	90	51.4%
NHM	Suffolk Community Healthcare	65	65	100.0%
RCX	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	569	418	73.5%
RGM	Papworth Hospital NHS Foundation Trust	48	32	66.7%
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust	502	147	29.3%
RGP	James Paget University Hospitals NHS Foundation Trust	266	97	36.5%
RGQ	Ipswich Hospital NHS Trust	709	709	100.0%
RGR	West Suffolk NHS Foundation Trust	356	347	97.5%
RGT	Cambridge University Hospitals NHS Foundation Trust	465	346	74.4%
RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	986	986	100.0%
RMY	Norfolk and Suffolk NHS Foundation Trust	544	251	46.1%
RQQ	Hinchingbrooke Health Care NHS Trust	242	175	72.3%
RT1	Cambridgeshire and Peterborough NHS Foundation Trust	151	58	38.4%
RY3	Norfolk Community Health and Care NHS Trust	207	35	16.9%
RYC	East of England Ambulance Service NHS Trust	798	501	62.8%
RYV	Cambridgeshire Community Services NHS Trust	175	75	42.9%
Q57	**Essex**	**5,118**	**2,211**	**43.2%**
06Q	Mid Essex CCG	2	-	0.0%
06T	North East Essex CCG	21	7	33.3%
07G	Thurrock CCG	11	-	0.0%
07H	West Essex CCG	16	7	43.8%
99E	Basildon and Brentwood CCG	45	2	4.4%
99F	Castle Point and Rochford CCG	20	11	55.0%
99G	Southend CCG	45	-	0.0%
NQ1	Anglian Community Enterprise Community Interest Company (Ace CIC)	67	26	38.8%
NQA	Provide	163	66	40.5%
RAJ	Southend University Hospital NHS Foundation Trust	883	516	58.4%
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust	833	267	32.1%
RDE	Colchester Hospital University NHS Foundation Trust	1,257	-	0.0%
RQ8	Mid Essex Hospital Services NHS Trust	839	663	79.0%
RQW	The Princess Alexandra Hospital NHS Trust	389	389	100.0%
RRD	North Essex Partnership University NHS Foundation Trust	138	38	27.5%
RWN	South Essex Partnership University NHS Foundation Trust	389	219	56.3%
Q58	**Hertfordshire and the South Midlands**	**4,118**	**2,088**	**50.7%**
03V	Corby CCG	7	-	0.0%
04F	Milton Keynes CCG	15	1	6.7%
04G	Nene CCG	40	5	12.5%
06F	Bedfordshire CCG	101	32	31.7%
06K	East and North Hertfordshire CCG	51	22	43.1%
06N	Herts Valleys CCG	41	16	39.0%
06P	Luton CCG	27	5	18.5%
NPH	Milton Keynes Urgent Care Services CIC	17	1	5.9%
NRG	Baby Ways Community Interest Company	nil	nil	.
NRR	Community Dental Services CIC	7	6	85.7%

RC1	Bedford Hospital NHS Trust	285	190	66.7%
RC9	Luton and Dunstable University Hospital NHS Foundation Trust	624	432	69.2%
RD8	Milton Keynes Hospital NHS Foundation Trust	395	395	100.0%
RNQ	Kettering General Hospital NHS Foundation Trust	369	-	0.0%
RNS	Northampton General Hospital NHS Trust	526	116	22.1%
RP1	Northamptonshire Healthcare NHS Foundation Trust	328	167	50.9%
RWH	East and North Hertfordshire NHS Trust	868	505	58.2%
RWR	Hertfordshire Partnership University NHS Foundation Trust	232	107	46.1%
RY4	Hertfordshire Community NHS Trust	185	88	47.6%
Q59	**Leicestershire and Lincolnshire**	**3,662**	**2,534**	**69.2%**
03T	Lincolnshire East CCG	32	3	9.4%
03W	East Leicestershire and Rutland CCG	6	-	0.0%
04C	Leicester City CCG	25	5	20.0%
04D	Lincolnshire West CCG	13	6	46.2%
04Q	South West Lincolnshire CCG	9	-	0.0%
04V	West Leicestershire CCG	109	50	45.9%
99D	South Lincolnshire CCG	5	1	20.0%
RP7	Lincolnshire Partnership NHS Foundation Trust	194	36	18.6%
RT5	Leicestershire Partnership NHS Trust	330	153	46.4%
RWD	United Lincolnshire Hospitals NHS Trust	712	198	27.8%
RWE	University Hospitals of Leicester NHS Trust	2,034	2034	100.0%
RY5	Lincolnshire Community Health Services NHS Trust	193	48	24.9%
Q60	**Shropshire and Staffordshire**	**2,756**	**1,073**	**38.9%**
04Y	Cannock Chase CCG	nil	nil	.
05D	East Staffordshire CCG	16	4	25.0%
05G	North Staffordshire CCG	29	4	13.8%
05N	Shropshire CCG	20	4	20.0%
05Q	South East Staffs and Seisdon Peninsular CCG	18	5	27.8%
05V	Stafford and Surrounds CCG	18	-	0.0%
05W	Stoke on Trent CCG	60	6	10.0%
05X	Telford and Wrekin CCG	22	1	4.5%
NRX	Midlands Psychology CIC	1	-	0.0%
R1D	Shropshire Community Health NHS Trust	77	36	46.8%
R1E	Staffordshire and Stoke on Trent Partnership NHS Trust	263	131	49.8%
RJD	Mid Staffordshire NHS Foundation Trust	268	70	26.1%
RJE	University Hospital of North Staffordshire NHS Trust	809	377	46.6%
RJF	Burton Hospitals NHS Foundation Trust	475	225	47.4%
RL1	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	87	37	42.5%
RLY	North Staffordshire Combined Healthcare NHS Trust	57	30	52.6%
RRE	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	92	41	44.6%
RXW	Shrewsbury and Telford Hospital NHS Trust	444	102	23.0%
Q64	**Bath, Gloucestershire, Swindon and Wiltshire**	**2,644**	**1,117**	**42.2%**
11E	Bath and North East Somerset CCG	27	5	18.5%
11M	Gloucestershire CCG	23	13	56.5%
12D	Swindon CCG	33	8	24.2%
99N	Wiltshire CCG	114	12	10.5%
NLX	Sirona Care & Health	49	32	65.3%
R1J	Gloucestershire Care Services NHS Trust	77	31	40.3%
RBB	Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	12	8	66.7%
RD1	Royal United Hospital Bath NHS Trust	365	314	86.0%
RN3	Great Western Hospitals NHS Foundation Trust	360	42	11.7%
RNZ	Salisbury NHS Foundation Trust	330	201	60.9%
RTE	Gloucestershire Hospitals NHS Foundation Trust	836	229	27.4%
RTQ	2Gether NHS Foundation Trust	146	67	45.9%
RVN	Avon and Wiltshire Mental Health Partnership NHS Trust	272	155	57.0%
Q65	**Bristol, North Somerset, Somerset and South Gloucestershire**	**2,515**	**1,538**	**61.2%**
11H	Bristol CCG	44	26	59.1%
11T	North Somerset CCG	24	12	50.0%
11X	Somerset CCG	62	3	4.8%
12A	South Gloucestershire CCG	12	1	8.3%
NLT	North Somerset Community Partnership Community Interest Company	26	16	61.5%
NLW	Bristol Community Health	31	15	48.4%
RA3	Weston Area Health NHS Trust	225	95	42.2%
RA4	Yeovil District Hospital NHS Foundation Trust	266	266	100.0%
RA7	University Hospitals Bristol NHS Foundation Trust	775	775	100.0%
RBA	Taunton and Somerset NHS Foundation Trust	182	132	72.5%
RH5	Somerset Partnership NHS Foundation Trust	113	93	82.3%
RVJ	North Bristol NHS Trust	755	104	13.8%
Q66	**Devon, Cornwall and Isles of Scilly**	**4,123**	**1,770**	**42.9%**
11N	Kernow CCG	19	5	26.3%
99P	North, East, West Devon CCG	95	23	24.2%
99Q	South Devon and Torbay CCG	9	4	44.4%
NLL	Peninsula Community Health CIC	120	70	58.3%
NR5	Plymouth Community Healthcare (CIC)	160	101	63.1%
NX0	Chime Social Enterprise	7	4	57.1%
R1G	Torbay and Southern Devon Health and Care NHS Trust	67	37	55.2%
RA9	South Devon Healthcare NHS Foundation Trust	241	40	16.6%
RBZ	Northern Devon Healthcare NHS Trust	324	22	6.8%
REF	Royal Cornwall Hospitals NHS Trust	491	119	24.2%
RH8	Royal Devon and Exeter NHS Foundation Trust	497	206	41.4%
RJ8	Cornwall Partnership NHS Foundation Trust	111	39	35.1%
RK9	Plymouth Hospitals NHS Trust	860	583	67.8%
RWV	Devon Partnership NHS Trust	336	66	19.6%
RYF	South Western Ambulance Service NHS Foundation Trust	786	451	57.4%
Q67	**Kent and Medway**	**3,479**	**1,554**	**44.7%**
09C	Ashford CCG	9	2	22.2%
09E	Canterbury and Coastal CCG	18	5	27.8%
09J	Dartford, Gravesham and Swanley CCG	14	3	21.4%
09W	Medway CCG	4	2	50.0%
10A	South Kent Coast CCG	12	3	25.0%
10D	Swale CCG	6	1	16.7%

10E	Thanet CCG	17	5	29.4%
99J	West Kent CCG	43	15	34.9%
NQ7	Medway Community Healthcare	143	-	0.0%
RN7	Dartford and Gravesham NHS Trust	451	231	51.2%
RPA	Medway NHS Foundation Trust	628	374	59.6%
RVV	East Kent Hospitals University NHS Foundation Trust	895	482	53.9%
RWF	Maidstone and Tunbridge Wells NHS Trust	574	197	34.3%
RXY	Kent and Medway NHS and Social Care Partnership Trust	376	169	44.9%
RYY	Kent Community Health NHS Trust	289	65	22.5%
Q68	**Surrey and Sussex**	**6,103**	**3,271**	**53.6%**
09D	Brighton and Hove CCG	49	6	12.2%
09F	Eastbourne, Hailsham and Seaford CCG	33	16	48.5%
09G	Coastal West Sussex CCG	67	31	46.3%
09H	Crawley CCG	15	5	33.3%
09L	East Surrey CCG	4	4	100.0%
09N	Guildford and Waverley CCG	37	30	81.1%
09P	Hastings and Rother CCG	32	13	40.6%
09X	Horsham and Mid Sussex CCG	10	7	70.0%
09Y	North West Surrey CCG	1	-	0.0%
10C	Surrey Heath CCG	3	2	66.7%
99H	Surrey Downs CCG	34	7	20.6%
99K	High Weald Lewes Havens CCG	23	10	43.5%
RA2	Royal Surrey County Hospital NHS Foundation Trust	430	234	54.4%
RDR	Sussex Community NHS Trust	204	96	47.1%
RDU	Frimley Park Hospital NHS Foundation Trust	382	105	27.5%
RPC	Queen Victoria Hospital NHS Foundation Trust	80	51	63.8%
RTK	Ashford and St Peter'S Hospitals NHS Foundation Trust	548	417	76.1%
RTP	Surrey and Sussex Healthcare NHS Trust	482	435	90.2%
RX2	Sussex Partnership NHS Foundation Trust	765	130	17.0%
RXC	East Sussex Healthcare NHS Trust	521	390	74.9%
RXH	Brighton and Sussex University Hospitals NHS Trust	1,126	537	47.7%
RXX	Surrey and Borders Partnership NHS Foundation Trust	130	48	36.9%
RYD	South East Coast Ambulance Service NHS Foundation Trust	605	415	68.6%
RYR	Western Sussex Hospitals NHS Foundation Trust	522	282	54.0%
Q69	**Thames Valley**	**3,546**	**2,195**	**61.9%**
10G	Bracknell and Ascot CCG	26	2	7.7%
10H	Chiltern CCG	60	16	26.7%
10M	Newbury and District CCG	18	3	16.7%
10N	North & West Reading CCG	10	1	10.0%
10Q	Oxfordshire CCG	40	-	0.0%
10T	Slough CCG	11	2	18.2%
10W	South Reading CCG	14	2	14.3%
10Y	Aylesbury Vale CCG	39	7	17.9%
11C	Windsor, Ascot and Maidenhead CCG	35	4	11.4%
11D	Wokingham CCG	14	3	21.4%
RD7	Heatherwood and Wexham Park Hospitals NHS Foundation Trust	548	548	100.0%
RHW	Royal Berkshire NHS Foundation Trust	411	-	0.0%
RNU	Oxford Health NHS Foundation Trust	225	76	33.8%
RTH	Oxford University Hospitals NHS Trust	890	667	74.9%
RWX	Berkshire Healthcare NHS Foundation Trust	210	94	44.8%
RXQ	Buckinghamshire Healthcare NHS Trust	613	556	90.7%
RYE	South Central Ambulance Service NHS Foundation Trust	382	214	56.0%
Q70	**Wessex**	**4,935**	**2,620**	**53.1%**
10J	North Hampshire CCG	26	20	76.9%
10K	Fareham and Gosport CCG	40	40	100.0%
10L	Isle of Wight CCG	9	1	11.1%
10R	Portsmouth CCG	11	4	36.4%
10V	South Eastern Hampshire CCG	35	35	100.0%
10X	Southampton CCG	31	8	25.8%
11A	West Hampshire CCG	174	94	54.0%
11J	Dorset CCG	61	8	13.1%
99M	North East Hampshire and Farnham CCG	11	4	36.4%
NCH	Talkplus	nil	nil	.
NWA	Echotech Ltd	nil	nil	.
R1C	Solent NHS Trust	295	156	52.9%
R1F	Isle of Wight NHS Trust	194	183	94.3%
RBD	Dorset County Hospital NHS Foundation Trust	428	428	100.0%
RD3	Poole Hospital NHS Foundation Trust	467	103	22.1%
RDY	Dorset Healthcare University NHS Foundation Trust	452	142	31.4%
RDZ	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	370	189	51.1%
RHM	University Hospital Southampton NHS Foundation Trust	563	383	68.0%
RHU	Portsmouth Hospitals NHS Trust	692	-	0.0%
RN5	Hampshire Hospitals NHS Foundation Trust	606	606	100.0%
RW1	Southern Health NHS Foundation Trust	470	216	46.0%
Q71	**London**	**20,646**	**9,832**	**47.6%**
07L	Barking and Dagenham CCG	3	1	33.3%
07M	Barnet CCG	4	2	50.0%
07N	Bexley CCG	25	15	60.0%
07P	Brent CCG	35	-	0.0%
07Q	Bromley CCG	28	16	57.1%
07R	Camden CCG	3	1	33.3%
07T	City and Hackney CCG	1	-	0.0%
07V	Croydon CCG	31	26	83.9%
07W	Ealing CCG	15	2	13.3%
07X	Enfield CCG	12	7	58.3%
07Y	Hounslow CCG	39	10	25.6%
08A	Greenwich CCG	47	8	17.0%
08C	Hammersmith and Fulham CCG	7	3	42.9%
08D	Haringey CCG	4	2	50.0%
08E	Harrow CCG	26	1	3.8%
08F	Havering CCG	1	-	0.0%
08G	Hillingdon CCG	14	1	7.1%
08H	Islington CCG	nil	nil	.
08J	Kingston CCG	8	4	50.0%
08K	Lambeth CCG	12	6	50.0%

08L	Lewisham CCG	19	16	84.2%
08M	Newham CCG	nil	nil	.
08N	Redbridge CCG	10	7	70.0%
08P	Richmond CCG	13	-	0.0%
08Q	Southwark CCG	2	1	50.0%
08R	Merton CCG	19	9	47.4%
08T	Sutton CCG	34	14	41.2%
08V	Tower Hamlets CCG	nil	nil	.
08W	Waltham Forest CCG	3	2	66.7%
08X	Wandsworth CCG	18	4	22.2%
08Y	West London (K&C & Qpp) CCG	28	9	32.1%
09A	Central London (Westminster) CCG	23	6	26.1%
NAL	Patientfirst Social Enterprise	nil	nil	.
NDA	Virgin Care Services Ltd	138	118	85.5%
NNV	Your Healthcare	22	13	59.1%
NQV	Bromley Healthcare	118	32	27.1%
R1H	Barts Health NHS Trust	2,451	224	9.1%
RAL	Royal Free London NHS Foundation Trust	652	441	67.6%
RAN	Royal National Orthopaedic Hospital NHS Trust	91	54	59.3%
RAP	North Middlesex University Hospital NHS Trust	497	323	65.0%
RAS	The Hillingdon Hospitals NHS Foundation Trust	423	61	14.4%
RAT	North East London NHS Foundation Trust	215	129	60.0%
RAX	Kingston Hospital NHS Foundation Trust	401	295	73.6%
RC3	Ealing Hospital NHS Trust	223	166	74.4%
RF4	Barking, Havering and Redbridge University Hospitals NHS Trust	771	459	59.5%
RFW	West Middlesex University Hospital NHS Trust	384	314	81.8%
RJ1	Guy's and St Thomas' NHS Foundation Trust	926	616	66.5%
RJ2	Lewisham and Greenwich NHS Trust	807	408	50.6%
RJ6	Croydon Health Services NHS Trust	705	705	100.0%
RJ7	St George's Healthcare NHS Trust	1,083	1083	100.0%
RJZ	King's College Hospital NHS Foundation Trust	980	367	37.4%
RKE	The Whittington Hospital NHS Trust	460	279	60.7%
RKL	West London Mental Health NHS Trust	444	178	40.1%
RNK	Tavistock and Portman NHS Foundation Trust	12	2	16.7%
RP4	Great Ormond Street Hospital for Children NHS Foundation Trust	123	123	100.0%
RP6	Moorfields Eye Hospital NHS Foundation Trust	249	118	47.4%
RPG	Oxleas NHS Foundation Trust	204	128	62.7%
RPY	The Royal Marsden NHS Foundation Trust	175	132	75.4%
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	356	356	100.0%
RQX	Homerton University Hospital NHS Foundation Trust	271	-	0.0%
RQY	South West London and St George's Mental Health NHS Trust	359	157	43.7%
RRP	Barnet, Enfield and Haringey Mental Health NHS Trust	293	34	11.6%
RRU	London Ambulance Service NHS Trust	1,060	-	0.0%
RRV	University College London Hospitals NHS Foundation Trust	788	521	66.1%
RT3	Royal Brompton & Harefield NHS Foundation Trust	65	57	87.7%
RV3	Central and North West London NHS Foundation Trust	538	241	44.8%
RV5	South London and Maudsley NHS Foundation Trust	561	176	31.4%
RV8	North West London Hospitals NHS Trust	784	177	22.6%
RVL	Barnet and Chase Farm Hospitals NHS Trust	336	-	0.0%
RVR	Epsom and St Helier University Hospitals NHS Trust	480	480	100.0%
RWK	East London NHS Foundation Trust	375	136	36.3%
RY9	Hounslow and Richmond Community Healthcare NHS Trust	82	-	0.0%
RYH	NHS Direct NHS Trust	68	50	73.5%
RYJ	Imperial College Healthcare NHS Trust	884	380	43.0%
RYX	Central London Community Healthcare NHS Trust	92	56	60.9%
TAF	Camden and Islington NHS Foundation Trust	216	70	32.4%
Other		**895**	**265**	**29.8%**
KO41a	First Contact Clinical	3	1	33.3%
KO41a	Bevan Healthcare CIC	nil	nil	.
KO41a	Health First ALW Community Interest Company	nil	nil	.
KO41a	St Pauls Way Medical Centre (MEEBBB Health CIC)	7	-	0.0%
KO41a	First Community Health and Care	16	10	62.5%
KO41a	City & Hackney Urgent Healthcare Social Enterprise	1	-	0.0%
KO41a	Allied Healthcare Group Limited	214	121	56.5%
KO41a	Herts Urgent Care	29	29	100.0%
KO41a	East Lancashire Medical Services	108	-	0.0%
KO41a	Accelerate Health CIC	1	1	100.0%
KO41a	Urgent Care 24	73	29	39.7%
KO41a	Integrated Care 24 (formerly South East Health Limited)	263	68	25.9%
KO41a	Willow Bank Partnership Community Interest Company(Willow Bank Surgery)	13	-	0.0%
KO41a	Annie's Healthcare Services CIC	nil	nil	.
KO41a	Care & Support Partnership Community Interest Company Limited	131	-	0.0%
KO41a	Carers' Break - Community Interest Company	nil	nil	.
KO41a	Connections (West Yorkshire) Health and Social Care CIC	nil	nil	.
KO41a	Falcare CIC Ltd	nil	nil	.
KO41a	Inclusion Healthcare Social Enterprise CIC	nil	nil	.
KO41a	Positive Support in Tees Community Interest Company	nil	nil	.
KO41a	SCIL Continuing Care Community Interest Company	nil	nil	.
KO41a	Support Horizons CIC	nil	nil	.
KO41a	Vernova Healthcare Community Interest Company	2	2	100.0%
NWL	My General Practice Limited	1	-	0.0%
X24	NHS England	33	4	12.1%

Notes:

Data above shows all NHS organisations, please note that some organisations will not have direct dealings with patients and in these cases will not provide any complaints data.

' nil ' refers to organisations that did not submit information on written complaints upheld

' .. ' refers to no data available

' - ' denotes zero.

' . ' denotes not applicable

Data as at 1 April 2013 - 31 March 2014

Source:

Table 20 General Practice (including Dental) Health Services : Written Complaints and Complaints Upheld by Service Area, 2013-14, England, experimental statistics

	Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
All Service Areas	**60,564**		**30,619**	**50.6%**
Medical	24,405		11,100	45.5%
Dental	6,973		4,004	57.4%
General Practice administration	22,643		12,115	53.5%
Other	6,543		3,400	52.0%

Data as at 1 April 2013 - 31 March 2014

Source:

Table 21 General Practice (including Dental) Health Services : Written Complaints and Complaints Upheld by Subject[1] of Complaint, 2013-14, England, experimental statistics

	Written Complaints Received	*of which*	Written Complaints Upheld	Percentage upheld
All Subjects of Complaint [1]	**61,196**		**31,678**	**51.8%**
Communications / attitude	13,275		7,203	54.3%
Premises	1,621		1,329	82.0%
Practice / surgery management	6,360		3,340	52.5%
General Practice administration	12,513		6,987	55.8%
Clinical	22,202		10,313	46.5%
Other	5,225		2,506	48.0%

Notes:

[1] A complaint can be made concerning more than one subject area. Where this has occurred, some Practices have recorded a complaint under each subject area contained within the complaint letter received.

Data as at 1 April 2013 - 31 March 2014

Source:

Table 22 General Practice (including Dental) Health Services : Written Complaints and Complaints Upheld by Service Area and NHS England Area Team, 2013-14, England, experimental statistics

Written Complaints Received

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55
Total general practice (including dental) health services Complaints	**60,564**	**1,287**	**1,075**	**2,742**	**4,323**	**1,403**	**1,548**	**2,548**	**1,654**	**2,884**	**1,960**	**2,082**	**574**
Medical	24,405	476	505	1,097	1,182	548	727	2,213	643	1,035	815	856	224
Dental	6,973	121	107	341	1,141	154	194	335	140	271	249	129	149
General Practice administration	22,643	615	346	1,072	1,157	561	487	-	708	1,319	694	916	139
Other	6,543	75	117	232	843	140	140	-	163	259	202	181	62

Written Complaints Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55
Total general practice (including dental) health services Complaints	**30,619**	**547**	**618**	**1,465**	**3,412**	**872**	**819**	**791**	**496**	**972**	**1,021**	**861**	**338**
Medical	11,100	199	278	514	850	311	337	706	184	347	412	349	121
Dental	4,004	66	53	172	984	92	123	85	50	102	140	62	76
General Practice administration	12,115	254	218	631	843	393	292	-	238	452	388	381	108
Other	3,400	28	69	148	735	76	67	-	24	71	81	69	33

Percentage Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55
Total general practice (including dental) health services Complaints	***50.6%***	***42.5%***	***57.5%***	***53.4%***	***78.9%***	***62.2%***	***52.9%***	***31.0%***	***30.0%***	***33.7%***	***52.1%***	***41.4%***	***58.9%***
Medical	*45.5%*	*41.8%*	*55.0%*	*46.9%*	*71.9%*	*56.8%*	*46.4%*	*31.9%*	*28.6%*	*33.5%*	*50.6%*	*40.8%*	*54.0%*
Dental	*57.4%*	*54.5%*	*49.5%*	*50.4%*	*86.2%*	*59.7%*	*63.4%*	*25.4%*	*35.7%*	*37.6%*	*56.2%*	*48.1%*	*51.0%*
General Practice administration	*53.5%*	*41.3%*	*63.0%*	*58.9%*	*72.9%*	*70.1%*	*60.0%*	.	*33.6%*	*34.3%*	*55.9%*	*41.6%*	*77.7%*
Other	*52.0%*	*37.3%*	*59.0%*	*63.8%*	*87.2%*	*54.3%*	*47.9%*	.	*14.7%*	*27.4%*	*40.1%*	*38.1%*	*53.2%*

Data as at 1 April 2013 - 31 March 2014

Source:

East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q56	Q57	Q58	Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
3,222	**2,190**	**3,552**	**1,450**	**1,855**	**1,683**	**2,081**	**2,550**	**1,942**	**3,260**	**1,886**	**3,644**	**7,019**	**150**
1,209	981	1,312	645	860	597	819	992	798	1,310	681	1,317	2,525	38
307	142	239	168	161	136	164	282	250	244	155	640	710	44
1,369	755	1,709	531	621	808	835	978	662	1,459	829	1,215	2,799	59
337	312	292	106	213	142	263	298	232	247	221	472	985	9

East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q56	Q57	Q58	Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
1,445	**1,322**	**1,368**	**665**	**333**	**1,056**	**1,072**	**1,406**	**1,014**	**1,758**	**1,110**	**1,907**	**3,872**	**79**
533	549	456	282	95	358	392	524	374	640	372	577	1,329	11
158	86	75	65	27	82	105	149	139	150	81	464	388	30
664	494	723	253	175	522	476	588	389	817	558	635	1,588	35
90	193	114	65	36	94	99	145	112	151	99	231	567	3

Percentage (%)

East Anglia	Essex	Hertfordshire and the South Midlands	Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q56	Q57	Q58	Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
44.8%	***60.4%***	***38.5%***	***45.9%***	***18.0%***	***62.7%***	***51.5%***	***55.1%***	***52.2%***	***53.9%***	***58.9%***	***52.3%***	***55.2%***	***52.7%***
44.1%	*56.0%*	*34.8%*	*43.7%*	*11.0%*	*60.0%*	*47.9%*	*52.8%*	*46.9%*	*48.9%*	*54.6%*	*43.8%*	*52.6%*	*28.9%*
51.5%	*60.6%*	*31.4%*	*38.7%*	*16.8%*	*60.3%*	*64.0%*	*52.8%*	*55.6%*	*61.5%*	*52.3%*	*72.5%*	*54.6%*	*68.2%*
48.5%	*65.4%*	*42.3%*	*47.6%*	*28.2%*	*64.6%*	*57.0%*	*60.1%*	*58.8%*	*56.0%*	*67.3%*	*52.3%*	*56.7%*	*59.3%*
26.7%	*61.9%*	*39.0%*	*61.3%*	*16.9%*	*66.2%*	*37.6%*	*48.7%*	*48.3%*	*61.1%*	*44.8%*	*48.9%*	*57.6%*	*33.3%*

Table 23 General Practice (including Dental) Health Services : Written Complaints and Complaints Upheld by Subject(1) and NHS England Area Team, 2013-14, England, experimental statistics

Written Complaints Received

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58
Total general practice (including dental) health services Complaints	**61,196**	**1,305**	**1,097**	**2,537**	**6,749**	**1,202**	**1,427**	**2,548**	**1,640**	**2,933**	**1,703**	**2,101**	**519**	**3,195**	**1,783**	**3,582**
Communications / attitude	13,275	223	311	629	1,333	320	297	589	337	580	417	435	137	608	365	660
Premises	1,621	14	8	26	1,054	6	21	28	12	28	16	17	1	35	9	41
Practice / surgery management	6,360	176	118	199	1,120	151	170	172	138	318	146	231	32	433	153	409
General Practice administration	12,513	326	158	524	927	219	257	460	340	682	338	442	94	616	344	865
Clinical	22,202	468	420	980	1,483	439	565	1,064	637	1,099	682	785	211	1,220	711	1,329
Other	5,225	98	82	179	832	67	117	235	176	226	104	191	44	283	201	278

Written Complaints Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58
Total general practice (including dental) health services Complaints	**31,678**	**562**	**639**	**1,268**	**5,660**	**815**	**766**	**791**	**502**	**1,003**	**842**	**892**	**295**	**1,452**	**1,045**	**1,467**
Communications / attitude	7,203	113	195	346	1,136	216	171	186	111	204	225	209	64	312	224	280
Premises	1,329	9	8	21	988	4	15	15	4	13	11	11	1	18	8	10
Practice / surgery management	3,340	84	57	99	968	120	102	59	51	101	79	98	11	174	91	151
General Practice administration	6,987	146	99	291	736	151	170	186	143	282	174	201	60	352	208	412
Clinical	10,313	179	229	436	1,121	288	246	285	175	360	322	312	135	498	383	500
Other	2,506	31	51	75	711	36	62	60	18	43	31	61	24	98	131	114

Percentage Upheld

	England	Cheshire, Warrington and Wirral	Durham, Darlington and Tees	Greater Manchester	Lancashire	Merseyside	Cumbria, Northumberland, Tyne and Wear	North Yorkshire and Humber	South Yorkshire and Bassetlaw	West Yorkshire	Arden, Herefordshire and Worcestershire	Birmingham and the Black Country	Derbyshire and Nottinghamshire	East Anglia	Essex	Hertfordshire and the South Midlands
		Q44	Q45	Q46	Q47	Q48	Q49	Q50	Q51	Q52	Q53	Q54	Q55	Q56	Q57	Q58
Total general practice (including dental) health services Complaints	***51.8%***	***43.1%***	***58.2%***	***50.0%***	***83.9%***	***67.8%***	***53.7%***	***31.0%***	***30.6%***	***34.2%***	***49.4%***	***42.5%***	***56.8%***	***45.4%***	***58.6%***	***41.0%***
Communications / attitude	*54.3%*	*50.7%*	*62.7%*	*55.0%*	*85.2%*	*67.5%*	*57.6%*	*31.6%*	*32.9%*	*35.2%*	*54.0%*	*48.0%*	*46.7%*	*51.3%*	*61.4%*	*42.4%*
Premises	*82.0%*	*64.3%*	*100.0%*	*80.8%*	*93.7%*	*66.7%*	*71.4%*	*53.6%*	*33.3%*	*46.4%*	*68.8%*	*64.7%*	*100.0%*	*51.4%*	*88.9%*	*24.4%*
Practice / surgery management	*52.5%*	*47.7%*	*48.3%*	*49.7%*	*86.4%*	*79.5%*	*60.0%*	*34.3%*	*37.0%*	*31.8%*	*54.1%*	*42.4%*	*34.4%*	*40.2%*	*59.5%*	*36.9%*
General Practice administration	*55.8%*	*44.8%*	*62.7%*	*55.5%*	*79.4%*	*68.9%*	*66.1%*	*40.4%*	*42.1%*	*41.3%*	*51.5%*	*45.5%*	*63.8%*	*57.1%*	*60.5%*	*47.6%*
Clinical	*46.5%*	*38.2%*	*54.5%*	*44.5%*	*75.6%*	*65.6%*	*43.5%*	*26.8%*	*27.5%*	*32.8%*	*47.2%*	*39.7%*	*64.0%*	*40.8%*	*53.9%*	*37.6%*
Other	*48.0%*	*31.6%*	*62.2%*	*41.9%*	*85.5%*	*53.7%*	*53.0%*	*25.5%*	*10.2%*	*19.0%*	*29.8%*	*31.9%*	*54.5%*	*34.6%*	*65.2%*	*41.0%*

(1) A complaint can be made concerning more than one subject area. Where this has occurred, some Practices have recorded a complaint under each subject area contained within the complaint letter received.

Data as at 1 April 2013 - 31 March 2014

Source:

Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
1,516	**1,920**	**1,595**	**2,129**	**2,321**	**1,875**	**3,207**	**1,898**	**3,506**	**6,767**	**141**
334	441	329	449	505	390	696	406	747	1,699	38
23	18	23	33	23	10	39	17	41	74	4
130	170	125	216	198	173	303	186	241	638	14
308	407	416	483	548	407	768	419	668	1,473	24
620	701	593	779	868	776	1,192	734	1,513	2,282	51
101	183	109	169	179	119	209	136	296	601	10

Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
693	**279**	**949**	**1,052**	**1,277**	**999**	**1,763**	**1,074**	**1,831**	**3,671**	**91**
188	50	196	253	302	203	412	235	425	921	26
14	5	15	16	19	8	27	9	32	45	3
50	44	73	79	86	99	135	99	97	322	11
155	65	289	271	359	267	459	293	354	848	16
250	89	327	368	428	355	612	391	793	1,201	30
36	26	49	65	83	67	118	47	130	334	5

Percentage (%)

Leicestershire and Lincolnshire	Shropshire and Staffordshire	Bath, Gloucestershire, Swindon and Wiltshire	Somerset, Somerset and South Gloucestershire	Devon, Cornwall and Isles of Scilly	Kent and Medway	Surrey and Sussex	Thames Valley	Wessex	London	Other
Q59	Q60	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q99
45.7%	***14.5%***	***59.5%***	***49.4%***	***55.0%***	***53.3%***	***55.0%***	***56.6%***	***52.2%***	***54.2%***	***64.5%***
56.3%	*11.3%*	*59.6%*	*56.3%*	*59.8%*	*52.1%*	*59.2%*	*57.9%*	*56.9%*	*54.2%*	*68.4%*
60.9%	*27.8%*	*65.2%*	*48.5%*	*82.6%*	*80.0%*	*69.2%*	*52.9%*	*78.0%*	*60.8%*	*75.0%*
38.5%	*25.9%*	*58.4%*	*36.6%*	*43.4%*	*57.2%*	*44.6%*	*53.2%*	*40.2%*	*50.5%*	*78.6%*
50.3%	*16.0%*	*69.5%*	*56.1%*	*65.5%*	*65.6%*	*59.8%*	*69.9%*	*53.0%*	*57.6%*	*66.7%*
40.3%	*12.7%*	*55.1%*	*47.2%*	*49.3%*	*45.7%*	*51.3%*	*53.3%*	*52.4%*	*52.6%*	*58.8%*
35.6%	*14.2%*	*45.0%*	*38.5%*	*46.4%*	*56.3%*	*56.5%*	*34.6%*	*43.9%*	*55.6%*	*50.0%*

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Responsible Statistician

Kate Bedford, Programme Manager

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For further information

www.hscic.gov.uk

0845 300 6016

enquiries@hscic.gov.uk