



National Audit Office

HEALTH FOCUS

NAO GOOD PRACTICE BRIEFING FOR THE DEPARTMENT OF HEALTH



Welcome to the summer 2006 issue of Health Focus, setting out the NAO's health-related work from the past year, as well as some of our future projects. I hope you will find this both informative and relevant to your work.

Since the last edition of this briefing in the summer of 2005, we have published seven value for money (VFM) studies relating to the National Health Service and produced a range of other outputs, publications and conferences. Many of our reports have been examined by the Committee of Public Accounts, the senior select committee of the House of Commons. The Committee produces its own reports and recommendations to which the government must respond in the form of a Treasury Minute. We have also published the second of our annual joint reports with the Audit Commission on the NHS summarised accounts and financial management in the NHS. Full copies of these reports and related materials are available from our website (www.nao.org.uk) and the website of the Committee of Public Accounts (www.parliament.uk/parliamentary_committees/committee_of_public_accounts.cfm).

The impact of our work can be measured in both financial savings and improved public services. In the past year alone, our reports delivered £10.7 million worth of savings to the National Health Service. Our stroke report was welcomed as "superb" by Greg Clark MP, a member of the Committee of Public Accounts, and the Department of Health said that implementing its recommendations would save 10 lives a week in England.



Following our recent report on out-of-hours care, Lord Warner of the Department of Health committed the Department to work "in partnership with the NAO to ensure all parts of the NHS reach the standards of the best, both in terms of the quality of patient care and the value for money their services deliver".

For the first time, this edition contains a back catalogue of all the Health reports published since 2000. Looking at this catalogue, which includes reports on hospital acquired infection, tackling obesity and patient choice, you will see how we have consistently been at the forefront of bringing important health topics to the attention of the public and policymakers alike.

We have undergone some important changes within the NAO's health team over the past year. Steven Corbishley is moving on after almost five years on health financial audit and we thank him for his valuable contribution to the team's work over this period. Sid Sidhu and Claire Rollo have assumed joint responsibility for financial audit. Claire will be focusing on the Department of Health, the Summarised Accounts and the Financial Management Report, while Sid focuses on arms length bodies and Foundation Trusts. Claire is now working from Newcastle, where she is leading the expansion of the current NAO office and will be further developing our health team in the North. Chris Shapcott and Karen Taylor continue as joint directors for Health VFM.

I always welcome your input and suggestions for areas that you think we should examine. If you believe an NAO investigation could improve the delivery of a service, help identify and spread good practice or highlight areas of concern, I would like to hear from you. Please do not hesitate to contact me directly at anna.simons@nao.gsi.gov.uk.

A handwritten signature in cursive script that reads "Anna Simons".

Anna Simons
Assistant Auditor General



Improving patient safety

A Safer Place for Patients: learning to improve patient safety (November 2005)

The Department of Health has estimated that one in ten patients admitted to NHS hospitals will be unintentionally harmed. The most common patient safety incidents are patient injuries (due to falls), medication errors, equipment-related incidents, record documentation error and communication failure. Around 50 per cent of these patient safety incidents could be avoided if lessons from previous incidents were learned.

In 2001, the Department published *Building a safer NHS for patients*, which set out the government's strategy for promoting patient safety by encouraging reporting of and learning from patient safety incidents. Our report focused on the quality of the strategy and examined whether the NHS had been successful in improving patient safety.

Overall, the report found that the culture within NHS trusts is now more open and fair and that the reporting of patient safety incidents has improved at a local level. However, progress on developing the national reporting system for learning has been slower than envisaged. There is also a need to improve evaluation and sharing of lessons and solutions by all organisations with a stake in patient safety, both locally and nationally.

The NAO report's recommendations include:

- The Department should enhance and sustain the development of an effective safety culture within NHS trusts, improve the reliability and completeness of safety incident reporting, and provide effective feedback of lessons and solutions to improve safety;
- Trusts should engage patients more in identifying important patient safety issues and designing solutions, and ensure that they fully investigate complaints and litigation claims, analysing trends in both, so as to learn from them; and
- The National Patient Safety Agency needs to expedite its evaluation and feedback programme and focus on developing solutions to nationwide problems to mitigate the risk that trusts will stop sending data to the National Reporting and Learning System. These solutions should be accompanied by a sample business case which trusts can then customise.

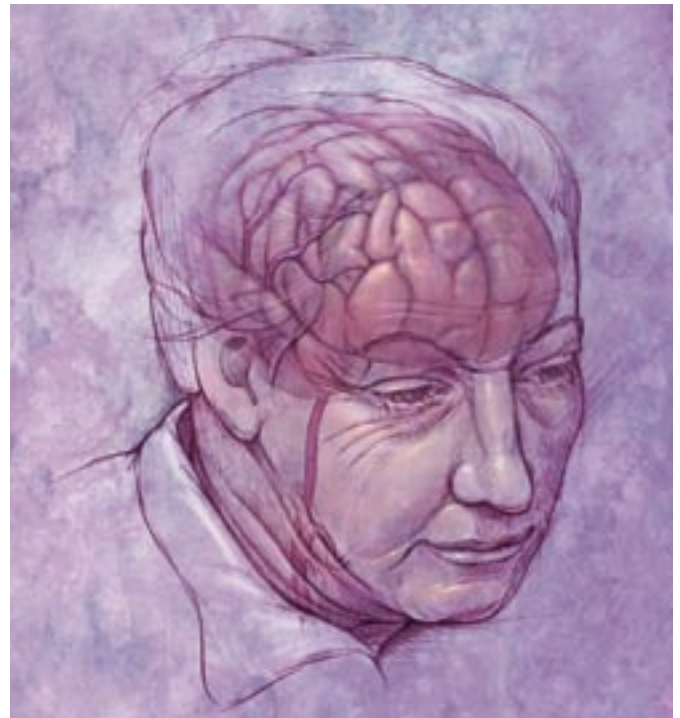
Better stroke care

Reducing Brain Damage: Faster access to better stroke care (November 2005)

Stroke is one of the top three causes of death in England and a leading cause of adult disability. There are approximately 110,000 incidents of stroke and a further 20,000 incidents of transient ischaemic attacks in England every year. There are more than 900,000 people who have had a stroke living in England, at least 300,000 of whom are living with moderate to severe disabilities as a result.

Our report highlights the fact that stroke care costs the NHS about £2.8 billion a year in direct costs (which is more than the cost of treating coronary heart disease) and costs the wider economy some £1.8 billion in lost productivity and disability. In addition, the annual informal care costs borne by patients' families are around £2.4 billion. The total cost of stroke care is predicted to increase in real terms by 30 per cent between 1991 and 2010.

Our report found that awareness of stroke and how to recognise its symptoms amongst the general public is low and that more emphasis needs to be given to primary and secondary prevention measures. Emergency response to stroke in acute care is generally lacking and patients should be treated on specialised stroke units with rapid access to brain scans. Following discharge, stroke patients need improved access to rehabilitation and support services. Overall, we found that, each year, more efficient practice could save £20 million, prevent 550 deaths and ensure a further 1,700 people fully recover from their strokes that would not have otherwise done so.



The NAO report's recommendations include:

- A significant proportion of stroke patients are not being treated on a specialist stroke unit, despite evidence that this is the most clinically effective model for acute care. Increasing the proportion of patients who spend most of their time on a specialist unit by 25 per cent could save more than 550 lives a year; and
- Transient ischaemic attack (TIA) is a strong predictor of later major stroke or vascular event, so GPs should refer suspected TIAs for diagnostic tests, and all PCTs should provide access to an outpatient stroke and TIA service. When carotid stenosis is detected, carotid endarterectomy should be performed, preferably within two weeks. Currently, only half of stroke patients have carotid ultrasound scans within twelve weeks. Providing carotid surgery within two weeks to patients who are indicated for it could prevent around 250 strokes a year.

Child obesity

Tackling Child Obesity – First Steps (February 2006)

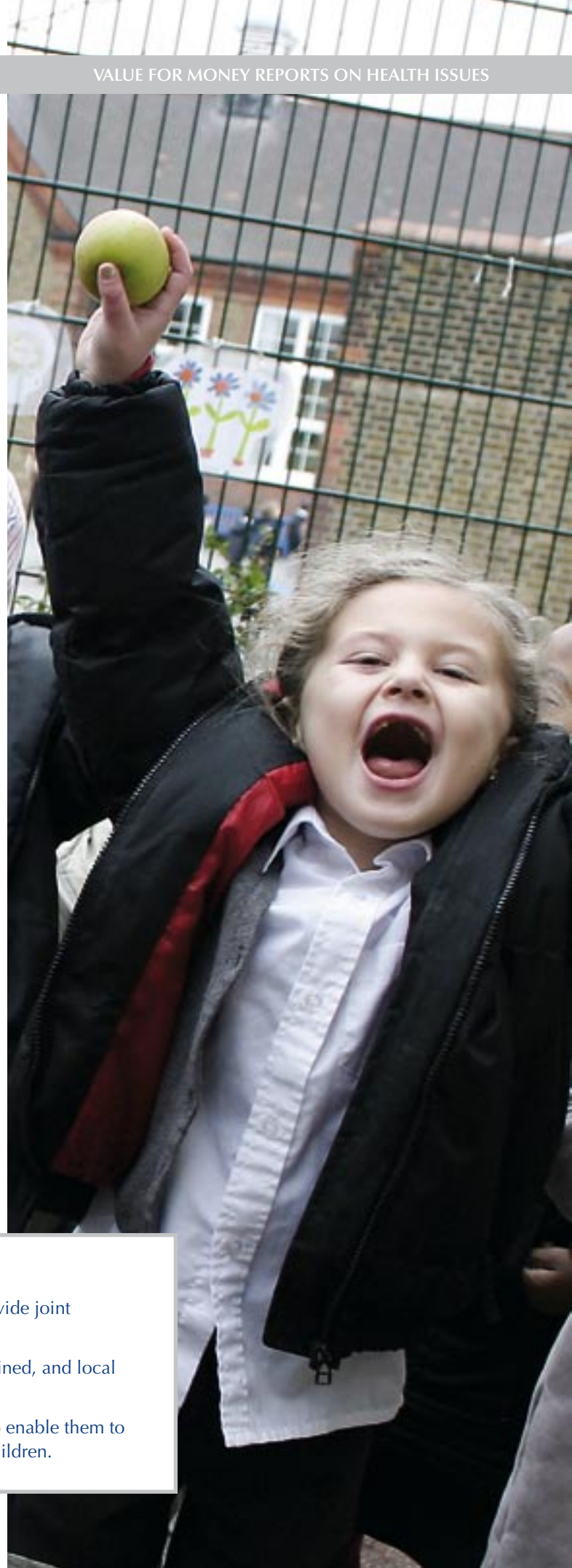
Child obesity is a complex public health issue that is a growing threat to children's health, as well as a current and future drain on NHS resources. Obesity now costs the NHS around £1 billion a year and the UK economy £2.3 billion in indirect costs. If this trend continues, the annual cost to the economy would be a further £3.6 billion a year by 2010. As a result, halting the rise in child obesity among children under eleven was made a Public Service Agreement (PSA) target in July 2004. The target is owned jointly by the Department of Health, the Department for Education and Skills, and the Department for Culture, Media and Sport.

This joint report between the Audit Commission, the Healthcare Commission and the NAO is one of three joint studies that analysed the delivery chains for Public Service Agreements. Their aim is to examine the characteristics of delivery chains and their capacity to deliver the PSA target for which they were designed. In so doing, we have identified ways in which the targets can be achieved more efficiently and effectively and how different organisations might work more closely together.

Our report on child obesity found that, while some initial steps have been taken to tackle this issue, including the development of a draft delivery plan and the establishment of a joint programme board to provide strategic direction, a lack of clear leadership and timely guidance has resulted in various organisations remaining unclear about their roles, leaving much to be done during the last three years covered by the target. The report therefore highlights a number of ways in which the delivery chain needs to be strengthened if the target is to be met.

The joint report's recommendations include:

- Target-holding departments should work closely to provide joint leadership to others in the delivery chain;
- Regional roles and responsibilities should be better defined, and local partnerships should be strengthened; and
- Frontline staff should be provided with more training to enable them to deliver clear and consistent messages to parents and children.



Out-of-hours care

The provision of out-of-hours care in England (May 2006)

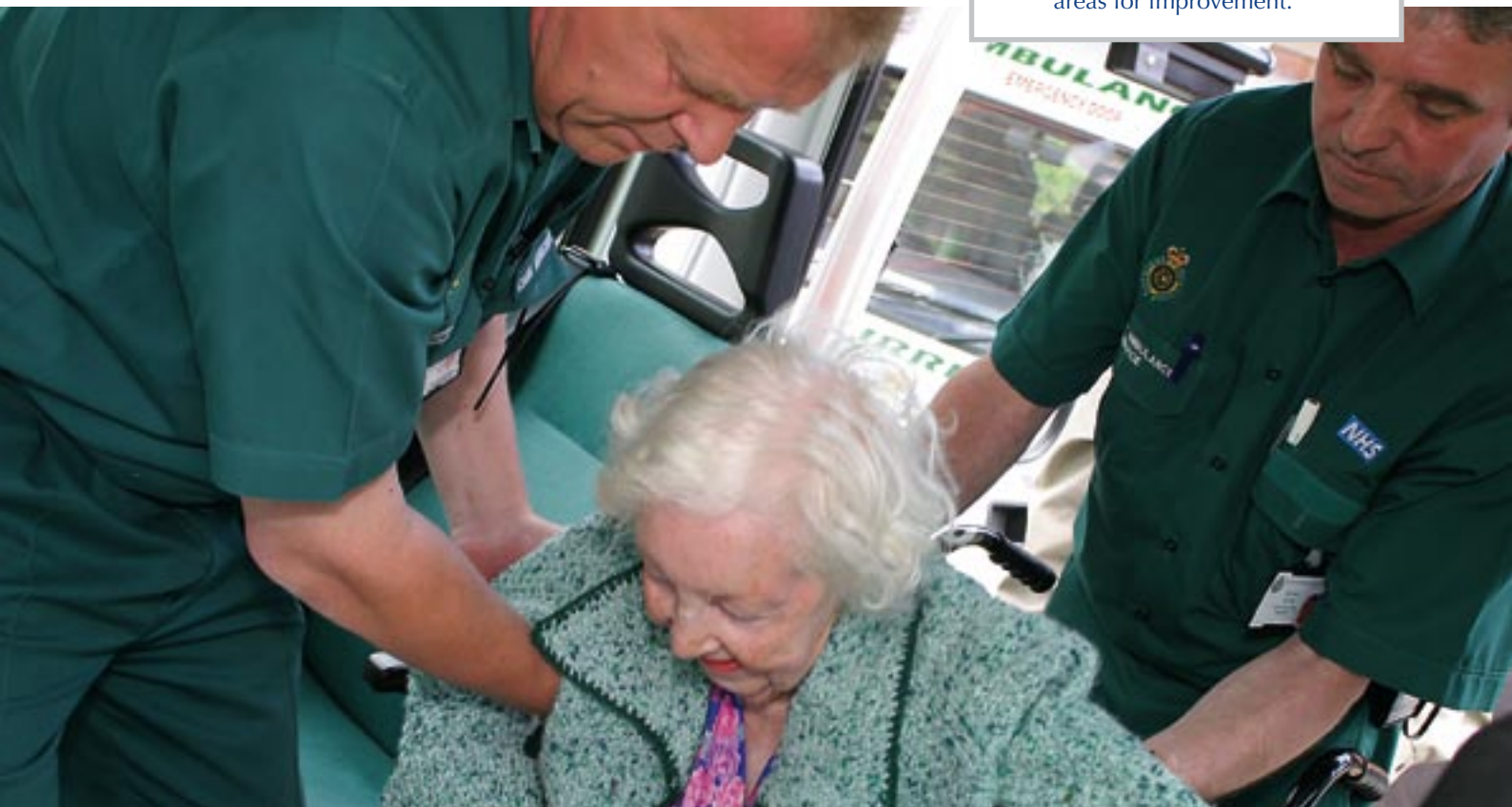
Out-of-hours care is defined as primary medical care delivered between 6.30pm and 8.00am on weekdays, and during all weekends, bank holidays and public holidays. In April 2004, some 90 per cent of General Practitioners (GPs) in England took the opportunity to opt out of organising out-of-hours care entirely under the terms of the General Medical Services contract. GPs that opted out gave up an average of £6,000 per annum and passed on responsibility for the provision of out-of-hours care to Primary Care Trusts (PCTs).

Our report found that there were some shortcomings in the commissioning process because PCTs lacked experience, time and reliable management data; out-of-hours providers are beginning to deliver a satisfactory standard of service but most are not yet meeting all the national quality requirements; the actual costs of providing out-of hours care are £392 million, considerably more than the £322 million allocated by the Department; and commissioners are entering into contracts with multiple providers and the market is maturing.

Our benchmarking analysis suggested that, if all PCTs matched the best in each rural/urban classification, a saving of £134 million could be achieved without compromising quality. This would be delivered through a number of actions, including analysing local demand patterns to help patients access the service more appropriately.

The NAO report's recommendations include the following:

- Although PCTs have the primary responsibility for out-of-hours services, the Department should nonetheless use all the levers at its disposal to encourage PCTs to improve the cost-effectiveness of the service through benchmarking of costs, improvements to local commissioning processes, and making available training and best practice; and
- PCTs should benchmark their costs against those of other geographically comparable PCTs to identify areas for improvement.





Paddington Health Campus

The Paddington Health Campus Scheme (May 2006)

The Paddington Health Campus was an ambitious attempt to build a world-class healthcare and research centre to replace three run-down hospitals – St Mary’s, the Royal Brompton and Harefield. The scheme ultimately proved to be beyond the capacity of the partner organisations to deliver. The Outline Business Case, approved in October 2000, estimated that the scheme would cost £300 million (£411 million at 2005 prices) and would be completed by 2006. When the scheme finally collapsed in May 2005, projected costs had increased to £894 million and the completion date had slipped to 2013.

We identified three main reasons behind the failure: the sheer number and scale of risks and lack of a single sponsor; the way in which the Campus partners organised and carried through the scheme, including the failure to secure adequate land for the scheme; and the lack of active strategic support for the Campus vision. We also highlighted that the Paddington scheme is not alone in its projected cost increase: the average rise above approved business case estimates for NHS schemes is 117 per cent, representing just over £4 billion. We concluded that the failure to deliver a replacement of hospital premises that are long overdue for renewal and specialist clinical services represents poor value for money for patients, visitors and staff. Whilst we acknowledged the need to develop a robust business case, we noted that taxpayers have lost out as the £15 million

spent did not deliver any new facilities. In addition, a rise in building costs in recent years will inevitably mean that any future scheme will be more expensive in real terms than if the scheme had been delivered to the original completion date.

The NAO report’s recommendations for future capital investment schemes include:

- **No capital investment scheme in the NHS should proceed without the formal identification of a single sponsor, even if this means trusts must merge prior to starting a procurement;**
- **No Outline Business Case should be approved where it has been subject to conditions imposed by an NHS trust which explicitly constrain the development of options or limit the value for money that may be secured; and**
- **No scheme should proceed without formal confirmation from commissioners, who would be expected to support the scheme, and the NHS trusts themselves, of assured funding for full development costs.**



NHS finances

Financial Management in the NHS (June 2006)

Our joint report with the Audit Commission found that there was a deficit across the NHS as a whole for 2004-05. This was the first time since 1999-2000 that the NHS had failed to break even overall. Compared with 2003-04, there was an increase in the number of NHS bodies with deficits, and more of these deficits were significant in size. The forecast position suggests that the deficit has worsened for 2005-06.

The report examines the ways in which some bodies have returned to financial balance by analysing the causes of deficits, the role of boards and management reporting, and the importance of developing an organisation-wide approach to financial management.

The report also briefly covers current developments such as the use of turnaround teams to review ninety-eight NHS bodies identified as facing particular financial difficulties. These teams of external consultants review the bodies' financial position and identify what action can be taken to assist financial recovery.

The joint report's recommendations include the following:

- NHS bodies should develop a whole-organisation approach to managing risks, particularly in delivering financial balance;
- The financial management of changes, such as the implementation of Payment by Results, and the identification of skills needed to respond to them, should be made an early, board-level priority;
- The current NHS financial regime should continue to evolve to ensure that it provides the right incentives and reporting arrangements to support long-term financial sustainability; and
- In order to ensure the faster closing of local NHS accounts, NHS bodies should review their accounts production processes with their auditors.

IT in the NHS

Department of Health: National Programme for IT in the NHS (June 2006)

The NHS depends on the successful handling of vast quantities of information to function safely and effectively. The National Programme for IT in the NHS is a ten-year programme which presents an unprecedented opportunity to use IT to reform the way the NHS in England uses information, and hence to improve services and the quality of patient care. Our report examined progress in delivering the systems against the original plans and costs of the Programme; the steps taken by the Department, NHS Connecting for Health and the NHS to deliver the Programme; how the IT systems have been procured; and how the NHS is preparing to use the systems delivered.

The report found that the Department, NHS Connecting for Health and the NHS have made substantial progress with the Programme, but recognised that its successful implementation continues to present significant challenges in three key areas: ensuring that IT suppliers deliver systems that meet the needs of the NHS within the agreed timescales; ensuring that NHS organisations play their part in implementing the systems; and winning the support of the NHS staff and the public.

The NAO report's recommendations include the following:

- NHS Connecting for Health should ensure that it has a robust timetable for delivery of the Programme, which it is confident that its suppliers are capable of achieving;
- The Department and NHS Connecting for Health should provide greater clarity to organisations and staff in the NHS as to when the different elements of the Programme will be delivered. NHS organisations should also communicate to members of staff how the delivery timetable will affect them; and
- The Department and the NHS should publish an annual statement quantifying the benefits delivered by the Programme, and commission a study in conjunction with NHS Connecting for Health to measure the impact of the Programme on local NHS IT expenditure.



Temporary nursing staff

Improving the use of temporary nursing staff in NHS acute and foundation trusts (July 2006)

Although the number of nurses in England has increased substantially over the last five years, trusts still rely on temporary nursing staff to meet fluctuating demands and to cover vacancies and short term absences. In 2004-05, trusts spent £790 million on temporary nursing cover. The use of temporary nurses is key to trusts remaining flexible to fluctuating demands and staff availability. However, high levels of unmanaged use can be costly and can have negative impacts on patient satisfaction.

Our report concludes that, to date, the NHS has focused mainly on reducing agency costs. Less attention has been paid to addressing the wider issues of controlling and managing the supply of and demand for all types of temporary nursing staff. Expenditure on agency nursing staff has reduced from a peak of seven per cent in 2001-02 to three per cent in 2004-05. However, total expenditure on all temporary nursing has only decreased slightly from 10 per cent of total expenditure in 1999-00 to 9.4 per cent in 2004-05. The variation between trusts is wide, with some trusts spending less than 5 per cent of total nursing expenditure on temporary staff and others as much as 29 per cent.

Many trusts do not have adequate and timely information on staffing needs and therefore do not have a clear understanding of the factors driving their demand for nursing staff. In addition, there is a need to improve management of permanent staff through more effective rostering and flexible contracts, which could result in savings of between £25 million and £50 million.

Whilst the NHS has made progress in reducing the unit cost of agency staff, we estimate that trusts could collectively make annual savings of between £13 million and £38 million through better procurement and by driving down still further the unit costs of the different grades of agency nursing staff.

As part of the study, the NAO worked with the Department of Health and NHS Employers to develop a good practice guide on managing the use of temporary staff. This is available at: http://www.nao.org.uk/publications/nao_reports/05-06/05061176_Good_Practice.pdf



The NAO report's recommendations include the following:

- NHS trusts should appoint a board member with responsibility for developing and monitoring a trust wide strategy in relation to its use of temporary staff as part of its people strategy. The board should set budgets on the use of temporary staff against which expenditure can be measured; and
- NHS Trusts should control demand for temporary staff by bringing together information on activity and dependency levels, permanent nursing staffing levels, vacancies and sickness levels. This information should be benchmarked internally and against other similar trusts using NHS Employers' proposed benchmarking groups.

Follow up work

Once each of our reports has been examined by the Committee of Public Accounts, the Committee publishes its own report, to which the government must respond. Below is a list of Committee of Public Accounts reports and the relevant responses, where available, which have been published in the last 18 months.

Tackling cancer: improving the patient journey

Recommendations by the Committee of Public Accounts included the following:

- The Department should work with GPs to reduce waiting times for referral to a specialist by improving the ability of GPs to identify symptomatic patients promptly; and
- To improve the quality and choice of end of life care, cancer networks should work with Primary Care Trusts and others to identify and break down the barriers preventing wider adoption of best practice, and the Department of Health should update earlier research with terminally ill patients to monitor the impact of their actions.

The Treasury Minute response to these recommendations included the following:

- An acceptance that it is vital that GPs refer patients with suspected cancer urgently. Cancer referral guidelines for GPs were updated by NICE in June 2005. The Department also commissioned work to test the feasibility of using an algorithm to improve GP referrals for suspected bowel cancer, the results of which will be available in 2006; and
- An acknowledgement that it is important for the Department to evaluate the impact that programmes such as the End of Life Programme, announced in 2004 and investing £12 million over three years, have on patient care.

The NHS Cancer Plan: a progress report

Recommendations by the Committee of Public Accounts included the following:

- The Department should publish progress against key cancer outcomes annually to provide a clear and consistent basis for the public to see how much progress is being made over time; and
- New guidance from NICE sets out best practice for referring patients with suspected cancer to specialist services on the basis of their symptoms. The information which is given to the public to help them understand the referral guidance should be adapted to ensure the key warning signs and symptoms of cancer are easily understood. These key indicators could then be widely publicised, for example through readily available cards or leaflets, targeting those groups that tend to delay going to the doctor with symptoms of possible cancer.

The Treasury Minute response to these recommendations included the following:

- An acceptance in principle to publish progress against key cancer outcomes; and
- The commissioning of five research projects into the extent and effectiveness of campaigns designed to raise awareness of the symptoms of cancer and initiatives to encourage earlier intervention. In addition, a commitment to piloting locally developed approaches to raising awareness of cancer amongst high risk communities in some PCT spearhead areas in spring 2006.



Working with the voluntary sector

Recommendations by the Committee of Public Accounts included the following:

- The Home Office and the Treasury should set a revised target beyond 2006 which provides a real incentive to departments to increase their engagement with the sector. The Home Office should agree supporting targets with individual departments and timescales for implementation; and
- Little hard data exists on how funding is distributed between voluntary sector organisations of different sizes, by region or demographically. The Home Office should establish a proper monitoring and reporting framework with departments to collect such data. It should evaluate such data to ascertain, for example, that new organisations are not deterred from entering the market, and that the poorest communities are not disadvantaged by the way funding is distributed, by the manner in which programmes are constructed or targeted, or by the absence of active voluntary sector organisations in some communities.

The Treasury Minute response to these recommendations included the following:

- An acceptance that Public Service Agreements should create a real incentive to deliver change, and a commitment to considering how the performance management framework should further evolve so that it continues to drive performance and responds to new challenges; and
- A commitment to consider whether State of the Sector Panel data can be used to analyse how funding is distributed.

The refinancing of the Norfolk and Norwich PFI Hospital

Recommendations by the Committee of Public Accounts included the following:

- The report again shows an authority too readily agreeing with refinancing proposals when more robust negotiations could have produced a better outcome. Staff managing PFI projects should be trained to understand refinancing issues and should appoint experienced advisers to assist in robustly negotiating refinancing; and
- In order to improve the management of the future PFI programme, the Treasury should provide an annual assessment of the effect of construction cost inflation on public building projects, including the effect on PFI projects and a comparison with private sector experience.

NHS Local Improvement Finance Trusts

Recommendations by the Committee of Public Accounts included the following:

- In preparing business cases for LIFT projects, Primary Care Trusts should compare the cost of LIFT to the cost of alternative procurement routes available, and make the implications for spending on other primary care facilities and services explicit; and
- The Department and Partnerships for Health have not yet developed a mechanism for evaluating LIFT, although they have started to do so. They should complete this work quickly and publicise the underlying mechanism and methodologies so that meaningful quantitative evaluation of the value for money of the LIFT programme and its schemes can be made.

Reducing brain damage: Faster access to better stroke care

Recommendations by the Committee of Public Accounts included the following:

- There are 640 patients per stroke consultant, compared with 360 patients per cardiac consultant. The limited number of health professionals with training in stroke is a barrier to providing high quality acute care and rehabilitation. Future workforce planning targets should enable the NHS to move to a position where there are as many stroke consultants per patient as heart disease consultants per patient; and
- The last clinical audit of stroke showed that only 22% of stroke patients had a scan on the same day as their stroke, and most waited more than two days. Scans for stroke patients are being delayed, though 'time lost is brain lost', and research shows that scanning patients immediately costs less and results in better patient outcomes than scanning later. All suspected stroke patients should be scanned as soon as possible after arrival at the acute hospital, ideally within three hours, and none should wait more than 24 hours for a scan. All Accident and Emergency and Radiology departments should have protocols in place for the rapid admittance and referral for scanning of stroke patients.

A safer place for patients: Learning to improve patient safety

Recommendations by the Committee of Public Accounts included the following:

- Doctors are less likely to report an incident than other staff groups. The National Patient Safety Agency has run a national initiative to encourage reporting by junior doctors, and should promulgate the lessons from this initiative across the NHS. Trusts should evaluate their own levels of under-reporting and target specific training and feedback at those groups of staff that are less likely to report; and
- Trusts estimated that on average around 22% of incidents and 39% of near misses go un-reported, and that medication errors and incidents leading to serious harm are the least likely to be reported. The National Patient Safety Agency should compare its own data with the incident reporting data collected by the National Audit Office. It should bring together trusts with low levels of reporting and those that have achieved high reporting rates to help improve incident and near miss reporting. The Healthcare Commission should evaluate compliance with reporting requirements as part of its performance assessment process.





Forthcoming reports

We are planning to publish the following studies in the near future:

- **Improving Quality And Safety - Progress In Implementing Clinical Governance In Primary Care** will examine whether patient care and patient experiences have been improved through implementing the clinical governance initiative in Primary Care Trusts. The study will: review the arrangements in place to help ensure effective strategic management of clinical governance; evaluate whether Primary Care Trusts are informed about progress in implementation of clinical governance; and identify whether trusts are achieving improvements in the patient experience and the quality of care delivered to patients (to be published Autumn 2006).
- **Joint Venture between the Health and Social Care Information Centre and Dr Foster LLP** will focus on whether the Health and Social Care Information Centre's investment of £12 million for a 50 per cent share of a private company offers good value for money, and whether the transaction was conducted fairly (to be published Autumn 2006).
- **Pay Modernisation for Consultants in the NHS** will examine whether the public and the NHS are receiving any benefits from the new consultants' contract, and whether it was implemented effectively. The study will identify examples of good practice, where trusts have managed to implement the contract to the benefit of patients, and publicise these for the benefit of all trusts (to be published autumn 2006).

Further details of our forthcoming studies can be found on our website at <http://www.nao.org.uk/publications/workinprogress/wipindex.asp>. All our reports will be made available online once they have been published.

Health Value for Money Studies back catalogue

All reports can be found on the NAO website at http://www.nao.org.uk/publications/nao_reports/chronindex.asp?type=vfm.

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| <i>Improving the use of temporary nursing staff in NHS acute and foundation trusts</i> HC 1176, Parliamentary Session 2005-06 | 12/07/2006 | <i>Hip Replacements: An Update</i> HC 956, Parliamentary Session 2002-03 | 17/07/2003 |
| <i>Department of Health: The National Programme for IT in the NHS</i> HC 1173, Parliamentary Session 2005-06 | 16/06/2006 | <i>A Safer Place to Work: Improving the management of health and safety risks to staff in NHS trusts</i> HC 623, Parliamentary Session 2002-03 | 30/04/2003 |
| <i>Department of Health: The Paddington Health Campus scheme</i> HC 1045, Parliamentary Session 2005-06 | 19/05/2006 | <i>Procurement of Vaccines by the Department of Health</i> HC 625, Parliamentary Session 2002-03 | 09/04/2003 |
| <i>The Provision of Out-of-Hours Care in England</i> HC 1041, Parliamentary Session 2005-06 | 05/05/2006 | <i>A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression</i> HC 527, Parliamentary Session 2002-03 | 27/03/2003 |
| <i>Tackling Child Obesity – First Steps</i> HC 801, Parliamentary Session 2005-06 | 28/02/2006 | <i>Ensuring the effective discharge of older patients from NHS acute hospitals</i> HC 392, Parliamentary Session 2002-03 | 12/02/2003 |
| <i>Department of Health – Reducing Brain Damage: Faster access to better stroke care</i> HC 452, Parliamentary Session 2005-06 | 16/11/2005 | <i>Safety, quality, efficacy: regulating medicines in the UK</i> HC 255, Parliamentary Session 2002-03 | 16/01/2003 |
| <i>A Safer Place for Patients: learning to improve patient safety</i> HC 456, Parliamentary Session 2005-06 | 03/11/2005 | <i>Innovation in the National Health Service – The Acquisition of the Heart Hospital</i> HC 157, Parliamentary Session 2002-03 | 19/12/2002 |
| <i>The Refinancing of the Norfolk & Norwich PFI Hospital: How the deal can be viewed in the light of the refinancing</i> HC 78, Parliamentary Session 2005-06 | 10/06/2005 | <i>Facing the Challenge: NHS Emergency Planning in England</i> HC 36, Parliamentary Session 2002-03 | 15/11/2002 |
| <i>Department of Health - Innovation in the NHS: Local Improvement Finance Trusts</i> HC 28, Parliamentary Session 2005-06 | 19/05/2005 | <i>The Management of Surplus Property by Trusts in the NHS in England</i> HC 687, Parliamentary Session 2001-02 | 21/03/2002 |
| <i>Department of Health: The NHS Cancer Plan – A Progress Report</i> HC 343, Parliamentary Session 2004-05 | 11/03/2005 | <i>NHS Direct in England</i> HC 505, Parliamentary Session 2001-02 | 25/01/2002 |
| <i>Tackling Cancer: Improving the Patient Journey</i> HC 288, Parliamentary Session 2004-05 | 25/02/2005 | <i>Inappropriate Adjustments to NHS Waiting Lists</i> HC 452, Parliamentary Session 2001-02 | 19/12/2001 |
| <i>Patient Choice at the Point of GP Referral</i> HC 180, Parliamentary Session 2004-05 | 19/01/2005 | <i>Inpatient and outpatient waiting in the NHS</i> HC 221, Parliamentary Session 2001-02 | 26/07/2001 |
| <i>Reforming NHS Dentistry: ensuring effective management of risks</i> HC 25, Parliamentary Session 2004-05 | 25/11/2004 | <i>Handling Clinical Negligence Claims in England</i> HC 403, Parliamentary Session 2000-01 | 03/05/2001 |
| <i>Improving emergency care in England</i> HC 1075, Parliamentary Session 2003-04 | 13/10/2004 | <i>Educating and Training the Future Health Professional Workforce for England</i> HC 277, Parliamentary Session 2000-01 | 01/03/2001 |
| <i>Improving patient care by reducing the risk of hospital acquired infection: a progress report</i> HC 876, Parliamentary Session 2003-04 | 14/07/2004 | <i>Tackling Obesity in England</i> HC 220, Parliamentary Session 2000-01 | 15/02/2001 |
| <i>Tackling cancer in England: saving more lives</i> HC 364, Parliamentary Session 2003-04 | 19/03/2004 | <i>The National Blood Service</i> HC 6, Parliamentary Session 2000-01 | 20/12/2000 |
| <i>The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England</i> HC 1143, Parliamentary Session 2002-03 | 06/11/2003 | <i>Charitable Funds Associated with NHS Bodies</i> HC 516, Parliamentary Session 1999-00 | 15/06/2000 |
| <i>Achieving Improvements through Clinical Governance: A Progress Report on Implementation by NHS Trusts</i> HC 1055, Parliamentary Session 2002-03 | 17/09/2003 | <i>Hip replacements: getting it right first time</i> HC 417, Parliamentary Session 1999-00 | 19/04/2000 |
| | | <i>Inpatient Admissions and Bed management in NHS acute hospitals</i> HC 254, Parliamentary Session 1999-00 | 24/02/2000 |
| | | <i>The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England</i> HC 230, Parliamentary Session 1999-00 | 17/02/2000 |

More than just reports...

While the publication of our value for money reports forms the core of our work, it is by no means all we do. You may have seen us speak at a number of conferences. In June of this year, we organised a joint conference with the Department of Health on the provision of out-of-hours care, at which Lord Warner introduced a number of speakers who outlined their experiences of providing innovative and cost-effective out-of-hours services.

As follow-up work to our published report on stroke care, we are holding a conference on *Joining Forces to Deliver Improved Stroke care* at the QEII Conference Centre on the 19th October. Following opening addresses by Rosie Winterton MP and Edward Leigh MP, the NAO and the Department of Health will provide an update on the actions to date, together with an analysis of the future potential for stroke services. Please contact Sarah Wainwright on 020 8541 1399 or sarah@healthcare-events.co.uk for more information.

A further conference – on the use of temporary nursing – will take place on the 11th October. This will give us an opportunity to share the lessons learned and good practice from our published work and help formulate practical solutions for staff from NHS organisations. For further information, please contact Jo Carabott on 020 7798 7524 or joanna.carabott@nao.gsi.gov.uk.

We also produce occasional pieces of guidance on topical or important issues. A recent example of this is our *Framework for evaluating the implementation of PFI*, published in May of this year. This is an updated framework for assessing PFI deals. Our original 1999 framework necessarily focused on issues arising during the procurement of deals, rather than during the life of the contract as, at that time, few deals had entered into their operational phase. The updated version builds on the 1999 framework and draws on the experience of the many deals that have become operational since then.

The assessment framework is based on a matrix structure that divides the lifecycle of a PFI project into six phases (three before a deal is signed and three after) and six business management themes, such as the fit with business requirements and risk allocation. An analysis sets out how the six business management themes apply to each phase of the lifecycle, highlighting the key issues that should be evaluated in each area.

Whilst the framework is intended to be used for retrospective audit, it has the potential to be used as a tool for the ongoing monitoring of projects. Service managers, lead project officers and departmental Private Finance Units may all find it to be a useful tool. It provides a checklist and has been designed to complement, but not replace, existing guidance (such as that issued by the Treasury) or sound management of projects in general.

The report setting out this framework is available in two volumes on our website:

http://www.nao.org.uk/publications/nao_reports/05-06/Framework_PFI_Projects_i.pdf

http://www.nao.org.uk/publications/nao_reports/05-06/Framework_PFI_Projects_ii.pdf

One of the ways in which the NAO is improving the service it provides to our clients is by offering them an **Organisational Health Check**. This is a short, intense qualitative review of all parts of an organisation. The objective is to understand the key risks and challenges from the organisation's perspective and to assist the organisation in meeting those challenges. Organisational Health Checks involve interviewing a significant proportion of an organisation's staff at all levels and on a range of topics covering all aspects of the organisation's business.

In November 2005 members of the team conducted a health check at the National Institute for Health and Clinical Excellence (NICE). Over two weeks we interviewed almost a third of NICE's staff, presenting our findings back to the entire organisation. Andrew Dillon, Chief Executive of NICE, welcomed our findings and said that our recommendations would be of value in helping the organisation to prepare the following year's business plan. The NAO has recently been invited to undertake a further organisational health check at the Medicines and Healthcare products Regulatory Agency. We aim to undertake two to three health checks annually. We would also be happy to share our experiences with other organisations that are considering undertaking such an organisational review themselves. If you are interested in the possibility of a health check of your organisation, please contact Jo Carabott on 020 7798 7524 or joanna.carabott@nao.gsi.gov.uk.

The Healthcare Concordat

The Healthcare Concordat is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. It was launched in June 2004, led by the Healthcare Commission. There are now 20 signatories, including the NAO, working together to coordinate activities such as audits, reviews and inspections in order to reduce the duplication and overlap of work. Further information on the Healthcare Concordat can be found at www.concordat.org.uk

To find out more visit www.nao.org.uk