Are we on track – can we monitor bed targets in the NHS plan for England?

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Summary

The NHS plan announced sustained increases in funding accompanied by wide ranging reform, the success of which would be measured by targets set across the board, including increases in numbers of beds, staff, hospitals and equipment. In this article we assess progress towards the target of 7000 extra beds in hospitals and intermediate care to be achieved by 2004. Summary points are as follows. (1) Although the 2003/2004 target for availability of general and acute NHS beds in England was achieved, the increase did not offset the overall decrease in all categories of beds. Bed availability fell by 2083, from 186 290 in 1999/2000 to 184 207 in 2003/2004, following a fall of 12558 from 1996/1997 to 1999/2000. (2) Lack of standardized definitions and data collection systems both within the NHS and for the independent sector, compounded by ambiguity over the funding of extra capacity for the NHS, call into question the accuracy of data collected about intermediate care beds. (3) Systems for collecting data about intermediate care should be made subject to the same code of practice as official NHS statistics in order to monitor future targets and plan for provision of care. (4) Changes in definitions, lack of detail about criteria used in setting targets and lack of data about private sector care, make it impossible to monitor the overall capacity available to the NHS and assess whether bed availability targets have been met.

Keywords: bed targets, NHS plan, intermediate care

Introduction

The NHS plan for England, published in July 2000, announced sustained increases in funding accompanied by wide ranging reform, the success of which would be measured by targets, many to be achieved by 2004. Targets were set across the board and included increases in numbers of beds, staff, hospitals and equipment, with improvements and investment throughout the service.

More recent documents claim that the government is well on track to meeting its targets. Verifying these claims is not easy. Most targets initially lacked precisely defined baselines and end dates, and many were not defined in a way that made it possible to assess progress using publicly available routine data. It subsequently became clear that the baseline was the financial year 1999/2000, and the 2004 target date was 4 years later, 2003/2004.

In this article we assess progress towards the target of 7000 extra beds in hospitals and intermediate care to be achieved by 2004. We use the Department of Health’s own routine data to compare targets with baseline figures and set these trends within the context of longer term hospital activity. In doing so, we discuss the problems inherent in measuring changes, as well as the impact of privatization on the availability of data.

The beds target was set in response to the report of the National Beds Inquiry, published in 2000. As well as recommending that 3000 additional hospital beds were required immediately, it recommended developing intermediate care services, which would be predominantly nurse led and delivered in care homes and people’s own homes and by non-NHS organizations.

How NHS hospital beds are defined and counted

Data about the average number of beds available in NHS hospitals in England on each day of the period reported, usually a financial year, are collected from NHS trusts through the KH03 statistical return. Bed availability data are currently published on the Department of Health’s website, along with the data definitions used and comments on data quality and completeness. Bed availability and occupancy are counted at midnight as part of hospitals’ routine bed management systems. Up to 1986, similar data were collected on the SH3 return. The beds are classified as mental illness, learning disabilities, maternity, acute and geriatric, and some categories are further subdivided by ward type. Numbers in the acute and geriatric categories are often added together in a single category described as ‘general and acute’.

More NHS hospital beds?

The target in The NHS plan was for an increase of 2100 general and acute beds and 5000 intermediate care beds from 1999/2000.
to 2003/2004. Data about intermediate care beds are counted through a separate system, described later in this article.

All beds

Overall, the availability of NHS in-patient beds continued to fall although less sharply than in previous years. Bed availability fell by 2083, from 186,290 in 1999/2000 to 184,207 in 2003/2004, following a fall of 12,558 from 1996/1997 to 1999/2000. These figures did not include the availability and occupancy of beds in wards open only in the daytime. These are counted in Part 4 of the KH03 return. Their number increased by 875, from 79,386 in 1999/2000 to 88,137 in 2003/2004. The return includes a category for numbers of day cases treated in wards that are open overnight, but these are not shown separately in published data. This means that these daytime-only beds may have also been counted as available in-patient beds.

Targets for general and acute beds

Although overall numbers of beds available daily decreased, numbers increased in the government’s target category of general and acute bed availability. The reported average number of general and acute beds available daily rose by 2,197 from 135,080 in 1999/2000 to 137,277 in 2003/2004, thus meeting the target for 2,100 extra beds in this category. This increase followed the considerable decline since 1974 shown in Figure 1. Numbers of available beds in this category had decreased by 26,386 from 166,901 in 1989/1990 to 140,515 in 1996/1997, the year before the change of government. After this, they decreased by a further 5,435 up to 1999/2000. As a result, the overall change in general acute bed availability since 1996/1997 was a decrease of 32,386.

The increase in bed availability from 1999/2000 to 2003/2004 did not occur throughout the general and acute category. The more detailed analysis of these beds by ward type in Table 1 shows decreases in geriatric beds and acute beds available for younger physically disabled adults, and children.

An overlap between ‘critical’ and ‘intensive’ care beds?

The NHS plan included a target for ‘a 30 per cent increase in critical care beds over the next three years’. Availability of beds for intensive care: wholly or mainly adult cannot be compared directly with data on critical care beds are compiled on a different basis. ‘Snapshot’ censuses are taken twice yearly using return KH03a. Data published by the Department show that the number of critical care beds rose by 851 from 23,626 on 15 January 2000 to 32,137 on 13 January 2003. As Table 1 shows, the availability of intensive care beds also increased over this period. It is therefore unclear whether the same beds were counted both in the census of critical care beds and also as intensive care beds in the availability of general acute beds, thus simultaneously contributing to the achievement of both targets.

Other beds

In contrast with acute beds, the availability of other categories of hospital bed declined from 1999/2000 to 2003/2004 (Table 1). The numbers of maternity beds declined by 894 while the availability of beds for people with mental illness or learning disabilities declined by larger amounts, as Table 1 shows. In both cases, there were decreases in short-term as well as long stay bed availability and increases in numbers of beds in secure units.

New bed targets for 2008: capacity versus productivity

More ambitious targets for the NHS and social services to meet by 2008 were announced in 2002 in a further document, Delivering...
Table 1 Average number of beds available in England, 1999/2000 and 2003/2004

<table>
<thead>
<tr>
<th>Ward type</th>
<th>1999/00</th>
<th>2003/04</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>General and acute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive care: neonates</td>
<td>1534</td>
<td>1491</td>
<td>−43</td>
</tr>
<tr>
<td>Intensive care: paediatric</td>
<td>282</td>
<td>239</td>
<td>−43</td>
</tr>
<tr>
<td>Intensive care: wholly or mainly adult</td>
<td>2531</td>
<td>3283</td>
<td>752</td>
</tr>
<tr>
<td>Terminally ill/palliative care: wholly or mainly adult</td>
<td>457</td>
<td>386</td>
<td>−71</td>
</tr>
<tr>
<td>Younger physically disabled</td>
<td>1176</td>
<td>914</td>
<td>−262</td>
</tr>
<tr>
<td>Other general and acute: neonates and children</td>
<td>9807</td>
<td>9191</td>
<td>−616</td>
</tr>
<tr>
<td>Other general and acute: elderly: normal care</td>
<td>26243</td>
<td>25957</td>
<td>−686</td>
</tr>
<tr>
<td>Other general and acute: elderly: limited care</td>
<td>1619</td>
<td>1874</td>
<td>255</td>
</tr>
<tr>
<td>Other general and acute: other</td>
<td>91430</td>
<td>94343</td>
<td>2913</td>
</tr>
<tr>
<td>Acute</td>
<td>107217</td>
<td>109846</td>
<td>2629</td>
</tr>
<tr>
<td>Geriatric</td>
<td>27862</td>
<td>27431</td>
<td>−431</td>
</tr>
<tr>
<td>General and acute, all</td>
<td>135079</td>
<td>137277</td>
<td>2198</td>
</tr>
<tr>
<td>Maternity</td>
<td>10203</td>
<td>9309</td>
<td>−894</td>
</tr>
<tr>
<td>Mental illness (excluding residential care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure unit</td>
<td>1882</td>
<td>2557</td>
<td>675</td>
</tr>
<tr>
<td>Short stay</td>
<td>21855</td>
<td>21233</td>
<td>−622</td>
</tr>
<tr>
<td>Long stay</td>
<td>10435</td>
<td>8620</td>
<td>−1815</td>
</tr>
<tr>
<td>Mental illness, all</td>
<td>34172</td>
<td>32410</td>
<td>−1762</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure unit</td>
<td>404</td>
<td>514</td>
<td>110</td>
</tr>
<tr>
<td>Short stay</td>
<td>1628</td>
<td>1440</td>
<td>−188</td>
</tr>
<tr>
<td>Long stay</td>
<td>4802</td>
<td>3258</td>
<td>−1544</td>
</tr>
<tr>
<td>Learning disabilities, all</td>
<td>6834</td>
<td>5212</td>
<td>−1622</td>
</tr>
<tr>
<td>Total for all wards</td>
<td>186290</td>
<td>184207</td>
<td>−2083</td>
</tr>
</tbody>
</table>

Source: Department of Health KH03 returns.

The NHS plan.5 This stated that ‘The extra investment will allow us to plan for an increase in treatment capacity equivalent to over 10000 extra beds’.5 It is unclear to what extent this target would be met through a real expansion in bed availability. The report suggested that increasing the proportion of operations done as day cases to 75% of the total would add the equivalent of an extra 1700 general and acute beds. Added to this would be ‘an additional 42 major hospital schemes mostly delivered through the PFI with 13 more schemes under construction’.5 As PFI hospitals tend to be associated with smaller hospitals than those they replace, it is unclear how they would contribute to expansion.6 An expansion of fast-track Diagnostic and Treatment centres was also mentioned, but many of these were for cataract surgery, which does not require in-patient beds. In addition, many of them would be run by the private sector, so their in-patient beds would not appear in NHS bed availability statistics, even though NHS commissioned use of their beds should be included in the Hospital Episode Statistics.

Monitoring private sector hospitals

Lack of data about private sector care makes it difficult to assess overall trends. Up to 2002, data about private nursing homes, hospitals and clinics in England were collected by the Department of Health as part of the inspection process under the Registered Homes Act 1984, and published in an annual statistical bulletin. The last such bulletin, for 31 March 2001, showed that numbers of beds in general nursing homes had declined from 165836 in 1998 to 144068 in 2001, while beds in mental nursing homes had increased from 28660 to 31944. Numbers of beds in private hospitals and clinics oscillated around 11000 during these years.7

In April 2002, responsibility for regulating private nursing homes and private hospitals, as well as residential homes, passed to the National Care Standards Commission which published a volume of limited data about residential and nursing homes in March 2004.8 Although the Department of Health still collects some data about care commissioned from private hospitals, the Healthcare Commission, which now regulates them, has yet to publish any data about their capacity. This means that data about care commissioned from these hospitals and care commissioned abroad is not related to the institutions’ capacity as it is for the NHS, so that overall supply cannot be measured.

Trends in private hospital capacity

The only source of data about the capacity of private facilities for health and social care is the series of detailed publications produced by Laing and Buisson. Only headline figures appear on Laing and Buisson’s website and the volumes themselves are sold at a substantial cost, as their function is ‘market intelligence’. Figure 2, based on incomplete data from these and other sources, shows that while there was an expansion of capacity in private acute hospitals in the early 1980s, it has since
tailed off. A Laing and Buisson press release suggested that private providers were giving a lukewarm response to the government’s policy of using NHS funds to use surplus capacity in the private sector because ‘there are doubts over whether existing private hospitals will find NHS tariff prices sufficiently attractive’.9

Private sector in-patient care for mental illness

The picture is different for mental illness. The stated aim of running down long-stay hospitals was to replace them by care in the community but it appears that the continuing need for in-patient care was underestimated. In 2004, a Laing and Buisson press release stated that ‘Mental health services continued to be the strongest growth area of independent sector hospital services, increasing by 7% (real terms) in 2003 to be valued at £537 million. An acute lack of NHS provision has led to sustained growth in the sector since the early 1990s, and robust spending on independent sector treatment by NHS agencies has continued to be the market’s main driving force. In 2003, NHS spending accounted for 67% of revenues, followed by privately insured patients (20%) and self-pay patients (13%).’10

Intermediate care beds

The NHS plan included ‘5000 extra intermediate care beds, some in community or cottage hospitals, others in specially designated wards in acute hospitals. Some will be in purpose built new facilities or in redesignated private nursing homes.’ In addition, it promised 1700 extra non-residential intermediate care places.1

The Statistical Supplement to the Chief Executive’s Report to the NHS published in May 2004 included numbers of intermediate care beds from 1999/2000 onwards. Updated data in the Statistical Supplement published in December 2004 showed that the number available daily increased by 4455 from 4242 in 1999/2000, the first year for which data were collected, to 8697 in 2003/2004, suggesting that the target of 5000 beds had nearly been met.2

A number of problems make it hard to interpret data about intermediate care beds.

1. Apart from headline figures in other reports,2,11 data about intermediate care beds are not widely available as they are collected through the system of Local Delivery Plan Reporting by the NHS to the Department of Health. These data are classified as management information for internal use and are therefore not covered by the National Statistics Code of Practice. Neither the data nor their definitions are routinely published, even though they are technically in the public domain. It took a considerable number of phone calls to the Department of Health to identify the relevant officials who then provided the most recent data, for the second quarter of 2004/2005, and the instructions to primary care trusts about how to report numbers of intermediate care beds.

2. The instructions about reporting numbers of intermediate care beds, shown in Box 1, point to the lack of a tight national standard definition. Definitions are imprecise and leave decisions to local discretion. Data for the second quarter of 2004/2005 were returned by 302 of the 303 primary care trusts. Of these, 66 reported fewer than 10 intermediate care beds, while nine reported over 100. Thirty per cent of the 8813 intermediate care beds were in the 26 primary care trusts reporting 70 or more intensive care beds. Such wide differences raise questions about whether
they arise from differences in reporting rather than differences in provision.

(3) The contribution of the private nursing home sector to NHS intermediate care is not identified in the data collected. Data on intermediate care beds were not collected before 1999/2000 although beds for continuing care had been funded by the NHS in private nursing homes. For these reasons, it is unclear to what extent the baseline of 4242 intermediate care beds in 1999/2000 were new or existing beds, and to what extent they were funded by the NHS or through local authorities and means testing. The data about residential and nursing homes published by the National Care Standards Commission in 2004 did not identify NHS intermediate care beds.8 The publication also warned that changes in the regulatory system made direct comparisons with earlier data difficult. As any data collected about private acute hospitals and homes are no longer published, it is not known if they contain intermediate care beds. Since 1991 an increasing amount of NHS long-stay care has been purchased in the independent nursing sector, so this may now be contributing to the count of NHS intermediate care beds.

(4) Ambiguity between NHS-funded and means-tested care makes it difficult to measure NHS provision. The National Beds Inquiry adopted a definition of intermediate care, which implicitly limited NHS services to 6 weeks, ‘a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to longer term residential care.

On the principle of fitting in with capacity planning and SaFFs we need to think in terms of ‘whole time equivalents’. Calculating the bed capacity provided can be done by adding up the beds commissioned, ensuring that they are year round provision. If additional beds are commissioned for 6 months of winter, these can be pro rata for the year,

e.g. 10 permanent beds + 10 extra for 6 months = 15 beds per year

If spot purchasing, then add up the bed days commissioned or calculate the overall capacity with the resource available. Beds provided by Social Services in a Local Authority residential home, with input from dedicated health staff for rehabilitation, are NOT NHS beds unless they are fully commissioned/funded by the NHS. If only the healthcare professionals providing the rehabilitation are funded by health, these do not constitute health beds.'

Source: Department of Health.

The Department collects data about numbers of care home residents supported by local authorities. As Figure 3 shows, their numbers increased after the introduction of community care policies in 1993, but decreased after 2001 in line with more
recent government policies of providing intensive home care.\textsuperscript{11,13} Again, trends are difficult to determine because of changes in definitions and funding streams. The distinction between private and voluntary homes was dropped in 1997.

In the absence of consistent and publicly available data, it is impossible to assess whether the government has met its target for intermediate care beds. It is likely that some existing provision, both NHS and local-authority funded and provided, has been relabelled as intermediate care rather than providing new facilities. To distinguish between these would require a dataset that could separately identify NHS funded and local-authority funded places in the independent sector. The Referrals, Assessments and Packages of Care system is restricted to care purchased or provided by councils with social services responsibilities and has suffered ongoing problems of non-response and poor data quality.\textsuperscript{14}

\textbf{Discussion}

This article focuses solely on the availability and adequacy of data for monitoring preset targets for the availability of NHS beds. It does not attempt to discuss the many other important purposes for which reliable data are needed. These include, for example, assessing whether either target or actual provision meets the needs of the population in the light of changes in clinical practice and the health of the people, planning the provision of services and monitoring equity of access to care.

Even for the limited purpose of monitoring whether targets have been met, the data fall short of what is required. Lack of standardized reporting arrangements for all categories of bed, combined with changes in methods of data collection arising from organizational changes and privatization have led to fragmentation. This makes it difficult to monitor trends over time and the impact of implementing new high profile policies such as intermediate care and the ‘Evercare’ experiment.\textsuperscript{15} While some data and accompanying data definitions are publicly available, others are not. The Statistical Supplement to the May 2005 Chief Executive’s Report to the NHS was published as this article was at the proof stage and showed a further rise in numbers of intensive care beds to 8928 in 2004/2005,\textsuperscript{16} but the question about the data quality remains unanswered.

In summary, there has been no increase in the total number of NHS beds available in England. Increases in some categories are offset by a continuing reduction in numbers of beds available overall since 1999/2000. Although the government’s target for an increase in general and acute beds was met, it has to be set in the context of an overall decrease in this category since it came to power and the continuing decline in overall bed availability, triggered in part by the high costs of private finance in building new hospitals.

The poor quality of the data about intermediate care makes it impossible to assess the extent to which it has been successful in offsetting the impact of this decline. They are inadequate for monitoring national trends and even more so for monitoring differences between primary care trusts. Reductions in bed availability particularly affect certain vulnerable groups of the population, such as people with learning disabilities or mental health needs, older people, and people with chronic illnesses and conditions whose care is transferred from NHS-funded provision into a means-tested system after a set time limit.

Better data are needed to monitor supply and provision of facilities for in-patient care, as well as for many other purposes. Unfortunately the Secretary of State for Health seems to be more concerned with reducing data collection than with ensuring the quality and availability of data.
2004, the Department of Health announced that 61 central items of data would no longer be collected, or would be reduced in size. On a more positive note, it announced the establishment of the Health and Social Care Information Centre and described its role in streamlining data collection and the use of information. The latter is a welcome move, provided that the new Centre launched in April 2005 is given adequate resources and is in a position to ensure greater transparency and public availability of data and adherence to accepted statistical standards. Most crucially, adequate resources are needed to ensure that the data available are adequate for all NHS purposes, rather than being restricted to those needed for performance management in relation to targets.

References