The Centre for International Public Health Policy

THE UNIVERSITY OF EDINBURGH

Ten years on – were the targets of the NHS Plan achieved? An evaluation of the capacity of the healthcare system in England and Scotland

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Key points

Beds

Capacity in NHS hospitals in England continues to decrease despite the NHS Plan pledge in 2000 to provide extra beds as part of its commitment to invest in resources.

The promised extra 7,000 NHS beds were not delivered and there are currently around 18,000 *fewer* overnight beds than when the Plan was published. If intermediate care beds are excluded there are around 23,000 fewer overnight and day beds.

The target for 2,100 extra general and acute beds by 2004 was achieved initially but the increase was not sustained. By 2007-08 there were around 13,000 *fewer* general and acute beds than in 1999-00.

It has been deemed no longer to be necessary to collect numbers of the new category of intermediate care beds introduced to 'build a bridge between hospital and home'.

In order to evaluate whether capacity meets the needs of the population, it is necessary to measure resources in the wider healthcare system. Care is not delivered solely in NHS hospitals but can take place in other settings such as Independent Sector Treatment Centres, private hospitals, and in nursing and residential homes administered by either the NHS, Local Authority, or independent and voluntary sectors. Care may be financed respectively by the NHS, Local Authority or by patients themselves. There are however difficulties in quantifying total capacity. Numbers of beds in Independent Treatment Centres are not collected, and places in private care homes and hospitals are only published by external independent organisations.

Workforce

In contrast to beds, the workforce targets set out in the NHS Plan for extra consultants, General Practitioners, nurses, therapists and specialist registrars were mostly achieved and exceeded.

Comparison with Scotland

As in England, the number of beds has reduced over time whilst the size of the workforce has increased.

Analysis

As capacity in traditional NHS hospitals has reduced, policy has been to develop this in alternative settings, though available data makes this difficult to measure. The current economic climate prompts expectations that there will be pressures on trusts to retain current staffing levels, whilst restrictions have been eased on rules allowing Independent Sector Treatment Centres to recruit NHS staff. The expansion of the workforce since the NHS Plan provides a pool of professional, trained and skilled personnel available to alternative providers of NHS care.

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I Introduction and objectives

It is timely to reflect on the capacity of the NHS now having passed its 60th anniversary year, and this paper evaluates its progress according to the programme established in the ten-year NHS Plan for England published by the Department of Health (DH) in July 2000.[1] This document set out a plan for far-reaching reform and a commitment to sustained increases in investment in the NHS. The success of the Plan was to be measured by achievements against a wide range of targets encompassing increases in numbers of beds, workforce, services and equipment, most of which were to be reached by 2004.

The bed targets of the NHS Plan were set in response to the report published for consultation for the Department of Health National Beds Inquiry (NBI) in 2000.[2] This Inquiry addressed concerns that the long term decline of staffed hospital beds might have gone too far (and the subsequent increase in bed occupancy levels). It found that the level of bed reductions could not meet the needs of the NHS and that the policy of cutting beds should be reversed, plus it recommended developing intermediate care services to 'act as a bridge between community and hospital care'. Responses to the NBI were used in formulating the NHS Plan.

Now as the end of the full term of the ten year time span covered by the NHS Plan approaches, we evaluate progress against targets in the key areas of beds and workforce. We monitor trends from the NHS Plan baseline date of 1999-00 through to the 2004 milestone, and then from the baseline through to the present time based on the most recently available data.

In addition, we set out to monitor the capacity of the entire healthcare system. This includes monitoring activity in all the settings that care is provided, including nursing and residential care homes, private hospitals (whether delivering care to NHS or private patients), and Independent Sector Treatment Centres (ISTCs) created since the publication of the Plan. This is in recognition that care is not solely delivered in traditional NHS settings, particularly for some groups such as the elderly, and to evaluate the relative capacity of the sectors.

We also present statistics and trends in beds and workforce in Scotland in a separate case study.

Although the term of the NHS Plan is not quite complete, a further ten year plan was published by Lord Darzi in June, 2008, High Quality Care For All – NHS Next Stage Review Final Report.[3] Whilst the focus of the NHS Plan was on capacity, the Darzi report was primarily concerned with improving the quality of care.

Methods

We used the Department's own routine data collections to monitor progress against the NHS Plan's key targets for increases in beds, staff and training places. In addition, in order to quantify the contribution of non-NHS sectors providing health care, we reviewed available data relating to these sectors. Such providers and settings include private hospitals and ISTCs, local authority social services, and private and voluntary nursing and residential homes. We provide definitions and a description of the data collections available from all the providers of health and social care.

Further, in order to set our findings in a wider context, we evaluate statistics from the Organisation for Economic Co-operation and Development (OECD). This organisation comprises 30 member countries and provides one of the world's largest sources of comparable economic and social data, including a range of health statistics.

II Results

Our results are split into two sections. The first section describes how data for beds and workforce are defined and collected, providing data definitions. The second section provides statistics, i.e. numbers and trends of beds and workforce.

1 *How data are defined and collected*

a Beds

i NHS funded hospital beds - directly provided

Beds open overnight and day only beds
Each NHS trust submits an annual return on form KH03 to the Department of Health (DH) on the average daily number of available beds (open and staffed) for wards open overnight, and the percentage occupancy, i.e. the proportion of available beds occupied at midnight. In addition, data are submitted on beds open during the day. These data are available from the DH Hospital Activity Statistics website sub-divided by sector, i.e. acute, geriatric (which together comprise the general and acute category), mental illness, learning disability and maternity.[4] Beds are classified according to the ward in which they are located.

ii NHS funded hospital beds - privately provided

Patients funded by the NHS may be treated in private hospitals and since 2003 in Independent Sector Treatment Centres. The number of available beds in ISTCs does not form part of the Hospital Activity Statistics collection as such beds are deemed to fall outside the provision available to the NHS. Therefore there are no routine available data published on the number of beds in ISTCs, with only the total contracted diagnostics and procedures, and percentage contract utilisation being published on the DH website.

Although bed numbers are not collected, it should theoretically be possible to identify ISTC activity in the form of Finished Consultant Episodes in the Hospital Episode Statistics (HES) collection to which ISTCs are required to submit, but difficulties have been reported and it is acknowledged that the quality of data is not good enough to undertake comparative analysis between the NHS and independent sector from HES.[5] [6]

International context: The OECD collects data on beds and describes individual sources and methods for measuring numbers for each member country. For the UK these are calculated by the Information Centre for health and social care, using data from the Department of Health in England; the Department for Health, Social Services and Public Safety in Northern Ireland; Information Services Division NHS Scotland; and the Health Service for Wales.

iii Mixed NHS/ local authority and self funded beds - long term care beds

Long term care according to the National Service Framework for Older People are defined as support services provided over a prolonged period of time or on a permanent basis to adults who have difficulties associated with old age, long-term illness or disability. Care may be provided in residential settings such as nursing homes, or in people's own homes.[7]

Long term care beds can be in hospitals, or places in nursing and residential homes for people unable to live at home without support. Beds and places may be funded by the NHS, by Local Authorities, by patients themselves, or through a combination of these arrangements.

International context: The OECD definition of long-term care is as follows:[8]
A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL), such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom.

Long-term care beds are defined as beds allocated for people who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence in activities of daily living. The total number of long-term care beds is the sum of such beds in hospitals and in nursing homes. The OECD states that care provided in each institutional setting can be a mix of health and social services and that a number of countries do not report long-term care beds in hospitals resulting in an underestimate of the total number of long-term care beds. There is currently no information on the public-private mix of long-term care beds in hospitals and nursing homes.

Beds include: All types of nursing and residential care facilities dedicated to long-term nursing care and beds used for palliative care.

Beds exclude: Beds in nursing and residential care facilities which do not provide ongoing health and nursing care (including ADL) together with accommodation and beds available in hospitals (even those beds dedicated to long-term nursing care).

iv NHS funded residential and nursing home beds
There are still some NHS funded residential care beds in nursing homes, residential care and group homes directly managed by the NHS (as opposed to Social Services or other agencies). The average daily number of available beds is collected annually by the DH on form KH03 from each trust according to three broad patient groups: mental illness, learning disabilities and 'other'.

v Local authority funded places

Local authority funded residents - directly provided care
Local authority data are based on the number of supported residents as opposed to the number of beds. Residents may be in a local authority staffed home, a voluntary or private sector residential or nursing home, or other type of accommodation. The SR1 return on local authority supported adult residents in residential and nursing care at 31st March by type of accommodation and client group is submitted to the Information Centre as part of the Personal Social Services statistical collection. Statistics include residents where the local authority makes a contribution to the cost of care, no matter how small, but excludes those who receive no financial support. The breakdown is not available in cases of mixed funding (where a resident may be funded by a combination of local authority, NHS and self paying). The four client groups are: people with physical disabilities; learning disabilities; mental health problems; and alcohol/drug misusers and others.

Local authority funded residents - privately provided care
Independent residential care comprises voluntary and private residential care homes. This is the largest sector providing care for supported residents, followed by independent nursing homes. As described in (1ei), the number of supported residents in private sector homes is collected in the Personal Social Services SR1 return.

vi Self funded places
There are no routine statistics published for those funding their own care in nursing and residential homes.

vii Intermediate care beds

The NHS Plan described a range of new intermediate care services 'to build a bridge between hospital and home'. These were intended to speed up discharge and could be provided either in a hospital, community or cottage hospital, or nursing home. NHS nursing care was to be free. The data collection for intermediate care beds started in 1999-2000.

Intermediate Care is defined by the DH as follows.[9] It describes services that meet *all* the following criteria:

- Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- Have a planned outcome of maximising independence and typically enabling patient/users to resume living at home
- Are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks and
- Involve cross-professional working, with a coordinated assessment process, single professional records and shared protocols

Generally data on intermediate care beds have not been widely available as they are collected through the system of Local Delivery Plan Reporting (LDPR, now succeeded by the Operating Framework) by the NHS to the DH. Such data are not covered by the National Statistics Code of Practice as they are classified as management information for internal use with neither the data nor their definitions routinely published, despite being technically in the public domain. The total annual number of intermediate care beds is available from the DH, but cannot be broken down in detail, for example by setting - community, cottage hospital etc. Further, there is some ambiguity about what constitutes an intermediate care bed as the definition sets time limits for such services to no longer than six weeks, after which care becomes a joint NHS and local authority responsibility. Therefore after this time patients may be funded partly by the NHS and partly by themselves or their local authority. This increases the difficulty in accurately identifying this category of beds that are not included in the DH Hospital Activity Statistics collection,[10] although intermediate care beds directly provided by NHS trusts should be included in the KH03 return.

Rather than expanding the data collection and bringing it into the realm of official statistics, it has now been dropped altogether in line with the DH's duty to evaluate the data burden. Therefore the monitoring of this key collection of promised extra beds which formed a key component of both the National Beds Inquiry and the NHS Plan has been deemed dispensable.

viii Private sector beds

There are a lack of available routine data about private sector beds. Until 2002 the DH collected this as part of the inspection process under the 1984 Registered Homes Act on private nursing homes, hospital and clinics in England. Responsibility passed to the National Care Standards Commission in April 2002 then subsequently to the Healthcare Commission in 2004. In April 2009 the Care Quality Commission became the new health and social care regulator for England, responsible for regulation for those private hospitals registered with it. The Commission does not currently collect information on the number of beds available in private hospitals in England, although each registered establishment will display this on their own individual certificate of registration. This leaves only external independent organisations collecting this data.

Laing & Buisson produce the main independent statistical source of data on independent sector

provision in the UK derived from official sources and their own survey. A key publication is their annual 'Healthcare Market Review', information from which is not permitted to be reproduced.

b Workforce

i NHS workforce

NHS workforce returns are submitted to the Information Centre. The main sources of data are derived from central returns based on annual censuses of staff in post on 30th September. These are the Hospital and Community Health Services (HCHS) medical and dental workforce census, the HCHS non-medical workforce census and the General Practice census. Staff are counted both as numbers (headcount) and as full time equivalents (FTEs) which provide a more accurate measure of resources.

The censuses currently only include NHS staff, so exclude those providing services to NHS patients in non-NHS settings such as Independent Sector Treatment Centres, from which workforce numbers and breakdown of roles are not routinely available.

ii NHS workforce

The number of local authority residential home staff is available from data from the Information Centre, by client group and activity in the annual bulletin on Personal Social Services staff of Social Services Departments.

iii Independent sector nursing and residential home workforce

Previously numbers of nursing home staff were recorded on the RH(N) Form and published in the Community Care Statistics, Private Nursing Homes, Hospitals and Clinics, Statistical bulletin. This is no longer published and the last edition was for 2000-01.

2 *Beds and workforce statistics*

a Beds

The following statistics were derived from the respective data sources described in the previous section in order to assess progress against NHS Plan targets. As the Plan was published in July 2000, the baseline is taken to be financial year 1999-00 for beds data, whilst for workforce data it is the preceding September 1999 census. Where available, data for 1997 are also provided to show trends since the current administration assumed responsibility in England.

i NHS funded hospital beds - directly provided

Table 1 summarises the numbers of directly provided NHS beds for the dates specified above and indicates an overall reduction, both by the 2004 target and up until the current time.

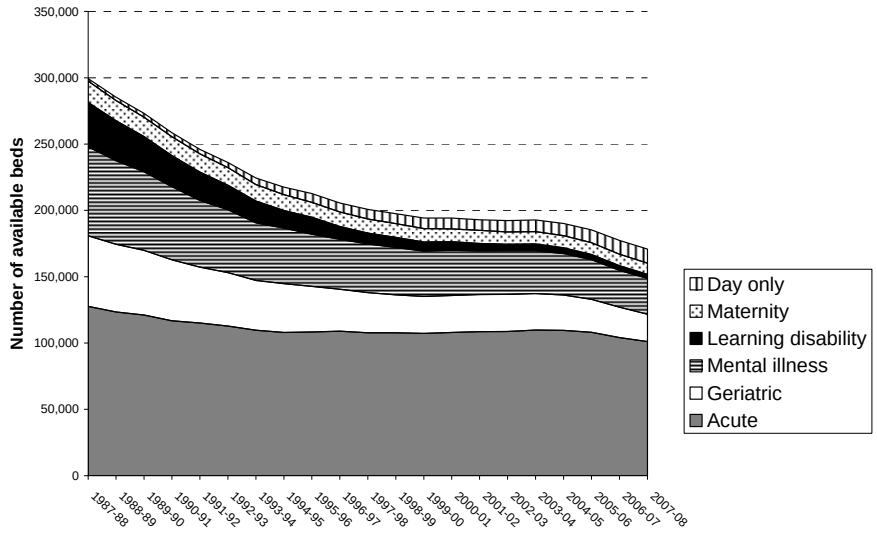
Table 1: Numbers of beds at NHS Plan baseline through to 2007-08, England

	1996-97	1999-00	2003-04	2007-08	Difference 1999 to 2004		Difference 1999 to 2008	
					Number	%	Number	%
Overnight	198,848	186,290	184,019	160,297	*-2,271*	*-1*	*-25,993*	*-14*
General and acute beds	140,515	135,080	137,247	121,780	*2,167*	*2*	*-13,300*	*-10*
Day only	6,766	7,938	8,813	10,511	*875*	*11*	*2,573*	*32*
Total NHS beds *excluding* intermediate care	**205,614**	**194,228**	**192,832**	**170,808**	***-1,396***	***-1***	***-23,420***	***-12***
Intermediate care beds	-	4,242	8,697	9,177	*4,455*	*105*	*4,935*	*116*
Total NHS beds *including* intermediate care		**198,470**	**201,529**	**179,985**	***3,059***	***2***	***-18,485***	***-9***
Total beds per 1,000 population *excluding* intermediate care	4.2	3.9	3.8	3.3				
Total beds per 1,000 population *including* intermediate care		4.0	4.0	3.5				
General and acute beds per 1,000 population	2.9	2.7	2.7	2.4				

NB: Rates are calculated using ONS mid year populations for England

Figure 1 below profiles the number of available beds over a 20 year period and illustrates how the decline is part of a much longer term trend. The largest proportional decreases have been for learning disability, geriatric and mental illness beds.

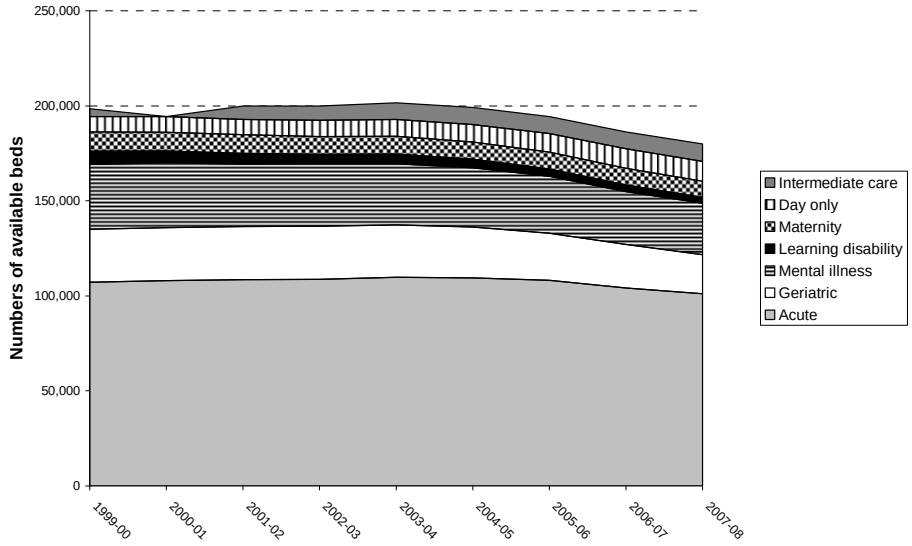
Fig. 1: Average daily number of available beds by sector, England, 1987-88 to 2007-08



Source: Department of Health, Hospital Activity Statistics, form KH03

Figure 2 shows trends in bed numbers from the time of the NHS Plan publication in 1999-00, and includes intermediate care beds which became available at this date. The graph illustrates the downward trend overall since 2003-04.

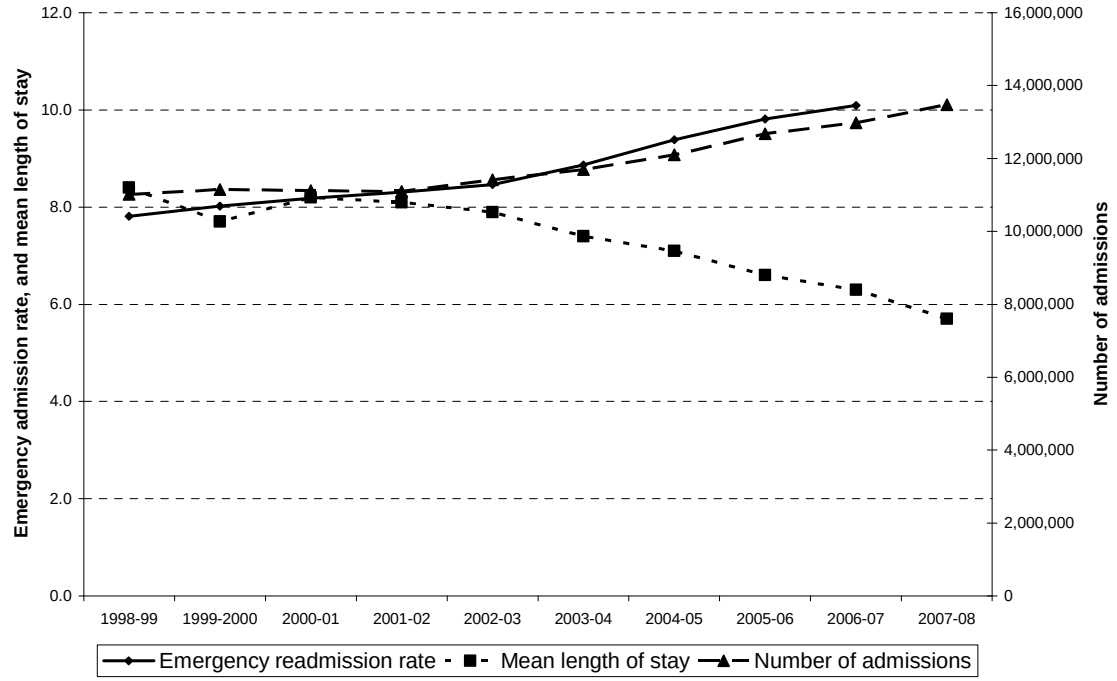
Fig. 2: Average daily number of available beds by sector, England, 1999-00 to 2007-08



Source: Department of Health, Hospital Activity Statistics, form KH03
NB: The number of intermediate care beds is not available for 2000-01

Figure 3 shows that as numbers of beds have reduced, so has length of stay, whilst emergency readmission rates are rising. This could suggest a 'rebound' effect as patients are discharged earlier in their recovery period.

Fig 3: Number of hospital admissions, mean length of stay, and emergency readmissions to hospital within 28 days of discharge, adults aged 16years and over 1998-99 to 2007-08



Sources: HESonline, mean length of stay and number of admissions
Clinical and Health Outcomes Knowledge Base, The Information Centre/National Centre for Health Outcomes Development, 2009, for readmissions

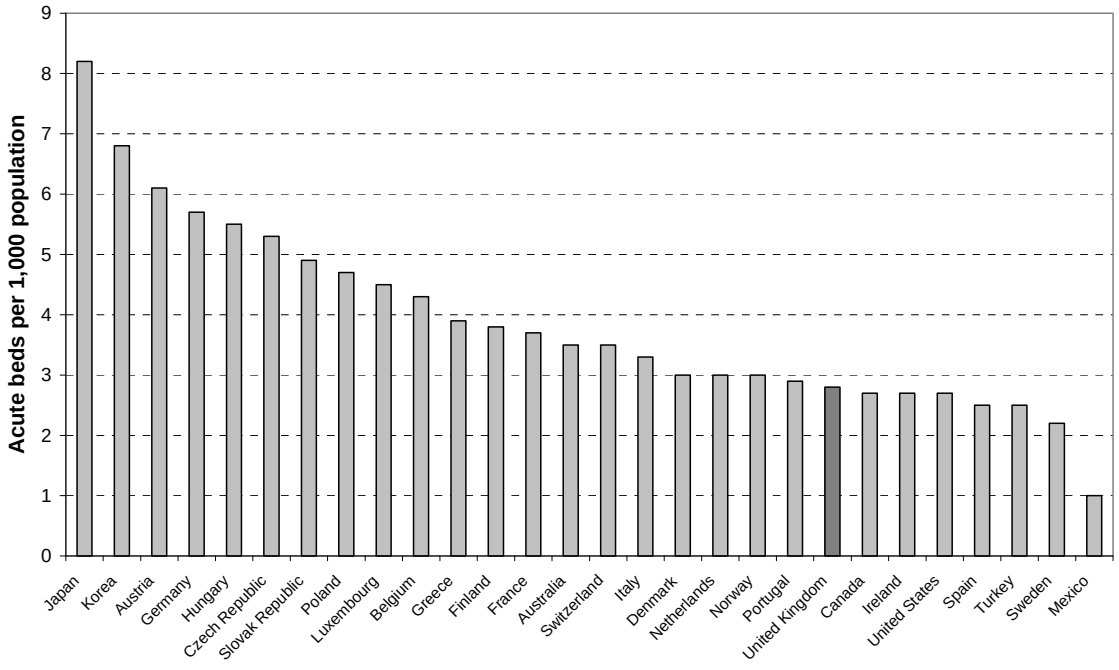
ii NHS funded beds - privately provided

Independent Sector Treatment Centres: To date the only information on ISTC capacity in the pubic domain is the total number of contracted procedures broken down by Health Resource Group (HRG) chapter. The DH published on its website that for Wave 1, as at end of September 2008, there had been 85% contract utilisation, and for Phase 2, there had been 25% contract utilisation for diagnostics, and 85% for elective procedures – calculated from reports from each ISTC provider and/or Primary Care Trust about the number and type of episodes of care.[11]

International context
The OECD compiles statistics on the number of acute care beds per 1,000 population.

Figure 4 shows acute beds per 1,000 population for 28 of the 30 member countries for 2006 (data was unavailable for the other two). At that time the UK ranked near the bottom coming 21st out of 28 countries. The rate ranged from 8.2 for Japan down to 1 for Mexico with the UK rate just 2.8.

Fig 4: Acute care beds per 1,000 population for OECD countries, 2006



Source: OECD Health Data 2009

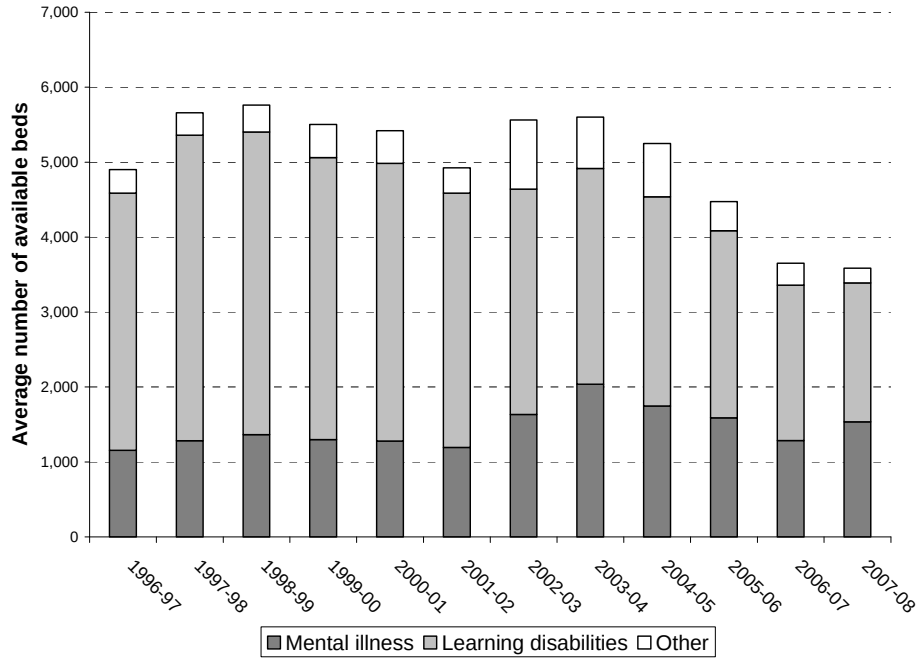
iii Mixed NHS/ local authority and self funded beds - long term care beds

A press release from Laing & Buisson stated that in 2007 there were 420,000 older and physically disabled people living in care homes or long stay hospitals, mostly on a permanent basis in the UK. The majority, 373,000 (89%) were in independent care homes, either private or voluntary, with 48,000 (11%) in public sector provision. This population has declined significantly since 1993.[12]

iv NHS funded residential and nursing home beds

Figure 5 shows trends in the number of beds in residential care homes directly managed by the NHS, illustrating a decline since 2003.

Fig 5: Average daily number of available residential beds by sector, England, 1996-97 to 2007-08



Source: Department of Health form KH03

v Local authority funded places

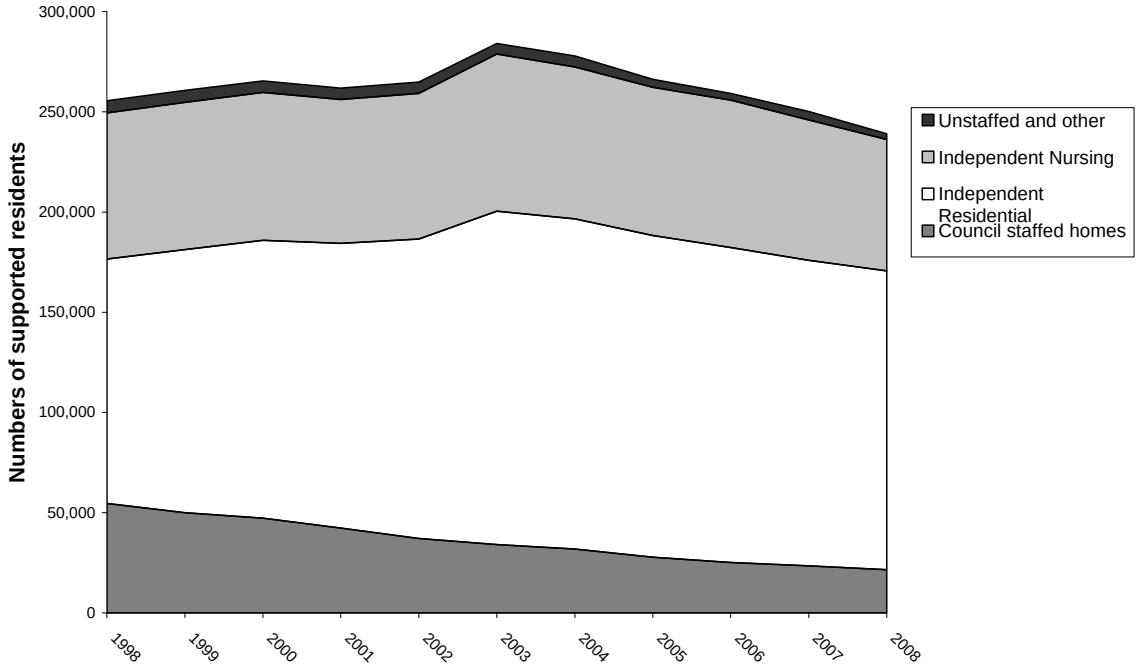
Local authority funded residents - directly provided care

Figure 6 below indicates that the number of residents supported in local authority staffed homes has progressively fallen, dropping by 54% since 2000 when the NHS Plan was published.

Local authority funded residents - privately provided care

Most local authority funded residents live in voluntary and private residential homes rather than directly provided residential homes. There was a rapid expansion of the independent nursing and residential home sector from 1993 when the 1990 Community Care Act was implemented, levelling off from 2003 onwards.

Fig. 6: Adult local authority supported residents at 31st March by type of accommodation and client group, 1998 to 2008



Sour

Source: Department of Health, Local Authority Personal Social Services Statistics, SR1
Since 2003 data includes clients formerly in receipt of preserved rights transferred to local authorities at that time

vi Self funded places

Although routine statistics are not published, it is estimated that approximately 30 per cent of older people in residential and nursing homes fund their own care.[13]

vii Intermediate care beds and places

Table 2 provides statistics from the intermediate care collection which commenced in 1999-00, though as beds for continuing care had previously been funded by the NHS in private nursing homes, it is unknown to what extent the 4,242 beds for that year were new or existing places. As described, 2007-08 is likely to be the last year for which intermediate bed data will be available as a result of the decision to abandon this collection.

The number of places in non-residential intermediate care schemes indicates an expansion, particularly until 2001-02. As for beds, it is not known how many of the baseline 1999-00 intermediate places were new.

Table 2: Number of intermediate care beds and places, England

	1999-00	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Beds	4,242	7,021	7,493	8,697	8,928	9,007	8,833	9,177
Places	7,149	13,878	19,078	17,298	20,558	20,637	23,403	

Sources: Department of Health (beds), Hansard, 19th March, 2007. Col. 732W (places)

viii Private sector beds

Statistics for beds in registered nursing homes up until 2001 are shown in Table 3. As described, this data has not been published since responsibility for inspection passed to the National Care Standards Commission in 2002. At this time there had been a reduction of 5% since 1996-97 and 3% since 2000.

Table 3: Registered nursing beds England, 1996-97 to 2000-01

	1996-97*	1998	1999	2000	2001
General nursing homes	154,215	165,836	160,203	150,749	144,068
Mental nursing homes	31,274	28,660	30,507	31,828	31,944
Private hospitals and clinics	10,780	11,089	11,441	10,753	10,816
Total number of registered beds	**196,269**	**205,585**	**202,151**	**193,330**	**186,828**

Source: RH(N) form A, *KO36 for the period 1st October, 1996 to 31st March, 1997

b Workforce

i NHS workforce

Table 4 summarises the size of the NHS workforce at the dates specified and indicates an expansion of each staff group.

Table 4: Key workforce numbers at the NHS Plan baseline through to 2008, England

Staff		1999	2004	2008	Difference 1999 to 2004 Number	%	Difference 1999 to 2008 Number	%
Consultants (including Directors of Public Health)	No.	23,321	30,650	34,910	*7,329*	*31*	*11,589*	*50*
	FTE	21,410	28,141	32,679	*6,731*	*31*	*11,269*	*53*
General Medical Practitioners (excluding GP registrars/retainers)	No.	28,467	31,523	34,010	*3,056*	*11*	*5,543*	*19*
	FTE	26,558	28,308	30,675	*1,750*	*7*	*4,117*	*16*
Nurses (total qualified nursing, midwifery & health visiting staff, and GP practice nurses)	No.	329,637	397,515	408,160	*67,878*	*21*	*78,523*	*24*
	FTE	261,340	315,440	329,372	*54,100*	*21*	*68,032*	*26*
Qualified Scientific, therapeutic & technical staff	No.	102,391	128,883	142,558	*26,492*	*26*	*40,167*	*39*
	FTE	86,837	108,585	122,059	*21,748*	*25*	*35,222*	*41*
Nurse consultants	No.	0	631	859	*631*		*859*	
	FTE	0	609	810	*609*		*810*	
Training								
GP registrars	No.	1,520	2,562	3,203	*1,042*	*69*	*1,683*	*111*
	FTE	1,475	2,454	3,055	*979*	*66*	*1,580*	*107*
Doctors training in the registrar group*	No.	12,682	16,823	35,042	*4,141*	*33*	*22,360*	*176*
	FTE	12,085	16,112	34,272	*4,027*	*33*	*22,187*	*184*

FTE = Full time equivalent

Source: The Information Centre

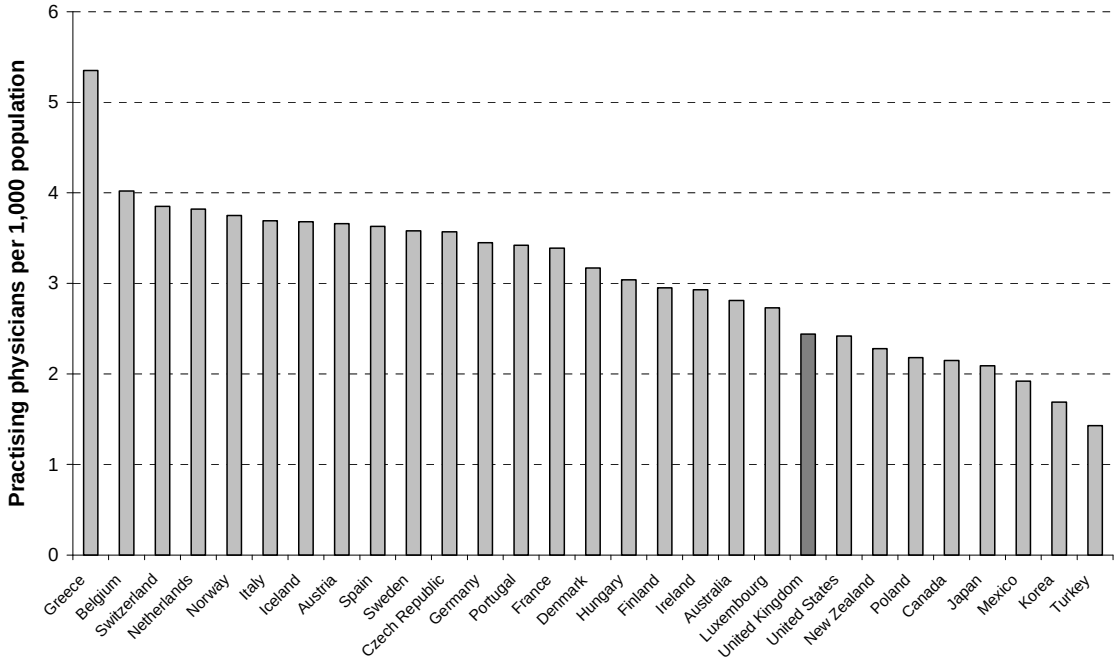
* 2007 onwards increase in registrar group numbers is due to changes from the Modernising Medical Careers programme. Senior House Officers classed 'as run through specialist trainees' now included in the registrar

group

International context
As well as beds, OECD compiles comparative statistics on the international workforce.

Figure 7 shows practising physicians per 1,000 population ranked according to 2006 figures. The UK ranked 21st out of the 29 countries for which data were available with a rate of 2.44.

Fig 7: Practising physicians per 1,000 population, OECD countries, 2006

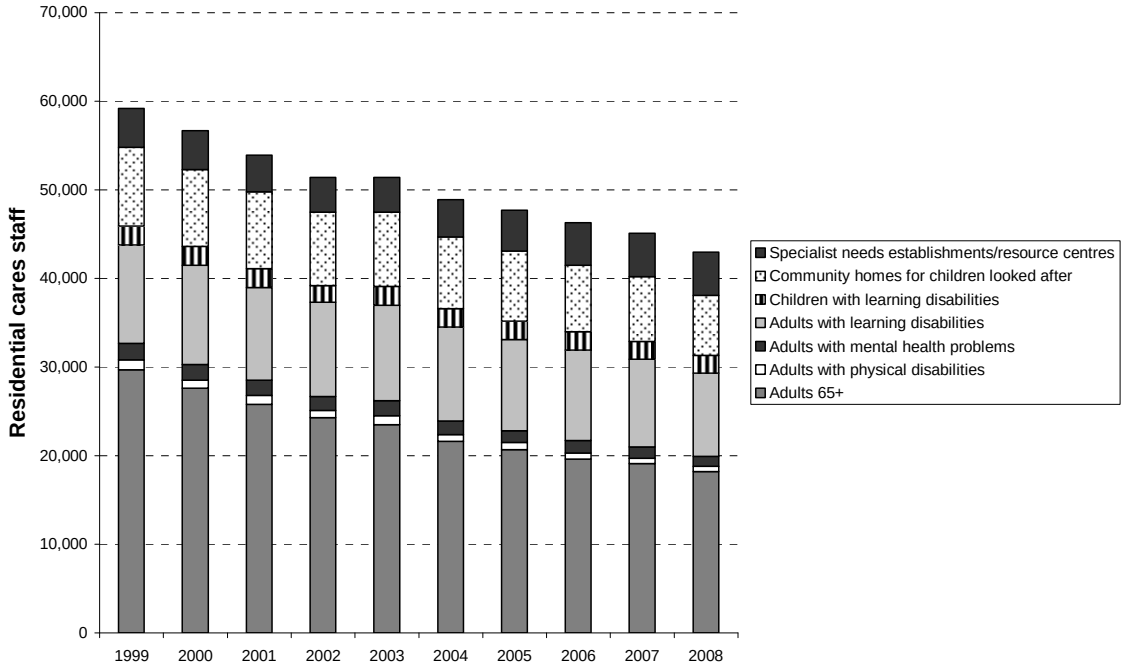


Source: OECD Health Data 2009

ii Local authority workforce

Residential Staff
At September 2008, there were 43,000 local authority FTE staff in residential homes, 27% less than in 1999. Staff working with those aged over 65 who accounted for the largest proportion of staff in residential homes reduced by 39% from 1999 in line with the growing role of the independent residential care sector.[14]

Figure 8: Residential care staff by client group and activity, 1999 to 2007, full time equivalents at 30th September



Source: The Information Centre

iii Independent sector nursing and hospital workforce

Statistics on nursing home staff in independent sector nursing homes, hospitals and clinics were available until 2000-01 from the RH(N) statistical return, indicating a drop in numbers over the three years shown below. Most qualified FTE nursing staff were Registered General Nurses (69%). Based on 2001 figures, most (68%) qualified FTE staff worked in general nursing homes, with 14% in mental nursing homes and 18% in hospitals and clinics.

Table 5: Total nursing home staff in private nursing homes, hospitals and clinics

Nursing staff	1998-99	1999-2000	2000-01
Number	197,488	186,874	178,100
FTE	146,985	140,825	134,750
Qualified FTE	54,828	51,163	49,660
Unqualified FTE	92,157	89,662	85,090

Source: RH(N) Form in Community care statistics, Private Nursing Homes, Hospitals and Clinics, Statistical bulletin

III Summary of key findings – progress against targets of the NHS Plan

1 Additional bed capacity by 2004

Numbers of available and occupied beds

Target: 7,000 extra beds in hospitals and intermediate care

Table 1 showed that by 2003-04, there were just over 3,000 extra beds including overnight, day only and intermediate care beds, falling short by nearly 4,000 from the target of 7,000 beds. So how has progress continued? By 2007-08 rather than gaining extra beds, the trend has reversed and there now 18,485 *fewer* beds (overnight, day only and intermediate care beds) than when the NHS Plan was published.

Excluding intermediate beds (which as described may be hard to measure accurately) and day only beds, there was a reduction of 2,271 overnight beds by 2004. By 2007-08 there were 25,993 *fewer* overnight beds than in 1999-00.

Therefore the target to increase the number of beds by 7,000 was never achieved, and despite an initial increase after publication of the NHS Plan through to 2004, numbers have fallen ever since. The initial rise was due to extra intermediate care beds, and if these are excluded bed numbers would have been shown to fall even through until 2004.

This reduction in beds is part of a long term trend which precedes the NHS Plan. The average number of available beds (excluding day cases, and intermediate care beds which were not available until 1999-00) reduced by 46% from 1987-88 to 2007-08, and by 14% from 1999-00 through to 2007-08.

Intermediate care beds

Target: 5,000 extra intermediate care beds

Statistics for intermediate care beds were first published in 1999-00 so it cannot be ascertained whether the baseline figure of 4,242 referred to new or existing beds. By 2004 the increase still fell short of the 5,000 target, with an additional 4,455 beds from the baseline. The latest data for 2007-08 shows the target has now almost been achieved with 4,935 extra beds since the baseline, but the data collection is to be abolished.

Target: 1,700 extra non-residential intermediate care places

This target was met,[15] but we have not been able to identify a data source for these places, many of which are likely to be in the independent nursing and residential care sector. Statistics available in response to a House of Commons question indicate that there has been a continuing rise in the numbers with more than 23,000 such places in 2006-07.

General and acute beds

Target: Around 2,100 extra beds in general and acute wards

By 2003-04 there was an increase of 2,167 beds so the target was met. But the extra numbers were not sustained and by 2007-08 there were 13,300 fewer beds than in 2000.

Adult critical care beds

Target: 30% increase in adult critical care beds over three years

The target was met by 2004, and there has been a 49% increase since July 2000.

2 Additional workforce capacity by 2004

Target: 7,500 more consultants representing a 30% expansion
By 2004 there had been a 31% increase (7,329 extra consultants headcount). This level of increase sustained and by 2008 represented a 50% increase from baseline.

Target: 2,000 more General Practitioners (GMPs)
The 2004 target was met and exceeded and numbers continue to rise.

Target: 20,000 extra nurses
The target was met and exceeded with nearly an extra 68,000 total qualified nurses (65,000 excluding GP practice nurses), and around 78,500 by 2008.

Despite the 21% increase overall between 1999 and 2004, not all staff groups achieved this, e.g. qualified midwives achieved only a 9% increase by 2004, health visitors just 4%, whilst district nurses actually reduced by 10%. Moving on to 2008, compared to 1999 there are now 13% fewer health visitors, and 27% fewer district nurses.

Target: Over 6,500 more therapists and other health professionals
Between 1999 and 2004 the target was met and exceeded for scientific, therapeutic & technical staff and numbers have continued to grow. There were around 26,500 extra qualified staff by 2004 and 40,000 by 2008. Although overall this represented a 29% increase by 2004, and 39% by 2008, this was not achieved by all professions, for example chiropody (just 14% increase by 2008). There were also reductions in some support staff (19% decrease in chiropody, 12% decrease in physiotherapy, 38% decrease in dental from 2004 to 2008).

Target: 1,000 nurse consultants by 2004
These posts were established in 1999. By 2004 there were 631, so the target was not met. In 2008 there were 859 nurse consultants (810 FTE).

Training Targets

Target: 1,000 more specialist registrars, targeting key specialties by 2004
The target was met by 2004 and the increase sustained and exceeded.

Target: 5,500 more nurses, midwives and health visitors being trained each year by 2004 than in 2000
In 2004 nearly 5,600 more students were reported to have entered training than in 1999, so this target was achieved.[16]

Target: 4,450 more therapists and other key professional staff being trained by 2004
In 2004, an increase of around 5,300 more were reported as having entered training than in 1999, so the target was met.[16]

Target: 450 more doctors training for general practice by 2004
There were more than 1,000 extra GP registrars by 2004, and levels of increase have sustained.

Target: Increase in number of medical school places of up to 1,000
Medical school intake increased by more than 2,000, well within the target time.

Trends in the total number of staff are shown in Table 6. More detail is available at Appendix 1.

Table 6: Summary of all NHS staff - Headcount

	1999	2004	2008	*Difference from 1999 to 2004*	*% difference from 1999 to 2004*	*Difference from 1999 to 2008*	*% difference from 1999 to 2008*
Total	**1,098,348**	**1,331,857**	**1,368,693**	*233,509*	*21*	*270,345*	*25*
Total employed staff (exc. GP retainers)	**1,097,376**	**1,331,087**	**1,368,186**	*233,711*	*21*	*270,810*	*25*
***Professionally qualified clinical staff (excl retainers)* (All doctors, nursing, scientific, therapeutic & technical, and ambulance staff)**	**540,792**	**660,706**	**701,324**	*119,914*	*22*	*160,532*	*30*
All doctors	94,953	117,806	133,662	*22,853*	*24*	*38,709*	*41*
Total qualified nursing staff	329,637	397,515	408,160	*67,878*	*21*	*78,523*	*24*
Total qualified scientific, therapeutic & technical staff	102,391	128,883	142,558	*26,492*	*26*	*40,167*	*39*
Qualified ambulance staff	14,783	17,272	17,451	*2,489*	*17*	*2,668*	*18*
Support to clinical staff	296,619	368,285	355,010	*71,666*	*24*	*58,391*	*20*
NHS infrastructure support	171,205	211,489	219,064	*40,284*	*24*	*47,859*	*28*
Other non-medical staff or those with unknown classification	2,427	497	353	*-1,930*	*-80*	*-2,074*	*-85*
Other GP practice staff	86,333	90,110	92,436	*3,777*	*4*	*6,103*	*7*

Source: The Information Centre: NHS HCHS and General Practice workforce at 30 September, England

IV Case study - comparison with Scotland – key beds and workforce statistics

The NHS Plan applied just to England whilst a Health Plan for Scotland, *Our National Health: A plan for action, a plan for change,* was published by NHS Scotland in the same year in December 2000.[17]

This short case study examines key health statistics trends in beds and workforce, using available routine data as for England.

1 *Beds*

Definitions and how data is collected
Data are available from ISD Scotland, National Statistics, ISD(1) on the average daily number of beds which are staffed and available for the reception of inpatients (including borrowed and temporary beds).

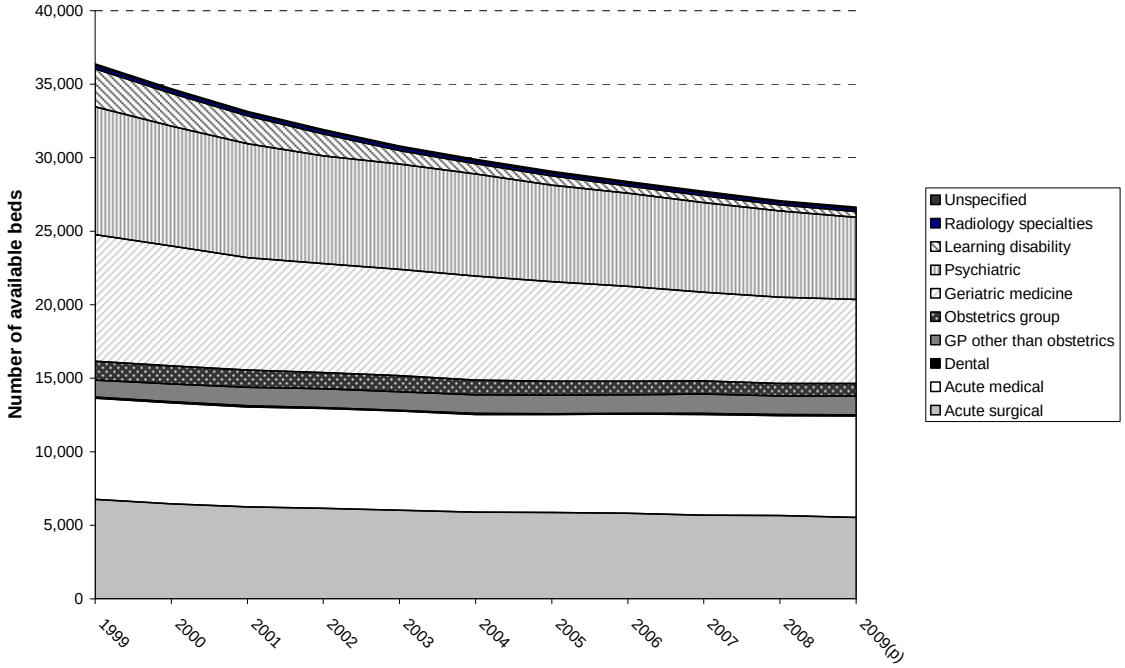
In addition are provided:

- Percentage occupancy, i.e. the percentage of available staffed beds that were occupied by inpatients during the year.
- Average length of stay per episode (in days) experienced by inpatients
- Throughput - the average number of inpatient discharges treated per bed per year

Figure 9 shows that as in England there has been an overall reduction in the number of available and staffed beds from 1999 to 2009, a decrease of 27%. The largest percentage decreases were for learning disability, psychiatric beds and geriatric medicine.

ISD Scotland cites the reasons for the decline as: changing medical practice which led to shorter lengths of stay, the growth in day case surgery, and the treatment of patients in a primary care setting.[18]

Fig. 9: Average daily number of available staffed beds, by sector, Scotland, financial year ending 31st March, 1999 to 2009



Source: ISD Scotland, National Statistics, ISD(S)1
NB: Data for 2009 are provisional

Care home beds: Nursing and residential home beds

Information is derived from the Scottish Care Home Census (SCHC) which combines two former surveys, Residential Care Homes Census and Private Nursing Home Census.

Table 7 shows that by far the greatest proportion of care home places is for older people. However, places per 1,000 population aged over 65 reduced from 49 in 2000 to 44 in 2008.

Table 7: Care home places for adults in Scotland by client group, 2000 to 2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total places	**45,823**	**44,744**	**43,957**	**43,503**	**43,786**	**43,677**	**43,416**	**42,675**	**42,874**
Older People	39,204	38,425	38,128	37,924	38,213	38,286	38,069	37,567	37,829
% of total	86	86	87	87	87	88	88	88	88
Physical Disabilities	823	663	628	568	578	548	552	549	507
% of total	2	1	1	1	1	1	1	1	1
Mental Health	1,197	1,256	1,214	1,165	1,180	1,187	1,159	1,018	1,086
% of total	3	3	3	3	3	3	3	2	3
Learning Disabilities	3,624	3,439	3,125	3,078	3,035	2,886	2,907	2,833	2,791
% of total	8	8	7	7	7	7	7	7	7
Other	975	961	862	768	780	770	729	708	661
% of total	2	2	2	2	2	2	2	2	2

Source: SCHC1 March 2008

Table 8 shows that the percentage of care home places in the private sector is increasing progressively over time.

Table 8: Care home places for adults in Scotland by sector, 2000 to 2008, and percentage of all care home places

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total places	**45,823**	**44,744**	**43,957**	**43,503**	**43,786**	**43,677**	**43,416**	**42,675**	**42,874**
LA/ NHS places	7,291	6,853	6,613	6572	6,708	6,408	6,247	6,001	5,750
% of total	16	15	15	15	15	15	14	14	13
Private sector	29,381	29,208	29,042	28,912	29,100	29,386	29,628	29,424	29,886
% of total	64	65	66	66	66	67	68	69	70
Voluntary sector	9,151	8,683	8,302	8,019	7,978	7,883	7,541	7,250	7,238
% of total	20	19	19	18	18	18	17	17	17

Source: SCHC1 March 2008

2 *Workforce*

Definitions and how data is collected

Workforce figures are provided in detail in Appendix 2. Information is captured through the Scottish Workforce Information Standard System (SWISS). This is the data collection and analysis system used throughout NHS Scotland developed to support its needs, for local, regional and national reporting.

V Discussion

This analysis has indicated that NHS beds continued to reduce whilst levels of staff mostly increased in line with the published targets of the NHS Plan over the course of its term.

1 *Additional bed capacity*

Despite the findings of the National Beds Inquiry following reductions in bed numbers spanning two decades, and the pledges of the NHS Plan, we find that rather than additional capacity, there are now fewer available NHS beds even than when the Plan was published.

At the same time that NHS bed capacity has decreased, there has been an expansion of alternative models of healthcare provision involving the independent sector. These arrangements were described in the Plan.

Since 2002, a government programme has established the introduction of two waves of Independent Sector Treatment Centres on the basis of the need to expand capacity and drive down waiting times through the extra provision of a limited range of elective procedures. As noted, it is not known how many additional available beds such facilities provide. Neither is it currently possible to accurately quantify levels of activity in ISTCs through HES, because although ISTCs are required to submit activity data in their commissioning data sets, data are not of comparable quality. The main reporting requirements of ISTCs have been through a separate system of Key Performance Indicators, accessible to the Department of Health Commercial Directorate and to their sponsoring Primary Care Trusts, data that are not published and not in the public domain. This means that the extent to which the reduction in NHS beds has been taken up through care in settings administered by the independent sector cannot be quantified.[19]

2 *Additional workforce capacity*

Despite that workforce targets appear broadly to have been met, there are currently threats of actual and potential losses and the future security of current staffing levels is uncertain. At the end of March 2007 a number of trusts announced plans to cut jobs in the midst of financial problems[20] whilst it was claimed at the Royal College of Nursing conference for 2007 that more than 22,000 NHS posts had been lost in England in the preceding 18 months, with specialist nurses particularly affected in light of NHS deficits.[21] Concerns have also been raised about threats to medical education and training.[22] Since that time, as the worldwide recession deepens, there are starting to be signs of NHS staff being affected, demonstrated for example by an increase of NHS job losses at three London hospitals.[23] Further, it has been announced by the NHS Chief Executive that the NHS is to make efficiency savings of £15bn to £20bn from 2011-14, and that "we need to move away from the NHS being built for growth to being able to sustain itself in a prolonged limitation on resources" and that the Department of Health would "really squeeze" the NHS as soon as 2010-11.[24]

In the light of the continued focus on the capacity of care outside traditional hospital settings, e.g. in intermediate care, private hospitals and nursing and residential homes whether funded by the NHS, local authority, a mixture of both, or by self-payers, it is necessary to include available beds and places in all sectors. For this reason we have attempted where possible to include other settings.

Although absence of data make it difficult to quantify accurately, there has been a rapid expansion of the workforce in the alternative provider sector. It is estimated that around 25% of staff in the first wave of the ISTC programme were seconded from the NHS.[19] For the subsequent wave, the

'additionality' rule for ISTCs was relaxed (which restricted clinical staff from working in centres if they had been employed by the NHS in the previous six months), thereby easing the barriers for staff to transfer from the NHS.

In summary, we have shown that as the number of NHS beds has continued to fall, at the same time there has been an overall expansion of the workforce since the NHS Plan. As additional bed capacity exists now largely in the independent sector (though lack of data makes this hard to measure), and restrictions on the recruitment of NHS staff are eased, a migration of trained and qualified staff away from the NHS can be predicted, particularly in the light of anticipated cost pressures that will force trusts to scrutinise and cap current staffing levels.

VI Conclusion

Despite the lack of progress in gaining extra NHS beds in line with key targets, many of the far-reaching NHS reforms set out in the Plan have taken place, for example the concordat with private providers of healthcare and the development of Independent Treatment Centres (called Diagnostic and Treatment Centres at the time of the Plan).

However, analysis by the Office for National Statistics indicates that although health care output has grown substantially (50 per cent higher in 2006 than in 1995), inputs have risen even more rapidly, with the volume of resources into the NHS being 67 per cent higher over this time period.[25] Productivity has therefore fallen over the period as a whole. So despite more patients being treated, the rise has failed to match the increase in investment. The increase in labour is one of the main factors in the rise in inputs, with especially high growth between 2000 and 2004, in line with the NHS Plan.

The NHS Plan promised new investment in the NHS to provide extra beds, staff and facilities alongside wide-ranging reform to match the ideals of its founding principles. Despite this, in its 61st year, the NHS is continuing to experience a major contraction in the number of beds, alongside forecasts of a significant workforce reduction. Yet coinciding with these developments is a burgeoning market of alternative providers incorporated into and offering services to the NHS which stand to benefit from the pool of an available skilled and trained workforce. The impact of this migration on traditional NHS provision, and ultimately on patients is as yet unknown.

So there remains a paradox - proliferating closures of NHS beds and reduced capacity, at the same time as an expansion in the hospital and primary care workforce and in training places. The levers are in place for a gearing up of a major transfer of staff outside the NHS, in line with the increased share of activity to the private sector.

The NHS Plan set out to redress the situation that England had too few hospital beds per head of population compared with most other health systems. Now almost at its full term, the spotlight has long fallen from monitoring progress against key targets, with little attention paid to the trend of continuing reductions. This is of concern as if there is insufficient capacity within the NHS, what will be the impact on patients? Already, as hospital throughput has increased and average length of stay has reduced, statistics indicate increases in emergency readmissions. Meanwhile many of the arrangements for and costs of earlier hospital discharge, and for further care beyond the NHS, fall to Local Authorities and to patients themselves to pick up.

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Appendix 1: Workforce statistics at 30 September, England

		1997	1999	2004	2008
Total	**Headcount**	**1,058,686**	**1,098,348**	**1,331,857**	**1,368,693**
	FTE	**846,298**	**873,547**	**1,071,462**	**1,125,131**
	Rate	**1,739**	**1,782**	**2,138**	**2,187**
Total (exc. GP retainers)	Headcount	1,058,686	1,097,376	1,331,087	1,368,186
	FTE	846,298	873,226	1,071,203	1,124,818
	Rate	1,739	1,781	2,138	2,186
Professionally qualified	*Headcount*	*519,714*	*540,792*	*660,706*	701,324
clinical staff (excl retainers)	*FTE*	*436,646*	*450,678*	*549,836*	593,636
	Rate	*897*	*919*	*1,097*	1,154
All doctors	**Headcount**	**89,619**	**94,953**	**117,806**	**133,662**
	FTE	**84,758**	**88,693**	**109,483**	**125,629**
	Rate	**174**	**180**	**218**	**244**
All doctors (excl retainers)	Headcount	89,619	93,981	117,036	133,155
	FTE	84,758	88,371	109,224	125,316
	Rate	174	181	218	244
Consultants (including	Headcount	21,474	23,321	30,650	34,910
directors of public health)	FTE	19,661	21,410	28,141	32,679
	Rate	40	44	56	64
Registrars	Headcount	11,909	12,682	16,823	35,042
	FTE	11,336	12,085	16,112	34,272
	Rate	23	25	32	67
Other doctors in training	Headcount	18,404	18,845	24,874	14,136
	FTE	18,251	18,414	24,542	14,026
	Rate	38	38	49	27
Other medical and dental staff	Headcount	8,443	9,146	10,604	11,854
	FTE	5,882	6,736	8,596	9,797
	Rate	12	14	17	19
GPs (excl retainers)	**Headcount**	**29,389**	**29,987**	**34,085**	**37,213**
	FTE	**27,660**	**28,033**	**30,762**	**33,730**
	Rate	**57**	**57**	**61**	**66**
GPs excluding retainers and	**Headcount**	**28,046**	**28,467**	**31,523**	**34,010**
registrars	**FTE**	**26,359**	**26,558**	**28,308**	**30,675**
	Rate	**54**	**54**	**56**	**60**
GP Providers	Headcount	27,200	27,681	28,781	27,347
	FTE	25,777	25,989	26,179	25,390
	Rate	53	53	52	49
Other GPs	Headcount	846	786	2,742	6,663
	FTE	582	569	2,129	5,285
	Rate	1	1	4	10
GP registrars	Headcount	1,343	1,520	2,562	3,203
	FTE	1,301	1,475	2,454	3,055
	Rate	3	3	5	6
GP retainers	Headcount	..	972	770	507
	FTE	..	321	259	313
	Rate	..	1	1	1
Total qualified nursing staff	***Headcount***	***318,856***	***329,637***	***397,515***	***408,160***
	FTE	***256,093***	***261,340***	***315,440***	***329,372***
	Rate	***526***	***533***	***629***	***640***

Appendix 1 continued		1997	1999	2004	2008
Qualified nursing, midwifery & health visiting staff	Headcount	300,467	310,142	375,371	386,112
	FTE	246,011	250,651	301,877	315,410
	Rate	506	511	602	613
GP practice nurses	Headcount	18,389	19,495	22,144	22,048
	FTE	10,082	10,689	13,563	13,962
	Rate	21	22	27	27
Total qualified scientific, therapeutic & technical staff	***Headcount***	***96,298***	***102,391***	***128,883***	***142,558***
	FTE	***81,601***	***86,837***	***108,585***	***122,059***
	Rate	***168***	***177***	***217***	***237***
Qualified Allied Health Professions	Headcount	49,893	53,105	65,515	71,301
	FTE	40,658	43,281	53,311	59,455
	Rate	84	88	106	116
Other qualified scientific, therapeutic & technical staff	Headcount	46,405	49,286	63,368	71,257
	FTE	40,943	43,557	55,274	62,603
	Rate	84	89	110	122
Qualified ambulance staff	**Headcount**	**14,941**	**14,783**	**17,272**	**17,451**
	FTE	**14,193**	**14,129**	**16,587**	**16,889**
	Rate	**29**	**29**	**33**	**33**
Support to clinical staff	***Headcount***	***283,871***	***296,619***	***368,285***	***355,010***
	FTE	***215,129***	***226,585***	***284,394***	***284,367***
	Rate	***442***	***462***	***568***	***553***
Support to doctors & nursing staff	Headcount	240,040	249,216	303,630	286,254
	FTE	180,477	188,917	231,652	226,952
	Rate	371	385	462	441
Support to scientific, therapeutic & technical staff	Headcount	38,074	40,465	55,025	55,689
	FTE	29,540	31,515	44,089	45,533
	Rate	61	64	88	89
Support to ambulance staff	Headcount	5,757	6,938	9,630	13,067
	FTE	5,113	6,153	8,653	11,882
	Rate	11	13	17	23
NHS infrastructure support	***Headcount***	***170,623***	***171,205***	***211,489***	***219,064***
	FTE	***141,637***	***142,071***	***178,098***	***187,177***
	Rate	***291***	***290***	***355***	***364***
Central functions	Headcount	70,647	73,996	99,831	105,354
	FTE	60,643	63,190	85,498	92,106
	Rate	125	129	171	179
Hotel, property & estates	Headcount	77,803	72,922	73,932	73,797
	FTE	59,560	55,503	56,593	57,135
	Rate	122	113	113	111
Manager & senior manager	Headcount	22,173	24,287	37,726	39,913
	FTE	21,434	23,378	36,007	37,937
	Rate	44	48	72	74
Other non-medical staff or those with unknown classification	***Headcount***	***2,820***	***2,427***	***497***	***353***
	FTE	***2,390***	***1,494***	***432***	***308***
	Rate	***5***	***3***	***1***	***1***
Other GP practice staff	**Headcount**	**81,658**	**86,333**	**90,110**	**92,436**
	FTE	**50,497**	**52,398**	**58,443**	**59,330**
	Rate	**104**	**107**	**117**	**115**

Source: Adapted from Workforce Statistics, The Information Centre

Rate = FTE per 100,000 population, based on mid year estimates for each respective year.

Appendix 2: Workforce statistics at 30 September, Scotland

		1999	2004	2008
Medical (Hospital, community and public health services)	Headcount	8,663	10,023	11,783
	FTE	7,667	9,063	10,753
	Rate	151	178	208
General medical services	Headcount	4,072	4,456	4,916
Dental (Hospital, community and public health services)	Headcount	610	635	752
	FTE	459	504	604
	Rate	9	10	12
General dental services	Headcount	1,999	2,156	2,703
Medical and dental support	Headcount			1,667
	FTE			1,440
	Rate			28
Nursing and midwifery	Headcount	61,627	64,822	69,965
	FTE	51,373	54,521	57,750
	Rate	1013	1074	1,117
Allied health professions	Headcount	8,320	10,078	11,342
	FTE	6,835	8,277	9,243
	Rate	135	163	179
Other therapeutic services	Headcount			3,722
	FTE			3,135
	Rate			61
Personal and social care	Headcount			826
	FTE			692
	Rate			13
Healthcare science	Headcount			5,781
	FTE			5,158
	Rate			100
Emergency services	Headcount	2,719	3,267	3,681
	FTE	2,616	3,139	3,558
	Rate	52	62	69
Administrative services	Headcount	21,751	27,380	29,755
	FTE	18,624	23,236	24,966
	Rate	367	458	483
Support services	Headcount	17,894	17,731	20,086
	FTE	12,138	12,246	14,368
	Rate	239	241	278
Unallocated / not known	Headcount			1,394
	FTE			1,429
	Rate			28

FTE = Full time equivalent
Rate = FTE per 100,000 population, based on mid year estimates for each respective year.
Source: Adapted from NHSScotland Workforce, ISD Scotland National Statistics release available at: http://www.isdscotland.org/isd/5363.html