Inspecting Informing Improving

Healthcare Commission

State of Healthcare 2005

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State of Healthcare 2005

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Foreword

Effective healthcare plays a fundamental role in improving a person's overall health and wellbeing, and providing a good quality of life. The Healthcare Commission is committed to helping services to provide effective healthcare, by promoting improvements in the care and treatment that they provide.

Our annual *State of Healthcare* report contributes to this aim by reporting independently about the state of healthcare services in England and, to a lesser degree because of current limitations on the information available, in Wales. It provides us with an opportunity to take a broad view of the state of healthcare – looking at the experiences of different people across different healthcare settings, as well as how services plan and work together to ensure that people receive 'joined up' care.

This year, we have chosen to report the state of healthcare from the point of view of the people who use healthcare services – this mainly refers to patients, but also includes carers and others who use services. We look first at whether people are able to gain access to the healthcare services that they need – whether services are safe, effective and sensitive to their needs. We then look at how well providers inform and involve people in the development and improvement of their services. Finally, we look at whether people are getting a fair deal from healthcare services and the lessons that we can all learn from their experiences.

The report draws on the day to day work of the Healthcare Commission, including investigations, inspections, complaints and the work we have commissioned or carried out in partnership with other organisations, as well as national data relating to Government targets and the findings of major national reviews carried out by other bodies.
The views of patients are also taken into account, through the results of surveys of patients and NHS staff and our recent consultation exercises.
In addition, we commissioned a series of focus groups across England and Wales to find out if people considered the findings of the report clear, credible and relevant to them.

This year's report identifies much that should be celebrated. People are now able to gain access to many healthcare services more quickly and easily than in the past. In England, long waits for hospital care have largely been eliminated and new services, such as NHS Direct and walk-in centres, are proving popular with users.

Other improvements, such as better access to drugs and operations, are helping to produce better outcomes for people with cancer and coronary heart disease.

However, the extent of improvements is less clear in areas of healthcare that are not subject to national targets or regular public scrutiny. Progress in improving the way in which different organisations and different parts of the NHS work together is patchy. The experiences of people from seldom-heard groups are often negative, and moves to give people more control and influence over services still require better support if they are to meet their potential, both in terms of delivering benefits to individuals and the wider NHS, and ensuring we really achieve a patient led NHS in line with the Government's objectives.

Providers of services also need to improve the way in which they implement and learn from examples of good practice. This would go some way to addressing the variations in the effectiveness of care that currently exist.

We expect that our new system for assessing the performance of healthcare services, the annual health check, which we have introduced with effect from April 2005, will help providers to rise to these challenges. We also hope that this report takes us all another step closer to understanding the experiences of people who use healthcare services and that improvements to services will continue with their needs, rather than the needs of those delivering services, in mind.

Professor Sir Ian Kennedy
Chair

Anna Walker CB
Chief Executive

Executive summary

Reception
4 PATIENTS

People who use healthcare services are at the heart of the work undertaken by the Healthcare Commission. This year's *State of Healthcare* report reflects this, painting a picture of the state of healthcare from the point of view of these people. In particular, we explore three key questions:

- do people receive effective healthcare?
- do people have enough control over the care that they receive?
- do some people get a better deal from healthcare than others?

The report largely covers people's experiences of healthcare services in England and, to a lesser degree because of current limitations on the information available, in Wales. Where possible, we also explore people's experiences of healthcare services in the independent sector.

Do people receive effective healthcare services?

In England, the overall satisfaction of patients with most NHS services is high. The focus on waiting times by the Government and healthcare services is beginning to pay off, in spite of growing demands on services.

People are able to gain access to many services more quickly and easily than in the past, with many taking advantage of new ways to receive care and treatment, for example, through NHS Direct and walk-in centres. The number of people waiting more than six months for admission as an inpatient in England is down by 85% from March 2000 to March 2005. There has also been a significant drop in the number of people waiting more than 13 weeks for an appointment as an outpatient – down by 92% over the same period.

There have been improvements in outcomes of care and treatment for people who have coronary heart disease or cancer. Mortality rates for cancer have gradually decreased, even as the number of people being diagnosed with cancer has increased, and fewer people are dying from coronary heart disease. More than 50% of people with a heart attack now receive clot busting drugs within an hour of a call for help, and 84% receive them within 30 minutes of arrival at hospital. In Wales, the target to reduce the amount of time people wait for cardiac surgery from 10 months to eight months is now being met.

While recent figures from the Government show that performance in meeting the 48 hour target for booking appointments with GPs is being met, people in some areas are now finding it increasingly difficult to book appointments in advance or see a GP out of normal working hours. Surveys of patients, carried out in 2004/2005 found that around a quarter of people were waiting more than two days for an appointment and a third of general practices would not book appointments more than two weeks in advance. Many people also experience problems gaining access to NHS dentists, with 58% of dental practices not taking on new NHS patients (up 40% from 2001).

In some areas, however, services still fall short of national standards, particularly in areas of healthcare which are not considered high priority or which are not subject to Government targets.

In mental health, only two thirds of community-based crisis resolution teams operate 24 hours a day and fewer than half of people who receive mental health services reported that they had access to crisis care.

The last major national survey of mental health also found that one in six adults requires some sort of support. Although up to half of these people are seriously ill, only a quarter are receiving treatment for their illness.

More than a quarter of people in urgent need of sexual health services wait more than 48 hours for an appointment, while a quarter of people with symptoms of sexual infection wait more than two weeks to be seen. The opening times of sexual health services was another cause for concern, with half of NHS clinics open for less than 21 hours a week. The Healthcare Commission's investigations have also uncovered significant problems in some maternity services such as poor standards of cleanliness, overcrowding and inadequate support for women whose first language is not English.

For patients, services can still seem fragmented and designed more to suit the needs of those delivering them rather than those using them. While most NHS patients say that they are treated with dignity and respect, around a quarter say that staff talked about them as if they were not there. Many also report problems such as appointments being cancelled and doctors giving unclear answers to questions.

Action to improve the safety of patients is having an impact, but it is not possible to provide a complete and accurate national picture because systems are still too new and information is limited. While it is encouraging that the majority (83%) of NHS staff who see errors say they report them, the number of staff who report errors and accidents remains high. There is still significant scope to improve the way trusts learn from mistakes and adopt good practice in relation to the safety of patients.

Do people have enough control over the care that they receive?

Although the majority of patients feel that they receive enough information about their care and treatment, there is worrying evidence on how they receive information, what information they receive, and whether they are involved in decisions about their care.

Around a third of patients said that they did not understand the results of their diagnostic tests and received conflicting information from different health professionals. Many did not receive information on the possible side effects of their medication and a fifth of patients who received medication when they were discharged from hospital were confused about what the drugs were for.

The outlook was better for people with some conditions. More people using of cancer services now receive printed information when they are diagnosed and a survey by the National Audit Office showed that 80% of outpatients were satisfied with the information they received about their condition and treatment.

Significant improvement is still needed in relation to the level of patient involvement in decisions about healthcare. A major international review comparing health systems in five countries found that the UK ranked lowest for involving patients in primary care. The Healthcare Commission's 2004 survey of patients with coronary heart disease found that most patients who were about to have an operation said they had the risks explained to them.

But far fewer patients (42% undergoing angioplasty and 22% undergoing coronary artery bypass surgery) were told about different treatments that could achieve the same results. Similarly, a survey by Asthma UK found that only half of asthma sufferers had discussed their medication with their doctor or nurse. The information provided to some patients when they leave hospital (such as advice on medication and information on breast feeding for new mothers) is also sometimes poor.

Giving patients more control over when and where they receive care has helped to cut waiting times and is making services more convenient. There is general agreement that people should be more involved in decisions about their care and treatment.

Initiatives such as the Expert Patients Programme are beginning to show how giving people control over their care can benefit the individual as well as the NHS. However, it is still early days. There is not enough reliable information available to patients to allow them to get more involved in decisions about their care, or to help them to make informed choices about where they are treated.

Moves to provide patients with greater choice are proving popular with many people. However, it is also clear that many others want to leave choices about their care to their doctor. For example, there was less support for greater choice among older people, who often prefer to be treated by their local hospital.

We have some concerns that people from more affluent groups are more likely to take advantage of this option, and there is a need for adequate support to help those who are less confident in dealing with healthcare providers, to ensure inequalities in health are not widened.

Do some people get a better deal from healthcare services than others?

Some people do get a better deal from services than others.

Last year's *State of Healthcare* report raised concerns about the distribution of funding across England. The distribution of funding now appears to be more in line with levels of deprivation and there is evidence that extra funding is going to areas with the highest levels of need. Similarly, progress has been made in Wales, where funding is now better matched to healthcare needs.

Patients from some groups within the community are getting a worse deal from healthcare services than others. This was evident among seldom-heard groups, such as travellers, homeless people and people with learning difficulties, and people who live in poorer areas of the community. For example, more than a quarter of homeless people are not registered with a GP, compared with 3% of the population as a whole. The take up and success of immunisation, screening and stop smoking services is also lower in poorer areas. These findings are particularly worrying because people from these groups are also often the people with the greatest need for effective healthcare services.

Concerns remain that the gap between the health status of the rich and poor is widening. A recent examination of information up to 2003 found that the difference in life expectancy between people from the richest and poorest areas of the UK has widened. A review of recent trends in rates of survival from certain cancers revealed a similar finding.

However, there are some encouraging signs. There have been moves by the Government to address inequalities in health status. Disparity in health status is now the subject of a number of national targets, although a major review in 2003 found that Wales was ahead of the rest of the UK in terms of its approach as a result of joint action across policy areas.

New ideas, such as health equity audits, could make a significant contribution to tackling problems of public health. The Healthcare Commission is also playing its part, with the development of a series of improvement reviews targeted at public health and inequalities as part of our new annual health check.

Lessons

This year's *State of Healthcare* report highlights a number of lessons for providers of healthcare and regulatory bodies, such as the Healthcare Commission. In particular, the report identifies the need to:

- improve how services are assessed
- provide better information about services
- involve patients in the design of services
- give people more control
- develop and spread good practice
- take action on wider inequalities of health

Introduction

Healthcare services in England and Wales

Healthcare services in England and Wales are complex and varied. The number and range of organisations involved in the provision of healthcare continues to grow. And as the Government's agenda of greater choice for, and involvement of, patients begins to take shape, the lines between the NHS, independent sector and community-based organisations are becoming increasingly blurred.

There are now more than 300 primary care trusts (PCTs) in England. PCTs plan and manage NHS services locally, either by commissioning services from other organisations or by providing services directly. They have been given a key role in running the NHS and improving the health of people in their local areas. Along with acute trusts, mental health trusts, foundation trusts and other providers of NHS services, they are changing the way the NHS works to ensure that the needs of patients are put first. Strategic health authorities cover larger areas and have a more strategic role in making sure that local NHS organisations are performing well.

In Wales, 22 local health boards are responsible for planning and commissioning healthcare services at a local level. These boards cover exactly the same areas as the 22 local Welsh authorities. This encourages much closer working between the NHS and the local councils, which is important for planning how to tackle long term problems with health.

Independent providers are playing a more central part in the delivery of essential and elective health care. Around 2000 independent providers of healthcare are registered, or are applying for registration, with the Healthcare Commission. This includes acute hospitals, mental health hospitals, treatment centres, private doctors, hospices, cosmetic surgery clinics and a range of other organisations.

About the Healthcare Commission

The Healthcare Commission exists to promote improvement in the quality of healthcare and public health. In England, we have a statutory duty to assess the performance of healthcare organisations, award annual performance ratings for the NHS and coordinate reviews of healthcare with others. Our role in Wales is more limited, the main aspects being national reviews covering England and Wales, and the production of this report.

To do this effectively, we have created an entirely new approach to assessing and reporting on the performance of healthcare organisations. The annual health check will look at a much broader range of issues in assessments, enabling us to focus on what really matters.

The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection. The commission was created under the Health and Social Care (Community Health and Standards) Act 2003. It has a range of new functions and took over some responsibilities from other commissions. It:

- replaces the Commission for Health Improvement (CHI), which ceased to exist on March 31st 2004
- takes over responsibility for independent healthcare previously carried out by the National Care Standards Commission, which also ceased to exist on March 31st 2004
- carries out elements of the Audit Commission's work relating to the efficiency, effectiveness and economy of healthcare

About this report

People who use healthcare services are at the heart of the work of the Healthcare Commission. This year's report paints a picture of the state of healthcare from their point of view. In particular, we explore three key questions:

- do people receive effective healthcare?
- do people have enough control over the care that they receive?
- do some people get a better deal from healthcare than others?

To do this, we draw on the day to day work of the Healthcare Commission – investigations, inspections, complaints, and data and findings from work that we have commissioned or carried out in partnership with other organisations – as well as from many other sources, including:

- the results of the Healthcare Commission's surveys of patients and NHS staff
- national data on waiting times and other key targets and areas of priority
- feedback from users of services, gathered during consultation on the new annual health check in England
- findings of major national reviews by other bodies, such as the National Audit Office

While the majority of the work of the Healthcare Commission covers services in England only, the report includes, when possible, equivalent or similar information on services in Wales. Similarly, coverage of independent healthcare is limited to those issues examined during inspections by the Healthcare Commission.

What do patients and the public want to know about the state of healthcare?

As part of the development of this report, we commissioned a series of focus groups across England and Wales. The main purpose was to find out if people considered the findings of the report clear, credible and relevant to them.

Each group received an early version of the report's key evidence and conclusions. Participants raised a range of concerns and suggestions. In particular, they said that:

- the topics covered by the report were of great importance and concern (particularly in relation to safety and accessibility)
- the overall message of the report was credible and gave a sense of balance ("things in the health service are improving, but there is still some way to go")
- they wanted to see more information on some areas, including services for older people, maternity, primary care and hospital cleanliness
- the sections were balanced overall, although they felt that findings in relation to access did not always reflect their own experiences or what they had heard through the media
- they found it difficult to judge the credibility of the report without knowing more about the sources of information (such as how surveys were run and whether the source was independent from Government)
- they were sceptical about some of the facts and figures in the report and tended to believe the 'bad news' statistics more than the 'good news' statistics
- targets were open to interpretation and were, therefore, not always a reliable reflection of what was happening in healthcare
- they were not interested in reading the full report or a summary, and most expected to hear about it through the media and to be able to access it if they wanted to, for example, via the internet
- the report encouraged greater openness and accountability within the NHS, and people felt they have a right to know about these issues as patients, members of the public and taxpayers
- their main interest was the standard of their local health service

Further information about the findings of the focus group is available on the Healthcare Commission website.

Chapter 1

Do people receive effective healthcare?

DO NOT USE

If healthcare is to be effective, people who use healthcare services need to be satisfied that four key 'building blocks' are in place. They need to be satisfied that:

- they can gain access to the services that they need
- their care and treatment will be provided safely
- they will receive prompt and effective care, including accurate diagnosis, the right medication, treatment, support and aftercare, and be cared for by competent and professional staff
- the care and treatment that they receive will be sensitive to their individual needs – from the basics, such as a clean and pleasant environment, to more complex emotional and cultural needs, such as being treated with dignity and respect

These needs do not exist in separate boxes. They combine to produce the experiences that patients have of healthcare. For example, a patient's condition may deteriorate while waiting for services, or the conditions on a ward once admitted to hospital may not be of an acceptable standard.

Gaining access to services

This section looks at how quickly and easily people can gain access to healthcare. For example, how easy is it to register with a GP or a dentist? How quickly can someone be seen by a mental health service or sexual health clinic? How quickly are people treated if they go to an accident and emergency (A&E) department?

Gaining access to local healthcare

For many people, healthcare is mainly provided in their local community by primary care staff, such as a GP, dentist or midwife. In England, it is estimated that there are more than 300 million contacts between members of the public and primary care staff each year.[3] On average, men visit their GP three times a year, while women average five visits.[4]

Registering with a GP

It appears to be easier to register with a GP in some parts of the country than in others. In the last year, the Healthcare Commission carried out detailed reviews of the work of 25 PCTs in England. While registering with a GP was not a major issue in any of the PCTs that we reviewed, other reports have noted that it is a significant problem in some areas of London, where four out of five general practices are unable to take on new patients.[5]

Making an appointment with a GP

In England, the Government has set two key targets in relation to access to local healthcare: people should be offered an appointment with a GP within 48 hours or with another primary care professional, such as a nurse in a general practice, within 24 hours. Recent figures from the Government show that performance in meeting both of these targets is improving, with nearly all general practices (more than 99.9%) able to offer people an appointment with a GP or primary care professional within the specified timeframe.[3]

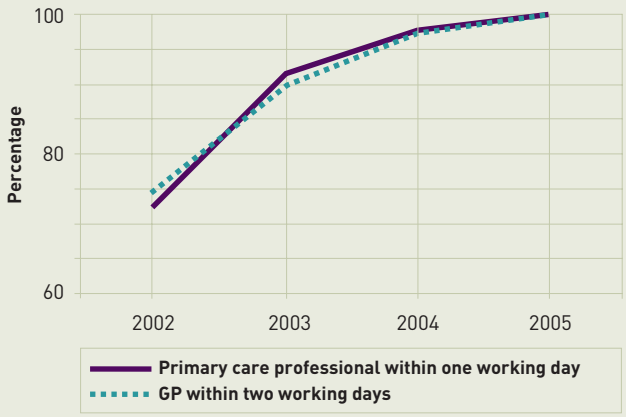
However, findings from other surveys carried out in 2004/2005 show that some people are experiencing problems in gaining access to a GP, for example:

- around a quarter of people said that they waited more than two days for an appointment[6]
- around 11% of people in towns and 17% of people in country areas had problems getting an appointment with their GP[7]
- a third of general practices would not book appointments more than two weeks in advance[8]
- almost a quarter (22%) of people said that they were deterred from going to their general practice because the opening hours were inconvenient (up from 19% in 2003)[6]

In nine of the 25 PCTs we reviewed, people were having problems booking appointments with their GP in advance or out of office hours, with some people having to wait up to three weeks for a routine appointment. Systems to book appointments had improved in seven PCTs through initiatives such as better systems for booking by telephone and greater use of telephone consultations with GPs.

However, a great deal of the work of GPs and other staff involves helping people with long term health problems. For these people, seeing the same professional every time that they need care and treatment may be more important than how quickly they can be seen.

Figure 1. The availability of appointments with GPs and primary care professionals in England

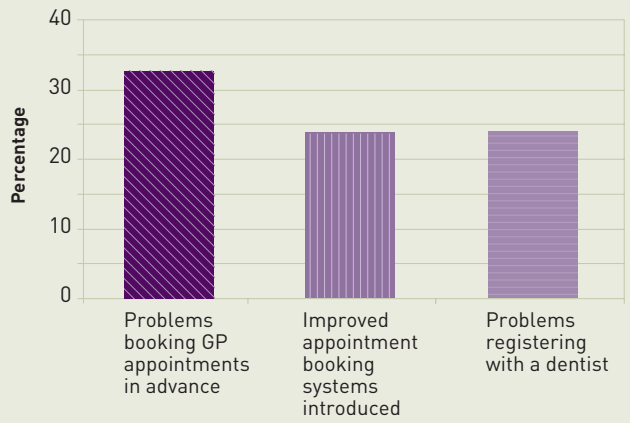


Source: Chief Executive's report to the NHS – Statistical supplement May 2005

Registering with an NHS dentist

There have been reports of people experiencing problems registering with an NHS dentist. In January 2005, a survey by the Consumers' Association, Which?, found that 58% of dental practices were not taking on new NHS patients. This was an increase from 40% in 2001.[9] This was also a cause of concern in just over a quarter of the PCTs that we reviewed. In some areas, we found that no dentists were taking on new NHS patients. These findings were confirmed by a recent survey of patients in which the majority of respondents who were not registered with an NHS dentist said that they would like to be.[6]

Figure 2. Features of clinical governance reviews of PCTs



Source: Healthcare Commission – analysis of 25 clinical governance reviews in 2004/2005

Gaining access to mental health services

GPs provide a great deal of support for people with mental health problems, such as anxiety, depression, work-related stress and phobias. Around a third of consultations with GPs are related to psychological or social problems.[1] However, many people also need access to more specialist support.

Five years ago, the Government published the National Service Framework (NSF) for Mental Health, setting out its plans for ensuring that people with mental health problems in England get the services that they need.

Teams specialising in crisis resolution, assertive outreach and early intervention have been established in local areas to provide additional support in local communities. Latest figures from the Government show that, by March 2005, there were 343 crisis resolution teams, 261 assertive outreach teams and 109 early intervention teams in England. Assertive outreach teams now provide support to 17,500 people each year and, in 2004/2005, crisis resolution teams responded to around 69,000 people, many of whom have mental health problems.

Community-based teams

Crisis resolution teams aim to prevent the need for hospitalisation of adults who have an acute psychiatric crisis. They provide 24 hour community-based treatment until the crisis is resolved.

Assertive outreach teams target adults (aged 18 to 65 years) with severe and enduring mental health problems and additional complex needs, such as homelessness, self-harm or neglect, or high levels of disability. Assertive outreach can achieve better outcomes than standard community care in relation to accommodation, employment and satisfaction of patients.

Early intervention teams provide community-based treatment and support to young people (aged 14 to 35 years) with a first episode of psychosis. This includes ensuring that they continue to be involved in education and work, and that any future prospects are not unnecessarily jeopardised.

Source: Mental health and social exclusion unit, Office of the Deputy Prime Minister [1]

Although the latest figures suggest that access to care for people with mental health problems has improved, some services still fall short of the standards set out in the national service framework. For example, while admissions to hospital have fallen (reflecting in part an increase in the provision of home care), only about two thirds of community-based crisis resolution teams operate 24 hours a day.[10] In addition, fewer than half of people with mental health problems surveyed in 2004 said that they had access to crisis care, such as an out of hours phone number of a mental health professional, when they needed it. In some mental health trusts, the situation was worse, with three quarters of people who needed crisis care saying that they did not receive it.[11]*

* This survey only includes users of mental health services on a care programme approach and excludes those under 16 and over 65 years.

While community-based teams have made it easier for some people to gain access to services, it is still difficult to know how long people are waiting for mental health care. Information on waiting times for mental health care is not collected nationally. And, although the use of non-clinical staff has increased, there are significant vacancies (around 11%) for consultant psychiatrists. This supports reports that people are waiting a long time for appointments with psychiatrists and other mental health professionals.[10, 12, 13]

There is also evidence that many people with mental health problems are not receiving the support that they need. Findings from the last major national survey of mental health show that around one in six adults needed some sort of support. Up to half of these people were seriously ill, but only a quarter were receiving treatment for their illness. For example, only half of the people with depression were receiving treatment, only 8% had seen a psychiatrist and only 3% had seen a psychologist. This is despite strong evidence that both drugs and psychological treatments could provide real benefits to people with mental health problems.[14] Indeed, national guidance for England and Wales recommends that both cognitive behavioural therapy (a type of psychological therapy) and drug treatments are considered for people with depression.[15]

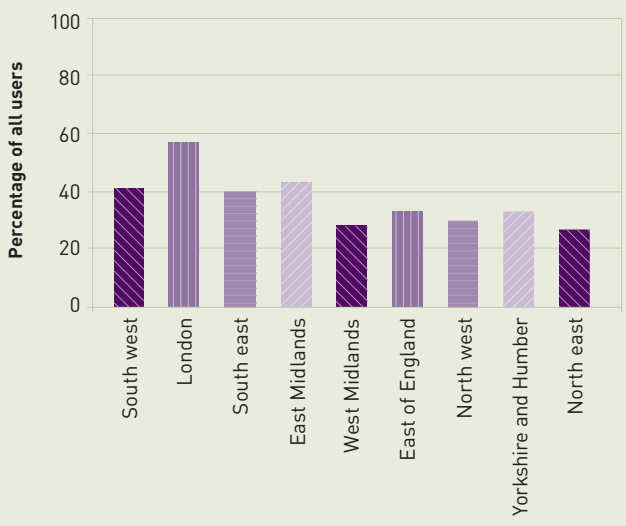
The reasons why people are not getting the services they need are complex. There is a lack of specialist staff and a lack of training for GPs in the assessment and treatment of mental health problems. However, a lack of public understanding of mental health is also likely to be a major contributing factor. Campaigns such as *From Here to Equality*, run by the National Institute for Mental Health in England, are beginning to address this problem.

Gaining access to sexual health services

People are waiting a long time for sexual health services. Twenty-eight per cent of people who need to be seen urgently are currently waiting more than 48 hours for an appointment at a clinic, while 29% of people who have symptoms of sexual infection are waiting more than two weeks.[16] Waiting a long time for services means that people suffer greater pain and discomfort, and also increases the risk that they might infect others. Problems with waiting times for sexual health services are particularly serious in some regions, but slightly better in London than in the rest of England.

Opening times for clinics also cause difficulties for people, with about half of NHS clinics in the UK advertising opening times of less than 21 hours a week.[17] Another UK study also identified problems with contacting clinics by telephone during normal opening times.[18]

Figure 3. Patients seen within 48 hours of contacting a sexual health clinic



Source: Health Protection Agency [16]

Waiting for hospital care in the NHS

Reducing waiting times for care in hospital in England is a key priority of Government. In recent years, there has been considerable investment in increasing the numbers of hospital staff. There are now 30,650 consultants (an increase from 23,320 in 1999) and 58,960 allied health professionals, such as physiotherapists, dieticians and radiographers (up from 47,920 in 1999). The Government has also set targets to cut the number of people waiting long periods for care in inpatient, outpatient and A&E departments.[3]

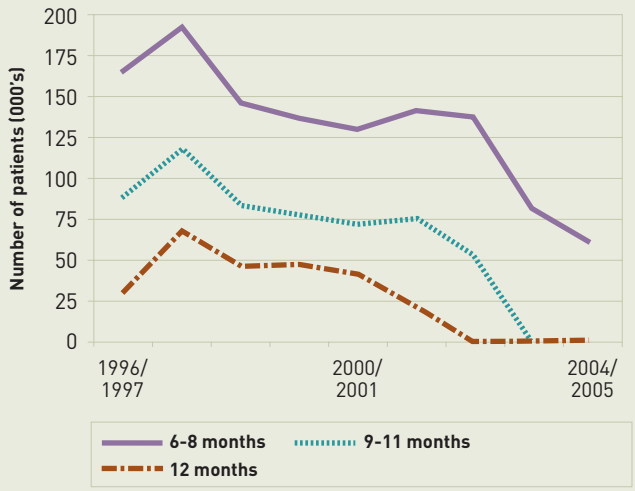
The focus on waiting times, together with the hard work of staff in NHS hospitals, is beginning to pay off. Although demand for hospital services is increasing (with NHS inpatient admissions increasing by 1.4% on average a year and outpatient referrals increasing by 1%) the latest figures from Government show that:

- the number of people waiting more than 13 weeks to be seen as an outpatient has fallen to 30,000, a reduction of 363,000 since 2000
- the number of people waiting more than six months for admission as an inpatient is now 41,000, down by 224,000 since 2000
- the total number of people waiting for admission as an inpatient fell to 822,000, its lowest recorded level (down by 84,000 in the last year and down from a peak of 1.3 million in 1998)

NHS waiting times for treatment of specific conditions are also falling. Latest Government figures show that:

- waiting times for coronary artery bypass grafts and cataract surgery are now less than three months for all patients
- more than 99% of people suspected of having cancer are seen by a specialist within two weeks of referral by their GP

Figure 4. Number of patients waiting for operations in England



Source: Chief Executive's report to the NHS: Statistical supplement May 2005

- more than 97% of women with breast cancer now get their first treatment within one month of diagnosis[3]

However, there is room for further improvement. For example, the Healthcare Commission's recent review of the care of those with coronary heart disease found that some patients were concerned about how long they had to wait for transfer between hospitals. There were average waits of more than two weeks for some procedures.[19] The review also found that there needed to be better access to rehabilitation for people following heart attacks and heart operations. And a survey by the National Audit Office found that 40% of people with cancer said that they were not seen within the recommended two weeks. These long waits were most common for people with cancer of the bowel and prostate.[20]

There continues to be a shortage of specialist staff in some areas, such as allergy services.[21] The National Audit Office also report that some delays in A&E could be linked to a lack of specialist advice on mental health and difficulties in recruiting suitably qualified clinical staff.[22]

Waiting times for hospital care in Wales

There has been less success in cutting waiting times for treatment in hospital for patients in Wales, but recent figures show improvements. In January 2005, the National Audit Office in Wales published a report on waiting times for hospital care. It found that before July 2004:

- about one in 10 people in Wales were on a waiting list
- more than 8,500 people had been waiting longer than 18 months for their first outpatient appointment or for admission as an inpatient or day case, but most patients waited for a much shorter period of time
- the number of people waiting longer than 18 months for admission as an inpatient or day case has fallen since December 2003
- NHS Wales has not consistently achieved targets for waiting times set by the Welsh Assembly Government

The report also found that waiting times in Wales were generally longer than in England, and that this gap was widening.[23]

As at March 2004, 11% of those on a waiting list in Wales were waiting longer than 12 months for inpatient or day case procedures, compared with none in England.

However, these problems are beginning to be addressed. Between December 2004 and March 2005:

- the number of people waiting longer than a year for admission as an inpatient was down from 6,293 to 840 (a reduction of 86.7%) – this includes 737 people who turned down an offer of faster care at an alternative hospital under the Welsh Assembly's 'second offer scheme'
- the number of people waiting longer than 18 months for an outpatient appointment was down from 6,270 to 28 (a reduction of 99.6%)
- the target to reduce the time that patients wait for cardiac surgery from 10 months to eight months was being met in March 2005 (no patients were waiting more than eight months and only 33 were waiting more than six months)

In Wales, there has been less emphasis on targets to reduce waiting times, although a number of targets are now set out in the new framework for planning healthcare services in Wales, *Designed for Life*. This is a 10 year framework to improve health and social care, which sets out plans to strengthen prevention of ill health and reduce waiting times.[24]

Accident and emergency (A&E) services

As with hospital services, improvements for A&E and ambulance services have occurred despite increasing demands on their services. Over the last year, attendances in A&E have increased by around 8% to 17.8 million and calls for ambulances are up 6.8% to 5.3 million.[25]

There is evidence that, while the performance of some services remains a way behind, the gap between the best and the worst performing services is closing. However, we did notice that some groups of patients were waiting longer on average than others, such as those who needed to be admitted to hospital.[25]

Latest figures for A&E services show that more than 98% of patients are seen and treated, or admitted to hospital, within the target time of four hours.[3]

Ambulances are also responding more quickly to calls, with 76% of high priority (category A) calls now being responded to within eight minutes.[3]

Do targets tell us all that we need to know?

Although figures show that the Government's targets are being met by healthcare services and waiting times are being reduced for many patients, they do not tell the whole story about the experience of people waiting for care.

One reason is that some waiting times are not recorded. For example, most targets relating to waiting times do not include the amount of time a person waits for diagnostic tests (such as MRI scans, endoscopy and pathology tests), or for rehabilitation services (such as physiotherapy, occupational therapy, and speech and language therapy).

These services can account for a large part of the total waiting time experienced by patients. Some targets, such as those aimed at reducing the time people wait from referral by GP to hospital treatment, are beginning to address this.

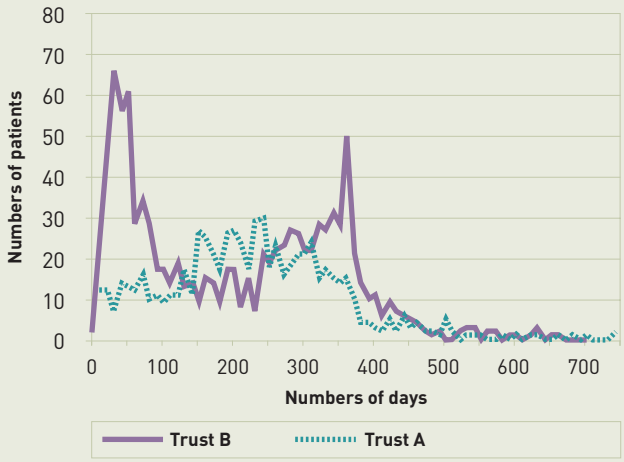
To obtain a better understanding of the experience of the average patient, it is useful to look at average (or median) waiting times. The average waiting time for an outpatient appointment fell from 54 days to 49.5 days between 1999/2000 and 2003/2004, while the average wait for an inpatient admission fell from 88.2 days to 59.5 days between March 2001 and March 2005. These reductions are less dramatic than Government figures suggest. This may explain why people's views about waiting times do not always reflect figures on progress in meeting targets.[26]**

Also, looking only at the performance of healthcare services by reference to targets does not reflect the experiences of different patients in different hospitals. For example, figure 5 contrasts the experiences of patients waiting for hip operations in two similar sized trusts. In trust A, most patients wait between five and nine months for a hip operation. In trust B, experiences are more varied, with some patients waiting less than three months and others waiting a year.

Targets aimed at reducing waiting times benefit people who wait a long time for care. However, the benefits, if any, of such targets for people who are already being treated within the specified time are less clear. For example, the majority of people waiting for hip operations in 2001/2002 were already seen within 12 months.

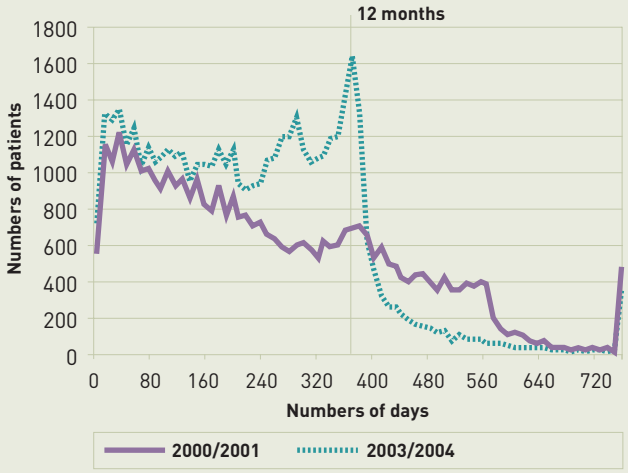
** Measuring average waiting times is not straightforward, and the results obtained depend on the approach used as discussed in a recent edition of Health Statistics Quarterly.[27]

Figure 5. Waiting times for hip replacements in two trusts with volumes of operations 2003/2004



Source: Healthcare Commission's analysis of Hospital Episode Statistic data

Figure 6. Waiting times for hip operations in England: 2000/2001 and 2003/2004



Source: Healthcare Commission's analysis of Hospital Episode Statistic data

Are targets always in the best interests of the patient?

Waiting time targets have clearly played a major role in improving the accessibility of NHS services. One area of concern is that existence of waiting time targets may lead some doctors and other staff to make decisions that are not in the best interest of the patient.

In October 2004, a report by the National Audit Office (NAO) on emergency care highlighted the risks associated with setting a maximum time, rather than an average time, as a target, particularly in relation to creating possible conflicts with clinical judgment. But the National Audit Office has found no information to suggest that patients were being discharged early from hospital or admitted to hospital unnecessarily in order to meet targets.[22]

In a more recent survey of A&E consultants in England by the British Medical Association, 82% reported that there were possible threats to the safety of patients, such as patients being discharged from A&E before they were adequately assessed and stabilised. Again, there is no evidence of this actually occurring. A quarter of respondents also said that non-emergency operations had been cancelled in order to meet targets.[26]

The possibility of targets leading to less optimal decisions for patients clearly needs to be recognised. The issue needs to be monitored but there is currently no evidence to suggest that it is a significant problem.

New ways to gain access to services

There have been major changes in the way in which people gain access to healthcare in recent years. New services, such as NHS Direct, are making access to services more convenient and flexible for patients. More than six million calls were made to NHS Direct in England in 2004/2005. NHS Direct Wales received 446,000 calls in this same period (or 150 calls per 1,000 population, compared with 120 per 1,000 population in England).

There were also more than nine million visitors to the NHS Direct website in 2004/2005, an increase of almost 42% from 2003/2004.[3]

The number of people receiving their care and treatment from places other than a hospital or general practice is increasing, as a result of these and other initiatives.

There have been major changes in community-based services, which were set up to support people who are leaving hospital or who have long term health problems. The number of intermediate care beds (beds for older people who would otherwise have to stay in hospital or move into a care home) continues to rise. There are now 8,928 intermediate care beds in England, up from 7,493 in 2002/2003.[3]

Nurse practitioners are increasingly taking on roles and responsibilities previously fulfilled by GPs, from providing treatments and prescriptions to running clinics. In A&E, emergency nurse practitioners are able to see and treat a wider range of patients, and paramedics now provide more specialised care to patients before they reach A&E.

Community pharmacists also offer services such as dispensing repeat prescriptions and reviews of medicines for people with long term conditions, and provide advice on healthy eating, stopping smoking and regular exercise. In addition, new roles have been created to support people in the community with mental health needs.

Generally, these new services have been well received by the public. Most are used regularly, although some appear to be dealing with needs that were not previously being met, rather than taking pressure off existing services. There are opportunities to improve how these services work within the existing healthcare system by, for example, addressing some confusion about the variety of different providers of emergency care that now exist.[22, 31]

New ways to gain access to services

Walk-in centres

In the last few years, there has been a major expansion in the provision of walk-in centres and minor injuries units. There are 64 NHS walk-in centres across England. Another 25 are due to open this year, including seven run by providers in the independent sector aimed specifically at meeting the needs of commuters. These centres offer people easy access to a range of services, including advice, information and treatment for minor injuries and illnesses. In 2004/2005, walk-in centres received almost 2.1 million visits, up almost half a million from the previous year. Each centre saw 108 people on average each day.[3]

Many trusts have set up minor injuries units to support existing A&E services. These now handle around 20% of all emergency attendances.[25] Independent providers have also set up walk-in centres, and some providers of primary care services have set up similar facilities.

Services in public places

Almost 700 defibrillators (machines to restart people's hearts) are now installed in busy public places, such as rail stations and airports, to help to meet emergency health needs.

This is an innovative new practice, which has already helped to save the lives of dozens of people.

Rapid access chest pain clinics

These clinics have been set up to improve the speed of diagnosis of conditions, such as angina, which enable people to avoid waiting times for outpatient appointments.

Treatment centres

Treatment centres, run by the NHS and independent providers, aim to provide fast access to common treatments and diagnostic tests. Treatment centres have provided care to 122,000 patients since their introduction. There are currently 46 NHS treatment centres schemes in various stages of development. The first independent sector treatment centre was registered in May 2005. A further 23 centres are due to open this year.[3]

Independent hospitals

Independent acute hospitals carried out around 1.1 million procedures in 2004, including an increasing number of diagnostic procedures and treatments for NHS patients.[30]

Safety of care and treatment

Safety in healthcare is concerned with a range of occurrences, including mistakes and delays in diagnosis, medication and treatment, infections acquired in hospitals, accidents, such as falls and slips and assault and harassment.

Concerns about safety range from the activities of Harold Shipman to the spread of MRSA (methicillin resistant Staphylococcus aureus). For patients, the consequences of things going wrong can range from inconvenience, discomfort and delays in discharge, to disability or death. Of course, these consequences can also occur without anything having gone wrong because many clinical decisions involve an element of risk and uncertainty. While it is usually clear when something has gone wrong, it is important to remember that safety is a complex issue in healthcare.

The national picture

The approach of healthcare services to safety has changed considerably since the publication of *An organisation with a memory* by the Department of Health in 2000, which examined how well the NHS was learning from adverse events involving risks to the safety of patients.[33] The term 'adverse events' is often used in healthcare to indicate when something has gone wrong and the safety of patients has been put at risk.

The National Patient Safety Agency (NPSA) was set up to "improve patient safety by reducing the risk of harm through error" in England and Wales. Other agencies, including the Healthcare Commission, have been given the responsibility for investigating and learning from errors, accidents and abuses in healthcare.

Tackling healthcare acquired infection

Infections that people can get as a result of healthcare, such as MRSA, are a major public concern. Guidance on prevention and on how to respond to an outbreak is available to healthcare organisations, and an advice pack has been published by the Department of Health. The Healthcare Commission is also examining how it can support improvements in this area through its new system of assessment. The commission will carry out an improvement review looking at the prevention and control of healthcare associated infections this year.

In September 2004, the Welsh Assembly Government launched *Healthcare Associated Infections – A Strategy for Hospitals in Wales*, aimed at tackling healthcare associated infections in NHS trusts across Wales.[32] Action plans will be produced by all hospitals in Wales in response to the strategy and a number of new initiatives are being introduced, including new packages for training staff in infection control.

It is not possible, however, to provide a complete and accurate national picture of the safety of healthcare across England and Wales. Many of the systems set up to improve safety are relatively new, so that only a limited amount of information is available on their impact. There is not enough information available in important areas, such as the safety of care provided by GPs and private doctors. Even when information is available, inconsistent reporting in the past, both in terms of the extent and manner of reporting, means that it is difficult to identify clear trends.

An increase in reported incidents may simply reflect greater use of reporting systems rather than an actual increase in the number of incidents. Another problem is the use of inconsistent methods to measure safety, in both the NHS and the independent sector. That said, there have been some attempts to estimate the total number of adverse events in the healthcare service. *An Organisation with a Memory* estimated that:

- adverse events occurred in around one in 10 NHS admissions to hospital
- around 400 people die from or are seriously injured in adverse events involving medical devices (such as equipment used in hospitals) each year in the NHS
- around 15% of infections that are caught in NHS hospitals are avoidable [33]

The Healthcare Commission's surveys of NHS staff provides one source of information about safety across the NHS. In the 2004 survey, 44% of staff reported that they had seen at least one error or near miss that could have harmed either staff or patients in the previous month. In 2003, this figure was 47%, indicating that the number of staff witnessing errors or near misses in the past year has decreased slightly.[34]

We also recently published an audit of safety in facilities caring for inpatients with mental health problems and learning disabilities in England and Wales, in conjunction with the Royal College of Psychiatrists. The audit uncovered high levels of violence against staff and those using services. We found that one in three people using services experienced violent or threatening behaviour while in care, ranging from raised voices and verbal aggression to the more rare use of a weapon to threaten or attack.[35]

In general, the picture from the UK is better than in some similar countries. A survey of five countries by the Commonwealth Fund in 2002 asked patients whether they had experienced a medication or other medical error in the last two years. In the UK, 18% of respondents said that they had, compared with between 23% and 28% of respondents in Australia, Canada, New Zealand and the United States.[36]

Information on legal cases handled by the NHS Litigation Authority, which is responsible for handling claims of negligence made against NHS bodies in England, provides another useful resource about safety. The overall number of new claims against the NHS has not increased in the last two years. There continue to be around 6,000 new cases each year.[37] An analysis of these cases highlights a number of common problems. In primary care, these include failures and delays in diagnosis and referral, errors in prescription and the failure to recognise or warn of side effects. In hospitals, common problems include failures and delays in diagnosis, unsatisfactory performance of a procedure, unintended injury during surgery and problems related to the delivery of babies.[38]

While it is not the purpose of this report to provide a full analysis of the safety of healthcare, there are a number of important lessons which can be learned, particularly in relation to the use of examples of good practice in the context of safety.

Learning from good practice

Adverse drug reactions

Adverse drug reactions are unwanted, negative consequences associated with the use of medications. These reactions often result from errors, such as prescribing the wrong drug, or the wrong dose, or not properly following instructions. A recent study estimated that adverse drug reactions accounted for around 6% of admissions to NHS hospitals and could result in serious consequences for patients, including death. The study found that around 70% of adverse drug reactions were avoidable.[39]

Regular reviews of medication, computerised prescribing and more involvement of pharmacists in prescribing can help to reduce the incidence of adverse drug reactions.

Findings from the Healthcare Commission's surveys of patients also highlight ways to improve this aspect of safety. They show that almost a quarter of patients who had been taking prescribed medication for at least a year had not visited their general practice to have their medication reviewed. Surveys also show that many patients (35% of those using NHS mental health services and 18% of GP patients) were not told of the potential side effects of their medication.[6, 11]

Identification of patients

Identification of patients is another area in which safety could be improved by following good practice. Last year's report by the Chief Medical Officer for England found that 10% (and up to 30% in some hospitals) of patients in NHS hospitals did not wear identifying wristbands, increasing the risk of incorrect treatment.[40] Similarly, when the Healthcare Commission reviewed pathology services in the NHS in England and Wales, we found that handwritten requests from GPs for pathology, such as requests for blood tests, were often partially illegible, which could lead to the wrong tests being performed, or results being misplaced.[41]

Reducing risk and learning from adverse events

When things go wrong, it is vital that systems are in place to identify what happened and to prevent the same thing from happening again. For these systems to work, it is also important that healthcare services are open and willing to learn from their own experiences and those of other organisations.

Systems for reporting, investigating and analysing adverse events that affect the safety of patients in trusts are crucial. Nationally, these systems are supported by the NPSA's National Reporting and Learning System, which allows trusts to confidentially report adverse events across England and Wales so that national trends can be identified. The findings from the Healthcare Commission's annual survey of NHS staff suggest that these systems are well used. By December 2004, all NHS trusts were able to report to the National Reporting and Learning System. In 2004, 83% of staff who saw an error said that it had been reported.[34]

The NPSA also provides a system to allow NHS staff to assess the culture of safety and to monitor the implementation of *Being Open*. This project supports NHS staff in communicating effectively with patients and carers who have been involved in an adverse event.

The Medicines and Healthcare Products Regulatory Agency is another organisation with an important role to play in protecting the safety of patients. The agency operates a scheme for reporting adverse events related to medicines and medical devices. In 2004, it received 8,840 reports.

This was a 0.5% increase from 2003 (although this may reflect increased reporting or increased use of the system by pharmacists, for example, who have only recently been allowed to use it). Nine per cent of the incidents reported in 2004 involved death or serious injury. The agency also has the power to take action to protect patients, by changing the design or labelling of a product, changing the way in which staff are trained to use a product, or recalling devices or medicines from use. During 2004, the agency issued 59 alerts to healthcare organisations and recalled 443 products from use.[42]

There is evidence that, as a consequence of these and other developments, action to improve the safety of patients is having an impact. For example:

- a report by England's Chief Medical Officer highlighted progress in the prevention of spinal injection errors[40]
- 98% of trusts now store potassium chloride (which has been administered in error to some patients and can be fatal) only in restricted areas[43]
- a type of breast implant that was found to be potentially dangerous was withdrawn[44]
- guidelines were issued to ensure that patients were marked in a consistent way before surgery to make errors less likely[45]
- improvements to the environment of care, such as the introduction of collapsible curtain rails, helped to reduce the number of inpatient suicides in mental health units from 195 in 2000 to 156 in 2002[10]

Similarly, the use of information technology (IT) to reduce errors in prescribing and manage patients' records more efficiently should help to improve the safety of patients.[46]

Learning from investigations and inquiries

National investigations and inquiries also play an important role in reducing threats to the safety of patients. Several national inquiries were carried out last year, including the final stages of the Shipman Inquiry and an inquiry into deaths in intensive care. These highlighted a range of factors related to the safety of patients, such as the way in which clinicians are registered, levels of staffing and procedures in intensive care units. In response to one of the recommendations in the fourth report of the Shipman inquiry, the Healthcare Commission was asked by the Government to ensure that all healthcare organisations in England have satisfactory arrangements in place for the safe use of controlled drugs. This new responsibility will take effect from April 2006.

Harold Shipman inquiry

Harold Shipman was a British GP who was convicted of murdering 15 patients in 2000. He had a personal history of misusing prescription drugs and murdered his patients mostly by injecting them with morphine.

An independent public inquiry made several recommendations following his conviction, aimed at improving the safety of patients. These include better systems for the management of controlled drugs (such as morphine), improvements in how death certificates are issued and changes to the way in which GPs are investigated when suspicions about their activities arise.

An important part of the Healthcare Commission's role is to carry out local investigations in response to allegations of serious failings in the NHS. Since November 2000, 15 reports of investigations have been published. Twelve were carried out by the CHI and three were conducted by the Healthcare Commission. These highlight a range of ways in which services could be made safer and more effective.

Learning from investigations carried out by the Healthcare Commission

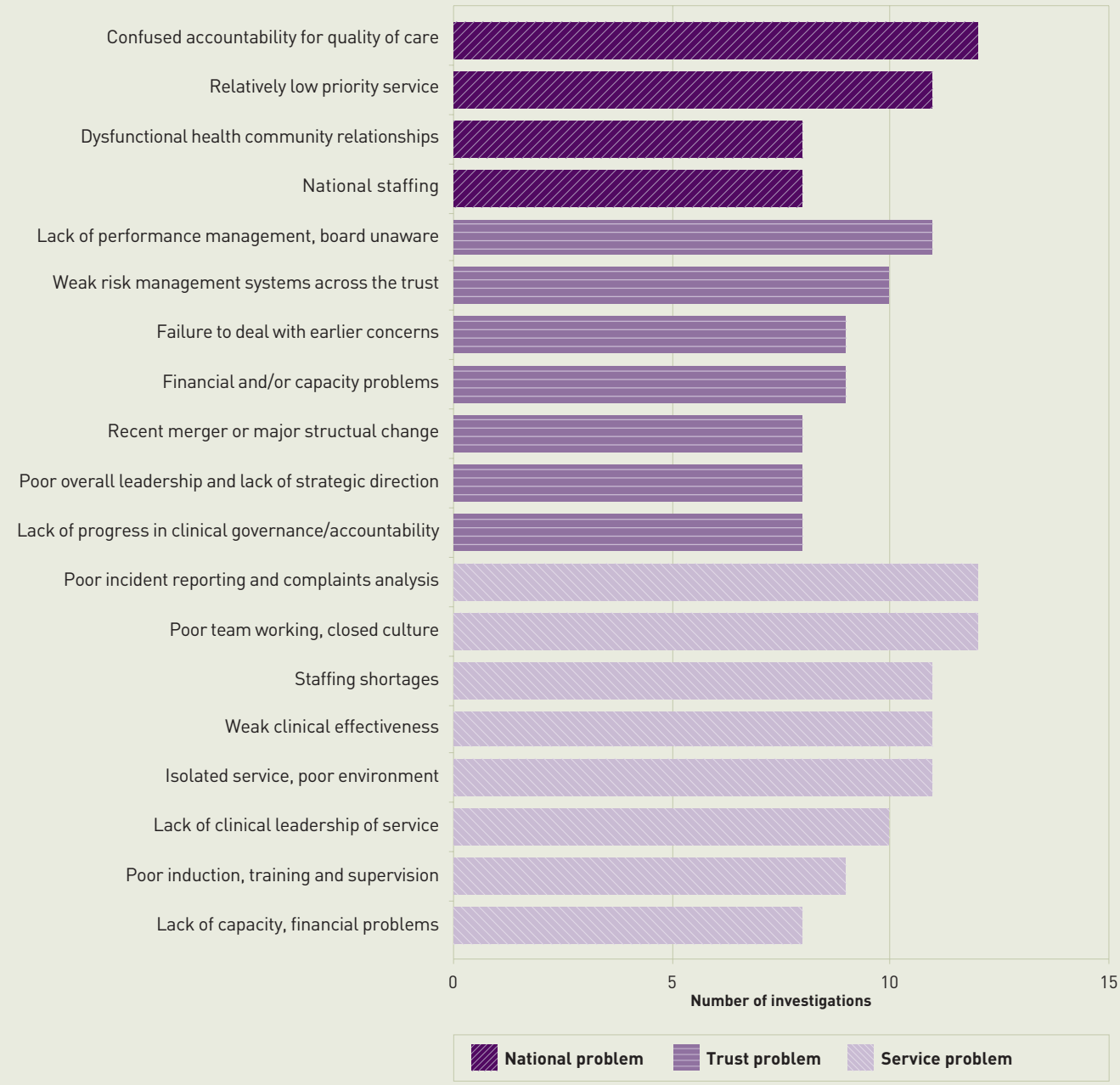
Investigations by the Healthcare Commission are often triggered by concerns about the safety of patients. Recent investigations have found evidence of:

- unexpected deaths following surgery, use of out of date equipment, long waits for treatment, and a lack of privacy and dignity for patients
- poor maternity care (with high levels of complications and medical errors), poor compliance with national guidelines, and particular concerns about the experiences of women from ethnic minority backgrounds and from areas of high deprivation

An action plan, agreed between the Healthcare Commission and the healthcare service in question, is produced at the end of each investigation with a focus on improving services. The Healthcare Commission then monitors the implementation of the action plan and has the power to intervene further if necessary.

Our investigations have highlighted the underlying reasons for failings in healthcare, including the way in which individual services are run, poor leadership and management, and how services are managed and funded at a national level.

Figure 7. Key features of the NHS investigations in England from 2000-2005



Source: Commission for Health Improvement: Lessons from CHI investigations (analysis updated by the Healthcare Commission)[47]

One of the key lessons for healthcare services is that failures most often occur in services that receive relatively little local or national attention by way of, for example, national targets. This is underlined by the high levels of investigations into maternity and mental health services, particularly mental health services for older people.

These lessons will inform the Healthcare Commission's new annual health check, helping to ensure that potential problems are identified early, before the safety and care of patients is compromised.

The Healthcare Commission also has an important role in ensuring the safe and effective operation of independent healthcare services through registration and inspection. We conduct annual inspections of registered independent providers to ensure that they continue to meet the standards required by the Care Standards Act 2000, including requirements directly related to the safety of patients such as the decontamination of reusable medical devices. All of our reports of inspections, including any recommendations and requirements placed on an organisation, are available on the Healthcare Commission's website.

If a provider is found not to be meeting the necessary requirements, we will take action to ensure compliance. We will also take action against those operating without the required registration.

Overall, our assessments of the facilities of independent healthcare providers have found that compliance with national minimum standards has generally improved. However, some independent acute hospitals need to improve decontamination procedures, arrangements for medical staffing, and processes for monitoring the quality and reporting of errors and accidents.

Some independent providers of mental health care need to improve their systems for carrying out criminal record checks on staff, implementing national clinical guidance and protecting children. They also need to improve how they use individual care programmes, and provide clarity on arrangements for the accountability of patients detained under the Mental Health Act 1983.

Learning from the inspection of providers of independent healthcare

In 2004, the Healthcare Commission was made aware of the possible illegal operation of four private slimming clinics in Salford, Stoke on Trent and St Helens. Despite repeated warnings to cease operation because they were not registered, the clinics continued to provide services. Their actions were considered to pose a risk to the health and safety of patients. Particular concerns were raised about the activities of one doctor who had been suspended from the General Medical Council register in 2003 in relation to the prescription of medicines used in the management of obesity. We were also concerned that a member of staff had been convicted of assault following an incident in a beauty clinic.

Officials from the Healthcare Commission found that:

- the clinics were operating without the necessary registration
- drugs controlled under the Misuse of Drugs Act 1971 (which are subject to the most stringent controls) and the Medicines Act 1968 were being handled, prescribed and sold to patients visiting the clinics, in contravention of these Acts and the Care Standards Act 2000
- there were inadequate arrangements to assess the suitability of patients who were being prescribed medication and to provide continuing care, as well as evidence that medication had been provided to patients for whom it was unsafe
- the care of patients was not in accordance with recognised national guidance on the management of obesity

Legal action was taken in order to protect the safety of patients. The Healthcare Commission obtained a permanent injunction to prevent the four clinics from operating. The clinics have now closed, and some other slimming clinics have ceased to operate until their applications for registration have been dealt with. This action has also helped to raise awareness of the need for providers to be registered, as well as of the importance of measures to protect the safety of patients in slimming clinics.

Effectiveness of care and treatment

Once the building blocks of good access and safe services are in place, people need to be confident that healthcare services are operating effectively. This means that patients are diagnosed promptly and accurately, their care and treatment are of a high standard, and the outcome is the best that it could be. It also means that people's psychological wellbeing is addressed, as well as their physical health.

Effective healthcare can help people to recover from medical conditions or cope with conditions that cannot be cured. However, what counts as a successful outcome depends on the individual situation of each person. For example, it could mean a full recovery, protection from a disease through immunisation, or management of a long term condition which minimises the risk of complications and provides the best possible overall health and quality of life.

Can we measure effectiveness?

Measuring whether healthcare is effective is not straightforward. It is difficult to gain an overall picture of the effectiveness of care across all healthcare services. We do know that life expectancy is increasing in England and Wales, and it is likely that improvements in healthcare have played some part in this.

It is difficult to measure the outcomes of care, such as quality of life. But, it is also difficult to assess the extent to which a person's lifestyle affects their health. For example, prospects of the patients recovering from heart surgery will depend on whether they smoke, whether they are obese and how much stress they are under.

One way of measuring effectiveness is to compare the quality of care delivered by a particular organisation with relevant national standards. Many national standards or guidelines identify which care and treatment will achieve the best possible outcome for patients. National standards also help to raise overall standards of care in the healthcare service and overcome differences in the quality of care that patients receive.

National standards and guidelines are set out in the national service frameworks, which have been developed by the Department of Health in England and by the Welsh Assembly Government in Wales. Assessments and guidelines have also been produced by the National Institute for Health and Clinical Excellence (NICE) and the royal colleges.

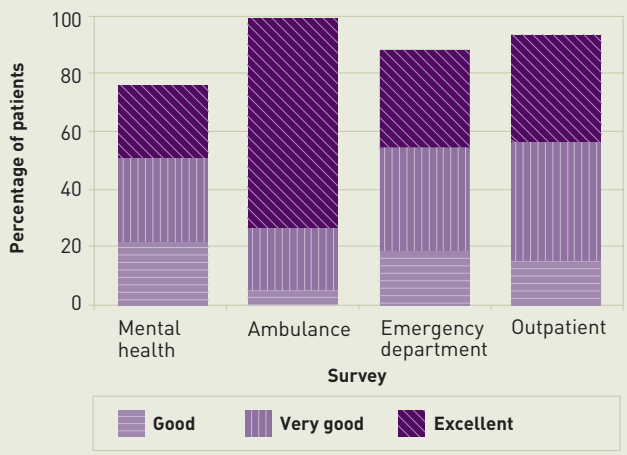
Overall effectiveness of care

Overall, the satisfaction of patients with most NHS services is high. However, when we look at a particular aspect of care, the level of satisfaction varies. For example, 31% of young people in hospital, 44% of people attending A&E and 23% of those using dentists think that more could have been done to manage their pain.[48, 49, 6]

A recent evaluation of the impact of NICE guidance on the use of 28 drugs and devices found that the guidance had been implemented reasonably in 12 instances, had been over-implemented in four instances and under-implemented in 12. Common reasons for under-implementation include a lack of resources, lack of professional support and poor local systems to implement such changes.[50]

There has also been a steady and continued general increase in the volume and cost of drugs being prescribed. In 2004, more than 685 million prescriptions were issued in England, an increase of 5.9% from 2003, at a total cost of £8 billion, an increase of 7.6%.[3]

Figure 8. Patients' rating of their overall care in England



Note: This chart summarises the findings of surveys of patients in different settings. It is not intended to directly compare the results of these different settings as they reflect different types of experiences and different groups of patients

Source: Healthcare Commission – national surveys of NHS patients in England 2004/2005

In order to get a more accurate picture, we examined the effectiveness of care of people with particular conditions. For example:

- more people who had a stroke are cared for in specialist stroke units – findings from clinical audits and a recent survey of stroke patients show that patients treated in these units generally receive a better quality of care, and are more positive about their care and treatment[56]
- there has been some progress towards the target for cutting tooth decay in children, although there is still a way to go before the target of no tooth decay in at least 70% of children under five years is achieved[52]
- improved access to operations for older people – an increased number of hip replacements, knee replacements and cataract operations were carried out, and there was an increase in the average age of people who receive coronary artery bypass grafts (heart bypass operations)[53]

Cancer

Improving the care and outcomes for people who have cancer is a priority for the Government, and the latest studies show some positive trends.

Mortality rates, that is, the number of people who die of the disease, have gradually decreased over many years, despite an increase in the number of cases being diagnosed. The reasons for this are complex, and include changes in behaviour, such as an increase in the number of people who stop smoking, as well as improvements in the quality of treatment for some cancers.

A recent report by the National Audit Office highlights improvements in gaining access to drugs and in the way in which the different services for people who have cancer work together. However, the report also found that there is some way to go before performance in this area catches up with some other countries, particularly in terms of early diagnosis and access to chemotherapy and radiotherapy.[51, 54]

There is also evidence of improvements in screening of breast cancer, with three quarters of women aged 53 to 64 years attending screening services for breast cancer during 2004 (although take up in some areas was less than 50%).[55]

Coronary heart disease

The latest update on the impact of the National Service Framework (NSF) for Coronary Heart Disease notes that fewer people are dying from the disease. Changes in lifestyle and improvements in treatment have played a key role in this area.

People who experience a heart attack have quicker access to clot busting drugs. More than half (54%) now receive clot busting drugs within one hour of a call for help, and 84% of people receive them within 30 minutes of arrival at hospital. Gaining access to other drugs has also improved. The use of antihypertensives (drugs that control high blood pressure) and statins (drugs which reduce the risk of heart attacks in high risk groups) went up by 14% and 30% respectively from 2003/2004.[3] It is estimated that statins saved around 9,000 lives in 2004.[53]

That said, the Healthcare Commission's recent review of the implementation of the NSF for Coronary Heart Disease highlights a number of areas in which further improvements were required. In particular, the review calls for better treatment and care of people with heart failure (an area to be covered by an improvement review carried out by the Healthcare Commission in 2005) and better access to diagnostic tests and rehabilitation services. It also highlights the need for more action to prevent coronary heart disease, for example, by targeting high levels of smoking and obesity in key groups.[19]

Mental health

Reducing the number of suicides in England is a key priority for the NSF for Mental Health. There are positive signs that the focus is paying off. Suicide rates are falling, including among young men, who are a high risk group.

The latest report on the impact of the NSF for Mental Health calls for further improvements to inpatient and specialist mental health services. But, it also highlights the need to pay more attention to mental health care in the community and raises concerns over access to treatment, variations in the availability of drugs, and the possible over-use of certain drugs.[10]

A sensitive approach to mental health care

Providers of mental health care need to be sensitive to the different ways in which communities and cultural groups approach mental health problems. Last year's *State of Healthcare* report found that people from some black and minority ethnic communities were more likely to be detained under the Mental Health Act 1983. To get a better understanding of this issue, a census of all people in NHS and private mental health care in England and Wales was carried out by the Mental Health Act Commission, in partnership with the National Institute for Mental Health in England and the Healthcare Commission. A survey to complement this data will be conducted to find out what people from different ethnic groups think of mental health care. The Healthcare Commission will publish the results in 2005.

Many mental health problems are successfully dealt with in primary care, but some studies have questioned whether best use is made of drugs and other treatments, such as psychotherapy.[14, 1, 65]

Cosmetic surgery

A major review of cosmetic surgery in private hospitals by the Healthcare Commission in 2004 found extremely high levels of compliance with standards. However, the report did recommend a number of actions aimed at further improving care and ensuring the safety and quality of this service for patients. As a result, the Government is expected to announce that a wider range of providers, such as those that carry out Botox injections, will be required to be registered with the Healthcare Commission.

Variations in care

The introduction of standards and guidelines should help to reduce the gap between people who receive the best care and treatment and those who are missing out. However, it is clear that the NHS needs to implement these standards and guidelines more consistently.

The National Sentinel Audit of Stroke in 2004, commissioned by the Healthcare Commission and published by the Royal College of Physicians, revealed that many stroke patients were still not being treated in specialist stroke units, even though more hospitals in England now have them. The audit also found that levels of staffing and skill varied widely between units, as did the way in which patients were treated. For example, 37% of patients were not assessed on their ability to swallow food properly (varying from 11% to 100% between units) and 41% had not received a brain scan within the recommended time (varying from 12% to 100% between units).[56]

Early results from the National Diabetes Audit, which is currently being rolled out across England, also show that basic clinical standards vary widely between PCTs. The records of more than 200,000 people with diabetes show that recommended blood tests are only carried out in around 25% of cases. This means that some people will not know if they are at greater risk of developing complications, such as blindness and heart disease.[57]

Similarly, a recent report of the Health Select Committee highlights low awareness in trusts of the need for assessment of the risk of blood clots (which has accounted for an estimated 25,000 deaths). For example, four in 10 orthopaedic patients are not receiving treatment to prevent blood clots.[58] High levels of variations in care have also been discovered by the work of the Healthcare Commission's acute hospital portfolio reviews.

These findings are echoed in the results of clinical governance reviews carried out in England and Wales over the last four years. An analysis of these reviews shows that most trusts did not have effective systems in place to check if, or how well, they were implementing clinical guidelines.

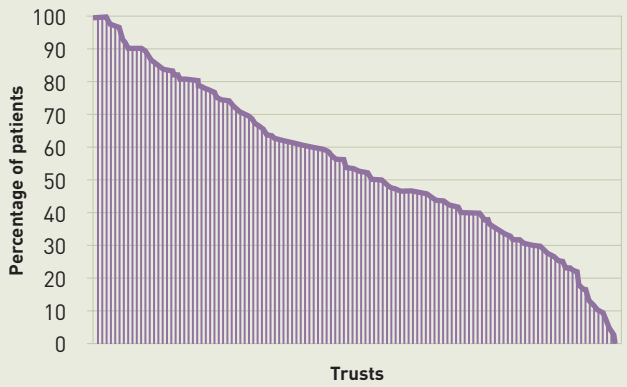
Learning from the acute hospital portfolio

The acute hospital portfolio is a collection of reviews carried out by the Healthcare Commission in England, covering key areas of service, resources or matters that are of concern to the managers of trusts and patients. Independent auditors assess the performance of the trust using local and national information and taking account of local circumstances. When they need to, they also provide an action plan for improvement.

In 2004, reviews were conducted of day surgery, ward staffing and A&E services. The findings of these reviews highlighted opportunities to provide more operations in day surgery units, the under-use of day surgery theatres, and links between the satisfaction of patients and how trusts managed ward staff.

Using a set of standards developed by the British Association of Emergency Medicine, the A&E review looked at whether best practice was being followed in relation to medication for children's pain, treatment for hip fracture, and what was done for patients who took an overdose of paracetamol. There were significant variations between trusts for many aspects of care, including a wide variation in the proportion of children who received medication to manage their pain within 60 minutes of arriving in A&E.

Figure 9. Percentage of children in pain receiving analgesia within 60 minutes of arrival in England



Source: Healthcare Commission's analysis of acute hospital portfolio reviews

Coordination of services

Clearly, clinical aspects of care influence effectiveness. However, the way in which different services work together also impacts on patients. For example, when staff from different departments in a hospital work together to coordinate the care of patients with cancer or when hospitals and social services work together to manage the discharge of patients into the community.

The coordination of services is important to people who use services. In a recent consultation exercise carried out by the Healthcare Commission, people with mental health needs commented on the importance of organisations, working in partnership with each other, particularly in addressing physical and psychological needs, providing support to the whole family, and supporting the transition from children's services to adult's services.

Better coordination between services is also necessary to meet some Government targets, such as waiting times from referral by a GP to the start of treatment, and the fast delivery of clot busting drugs, which requires coordination between ambulance services and A&E departments.

There have been some improvements in the coordination of A&E services. However, a report by the National Audit Office concluded that further improvements would depend on the way in which entire hospitals and other providers of health and social care work together.[22]

Coordination of mental health services

Mental health services are usually required to work in partnership with a wide range of other healthcare services. As a result, most already have systems for coordinating and planning services with other primary care services and local councils.[63]

However, recent studies have identified opportunities for improving how they work with other organisations. For example, a series of reviews of the work of youth offending teams in England and Wales found problems in the coordination of care for young people who were leaving prison, and in the provision of services for young people as they get older and start to use adult services. Studies also highlight the need for better coordination of services for people who need care for mental health and substance misuse, or people who need care for physical and mental health problems.[10, 64, 65]

The Healthcare Commission's survey of those who use mental health services found that many people received limited advice on matters such as benefits and housing. The majority of respondents (79%) were not in paid employment, while just over half (53%) of those who felt that they needed help to find work said that they did not receive help but would have liked some.

Coordination of care for older people

Good coordination of care between health and social services plays a key role in improving care for older people. The latest update on the progress of the NSF for Older People reports that there is now better coordination of services for older people who have had a stroke, but more work is still needed in areas such as mental health and continence. The introduction of single assessments of the needs of older people, covering both health and social care, should also help to ensure that these services are better coordinated.[61]

The number of delayed discharges from hospital of older people has decreased. In 2003/2004, 46 out of 100,000 discharges of people over 65 years were delayed because the right services were not available in the community, compared with 57 in the previous year.[61]

However, the management of discharge is still a cause for concern. A report by the Commission for Social Care Inspection found that the number of older people admitted directly from hospital into care homes was greater in some areas (one in three) than in other areas (one in 25), with some people being admitted to care homes when they could have been supported in their own homes. The report also found wide variations (from 8% to 50%) in the number of patients being readmitted to hospital within three months of being sent home, possibly indicating that some patients are discharged before adequate support is in place.[62]

Learning from reviews: Whole system review of services for older people

The Healthcare Commission has been working, in partnership with the Commission for Social Care Inspection and the Audit Commission, to develop a programme of reviews of services for older people with reference to the NSF for Older People.

The programme involved interviews, group discussions and public meetings with around 2,000 older people. Concerns raised about their experiences of healthcare included frustration with systems that did not allow people to book appointments with GPs in advance, difficulty in gaining access to dental or chiropody services, and the need for information that was easier to understand. However, there were some positive messages about new ways to gain access to healthcare, particularly NHS Direct, and improvements in the provision of information.

The coordination and integration of services was a key theme throughout. While figures showed that there were improvements, many older people were still concerned about the lack of coordination of services from diagnosis to discharge.

"After the diagnosis of Alzheimer's it was three months before anyone made contact with us."

"People are being discharged home from hospital too soon. I was sent home in a taxi when I thought I would be going in an ambulance. I had no care and no support, despite the fact that my legs were awfully swollen. I went home to an empty flat."

Coordination of services in Wales

The Social Services Inspectorate for Wales reports that assessment of the coordination of care between the health and social services is in the early stages of development in most healthcare organisations and local authorities. It also reports that patients experience more problems relating to ineffective coordination of services within hospitals, and between hospitals and GPs. Fewer problems arise between hospitals and social services departments.[59]

The impact of health promotion

Healthcare services targeted at improving the health of the population through promotion of health and prevention of disease are beginning to show some signs of success.

Around 71% of people aged over 65 were immunised against flu last winter, a slight increase on the previous year. The number of people who stopped smoking four weeks after using a 'stop smoking' service has also increased. More than 200,000 people were reported to have stopped smoking in 2003/2004 (up 65% from the previous year). However, the rate of success drops significantly when measured at 52 weeks.[19, 3]

Sensitivity to people's rights and needs

Previous sections have focused on the healthcare that people receive: when they get it, how safe it is and whether it is effective. Here, we look at where and how care is provided, particularly in relation to whether care is sensitive to people's rights and needs.

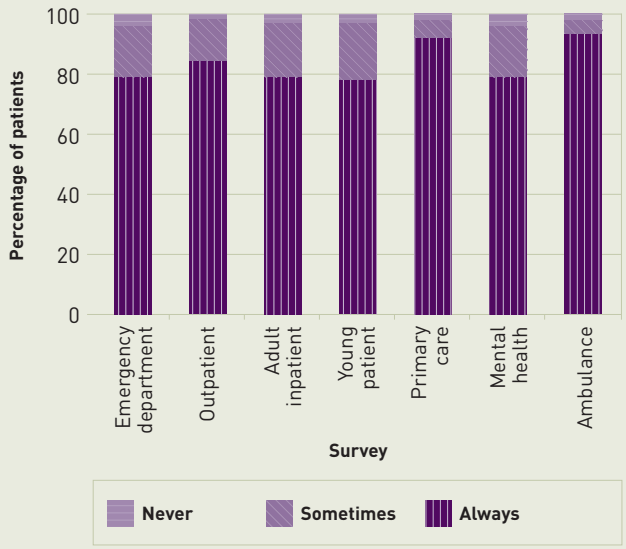
Many of the issues we discuss relate to people's basic human rights, as set out in the Human Rights Act 1998, such as privacy and confidentiality, access to facilities for education or prayer, and freedom from degrading or discriminatory treatment.

Sensitivity in dealing with patients

A study of the views of patients indicates that being treated with dignity and respect is an important factor that affects their overall satisfaction with the care they received.[66] Most of the people surveyed by the Healthcare Commission reported that they felt that they were treated with dignity and respect. However, the findings from other surveys show that some patients have experienced poor standards of care in this respect:

- 14% of patients in PCTs reported that they had some problems with the receptionist's manner, while 12% of A&E patients rated the receptionist's manner as fair, poor or very poor
- between 12% and 28% of patients (depending on the type of trust) reported that staff talked about them as if they were not there
- 21% of outpatients and 26% of A&E patients said that doctors did not always listen carefully to what they were saying
- 9% of inpatients reported that were not given enough privacy while discussing their treatment

Figure 10. The views of NHS patients in England – were you treated with dignity and respect?



Source: Healthcare Commission – national surveys of NHS patients 2004/2005

In a recent survey, cancer patients rated their treatment by staff highly, with 94% saying that staff treated them with sensitivity when they received their diagnosis. In addition, 90% of patients with religious beliefs felt that their beliefs were taken into account by hospital staff.[20] A recently published report on arrangements to safeguard children noted that the way healthcare services communicated treatment and care plans to children had improved significantly.[67]

However, there are signs that communication skills in general need to improve. Surveys of inpatients, outpatients and those using primary care services showed that only two thirds felt that doctors and nurses answered their questions in a way that they could understand.***

A study in the British Medical Journal, which looked at how doctors discussed treatment options with patients who had life threatening illnesses, also found that doctors tended to focus on technical issues rather than discussing issues more important to the patient, such as their fears or what day to day activities they would and would not be able to do.[68]

People detained under the mental health act

Treating people with dignity and respecting people's rights is particularly important for people detained under the Mental Health Act (1983), primarily because they are not allowed to leave.

The Mental Health Act Commission, the body that safeguards the interests of patients who are detained under the Act in England and Wales, has raised concerns about:

- the vulnerability of children admitted to establishments for adults
- the safety of women, particularly those detained in facilities predominantly for males
- patients being unable to use therapeutic and recreational facilities on many wards
- the use of seclusion and restraint[69]

A recent survey found that only 43% of respondents who were detained under the Mental Health Act in the last 12 months felt that their rights had been explained completely. A further 32% said that they had been explained to some extent, and 25% reported that their rights had not be explained to them at all.[11 †]

*** PCT survey 2004 – 76%, outpatient survey 2004/2005 – 69%, inpatient survey 2004 - 68%.

† This was a survey of users of community mental health services: 8% of respondents had been detained under the Mental Health Act in the previous 12 months.

Sensitivity to individual needs

Most of the subjects covered so far are about people's experiences, where needs and expectations are broadly the same for most people. However, it is also important that healthcare services are able to deal effectively with people who have different or particular needs, such as:

- physical or learning disabilities
- not speaking English
- preferences based on faith or culture
- belonging to different age groups

Communicating with people with disabilities
Healthcare services need to communicate with a wide range of people with different needs, including people with disabilities.

A report by Mencap in 2004, *Treat Me Right*, highlighted some of the negative experiences of people with learning disabilities in the NHS. These included appointments that were too short to allow treatments to be explained effectively and clinicians who failed to see beyond the learning disability to treat individual needs. Another recent report found that doctors sometimes missed important symptoms because they assume they are related to a patient's learning disability.[71]

Mencap also reported that 75% of GPs involved in the survey said that they were not trained in the needs of people with learning disabilities, and 70% did not provide information in a suitable form.[70]

In Wales, 87% of general practices did not have procedures for booking sign language interpreters and 96% did not have a hearing loop (which can help to pick up sound in conjunction with a hearing aid).[72]

There is also evidence that people with hearing problems and with needs for mental health care often come away from appointments with very little of the advice they need.

When we asked people with learning disabilities about their experiences, problems of communication were again highlighted. Some people reported that clinicians talked too fast, or talked to carers instead of patients.

Language, faith and culture
It can be difficult for people whose first language is not English to find their way around healthcare services. Needs and preferences arising from faith and culture can also affect people's experiences of healthcare.

Market research company, MORI found a strong relationship between the ethnic diversity of a local population (a measure of how ethnically mixed the population is) and the satisfaction of patients with their local healthcare services. This link suggests that trusts with multi-ethnic communities find it difficult to cater for the diverse needs of their population, such as language and cultural needs.[66]

Until recently, there was little training in cultural diversity in the curriculum of medical schools. However, a survey carried out in the UK in 2003 showed that 72% of medical schools now provide some formal teaching about cultural diversity. While this is an improvement, it still compares unfavourably to other countries such as the United States, although it is better than in Canada.[73]

Investigations carried out by the Healthcare Commission highlight particular concerns about the ability of maternity services to meet the needs of different groups of people.

Women's experiences of maternity services

To date, the Healthcare Commission and CHI have carried out three investigations of serious failings in maternity services. As part of these investigations, we interviewed and surveyed a wide range of women using services. While many rate the quality of their care highly, they did highlight some areas of concern including:

- not enough time for doctors and midwives to properly explain what was happening
- inadequate information and support for women and their families, whose first language was not English, as well as a lack of cultural understanding among staff
- overcrowding and poor standards of cleanliness, particularly in toilets and bathroom areas, in some wards (more than a quarter of women in one trust said the ward was not clean enough)
- the quality of food (in one trust, only 40% rated the food as good or very good)
- lack of advice and support on issues such as feeding and bathing, handling, settling and looking after the health and recover of the baby as well as that of the mother (at one trust, 15% of women received no such information while in hospital)
- delays caused by faulty equipment
- lack of information and insufficient support for bereaved families

These findings are supported by a recent survey by the National Childbirth Trust, which also highlighted how some facilities did not meet the needs of women. Fifty eight per cent of women said the environment was too clinical and 49% said that they had no control over who came into the room.

Similar concerns were reported by the Maternity Alliance when it looked at maternity services for Muslim women, particularly in relation to the provision of space for prayer and the reliance on family members, for example, to provide appropriate food or act as interpreters.[76]

A recent audit published by the Healthcare Commission and the Royal College of Psychiatrists found that 12% of people using mental health and learning disability services in England and Wales felt that their cultural needs were not respected while they were on the ward. Their problems were often associated with religious or dietary needs.[35]

Sensitivity to age

People of different ages have different needs. A survey by the Healthcare Commission found that young people generally felt that wards were safe and secure, and that facilities for parents, for example, to stay on wards, were good in most hospitals. However, facilities for adolescents and older children could be improved: 58% of young people who would have preferred to be on a ward for adolescents were placed on a children's ward, and 16% were placed on an adults' ward.[48] Our recent review of A&E services also found evidence of shortcomings in the specialist support provided for children in A&E and day surgery departments.[25]

Seeing past stereotypes

A common experience reported during our consultations with seldom-heard groups was that people were often treated as stereotypes: that is, they were seen by staff only in terms of the groups they were part of.

Consultation with people using community mental health services identified similar concerns. The key message was that people wanted to be treated as a whole person, not just as someone with mental health problems.

Quotes from patients

"Older people get patronised a lot, not talked to but talked over, called 'dear', have words put in their mouth, assumed that they are doing everything on the cheap and assumed they are mentally past it. In fact they are not!"

Older gay and lesbian group in London

"I know people who have gone into hospital and they've been treated that bad because they class it as self inflicted because you're a drug addict ... a lot of them do discharge themselves."

Drug user group

"Doctors and nurses talk to the carer, not the disabled person. Staff refused to do a hearing test on me until my carer returned from the pharmacy. "I am not stupid," I said."

Disability group

"The doctor cannot understand me as I have a speech problem. They speak to my carer, so I never know what is the matter with me."

Learning disability group

"We appreciate that they (the services) are busy, but there is no one trained to be aware of disabled people, so I'm stuck wandering the corridors until someone helps me. It would just be helpful if the health services gave some training to their staff."

People with disabilities from rural communities

"I am treated with respect by my GP, who treats me like a person not a commodity – she listens."

Older persons group/London

"I had an operation and later that day the ward sister telephoned to see how I was, she took that extra time and showed she cared."

Older persons group

"It's easy to talk to her (specialist health worker) because she understands how travellers go. She understands everything about them."

Traveller[75]

How well are services designed for patients?

People's experiences of healthcare are not only influenced by how they are treated by individual staff. They can also be influenced by how their journey through the system is managed. People want to be treated as individuals, with the system designed around their needs rather than the needs of the organisation delivering the service. For example, they may want to have a range of tests arranged for the same day, so that they do not have to make several visits to a hospital.

The Healthcare Commission's surveys of patients show that the majority of outpatients (97%) and inpatients (96%) felt that their care was very or fairly well organised.[49] But, the surveys also show that the way healthcare services are organised often means that they are not focused on meeting the needs of patients. For example:

- patients often reported that the dates of their appointments were changed – 43% of mental health patients and 20% of outpatients reported that their appointment had been cancelled or changed by the hospital or mental health service at least once in the last year
- 21% of inpatients had the date of their admission to hospital changed at least once
- 6% of A&E patients, 4% of PCT patients, 3% of outpatients and 13% of people using mental health services felt that they were not given enough time to discuss matters of concern properly with doctors and other healthcare professionals
- 92% of those questioned in the Healthcare Commission's survey of patients at PCTs were not told how long they would have to wait to be seen; for users of A&E services this figure was 56%

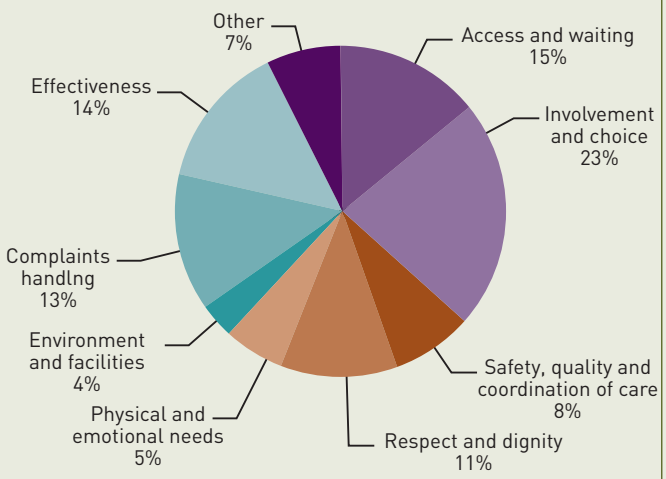
The Healthcare Commission's review of day surgery shows how services could adapt to improve the way they meet the needs of patients. For example, despite evidence that people prefer day surgery and that day surgery operating theatres are under-used, the review found that many patients who could be treated as day cases were still being admitted to a hospital for at least an overnight stay. Almost half of patients were not assessed for the suitability for their treatment before they arrived for their operation, and only a quarter of units telephoned patients shortly before admission to remind them of their appointment. These factors could be contributing to the rates of cancellations in day surgery units: one in four day surgery units cancelled around one in 10 admissions.[92]

Similar lessons about designing systems from the point of view of the user also emerge from people's complaints about healthcare in the NHS and independent sector.

Learning from complaints in the NHS and independent sector

In England, the Healthcare Commission is responsible for reviewing complaints about the NHS that have not been resolved locally – these are called 'second stage complaints'. From July 2004 to May 2005, we received more than 7,000 complaints, covering all aspects of people's experiences of healthcare.

Figure 11. Breakdown of NHS complaints received by the Healthcare Commission (for trusts in England)



Source: Healthcare Commission's analysis of complaints

We also received 395 complaints about independent healthcare providers, 278 about hospital services and 117 about independent providers of mental health services. Most of them relate to the quality of treatment and care.

Our aim is to try to resolve problems locally and to learn from them so that improvements can be made.

For example, an investigation of recent complaints led to better monitoring of the quality of nursing care for older patients, better information for patients (particularly in relation to cosmetic procedures) and improvements in how complaints are dealt with locally. Analysing the pattern of complaints is also helping us to identify underlying problems in NHS trusts with high levels of complaints.

Our work on complaints highlights the importance of designing systems, including systems to investigate complaints, from the point of view of the user. For example:

- many complaints can be resolved through an organisation's existing systems, if they are working effectively (for example, if complainants are kept informed about the progress of their complaint)
- organisations need to respond to complaints quickly, so that frustration and anxiety does not build up and make things worse
- organisations should keep in touch with the complainant throughout the process, providing opportunities to discuss matters face to face
- providers should acknowledge when things have gone wrong: complainants often report that a straightforward apology and an assurance that lessons are learnt would be an sufficient outcome

The environment of care

The environment in which healthcare is provided can affect patients' views of care. They may be unhappy with the care they receive because of their surroundings, rather than the quality of the care itself. In fact, research has shown that people feel more respected, valued and better cared for if they are treated in a pleasant, welcoming environment.

Premises

A great deal of money has been invested in NHS buildings in recent years. Six new hospitals opened in 2004/2005, increasing the number of beds available to patients.[3] Overall, the quality of existing NHS buildings is improving as the backlog of repairs and maintenance is being addressed (although less progress had been made in London and the south east).[41] There are some concerns about whether older premises can meet the needs of modern care.

Access for people with disabilities

Healthcare services are required to provide good access for people with disabilities under the Disability Discrimination Act 1995. Reviews carried out by CHI showed that access for the disabled in the NHS was generally good.[78] However, responses to a consultation exercise carried out by the Healthcare Commission in 2004 indicated that people had problems with the cost and availability of car parking and public transport. This was a particular concern for people with disabilities, but was also raised by other groups of people, including those living in rural areas.

The National Audit Office found that staff considered A&E departments built before the 1990s less suitable and flexible than more modern buildings, despite the money being spent on improvements.[22]

Clear signposting is important to patients, visitors and staff. However, a 2002 survey showed that many patients found it difficult to find their way around hospitals. The survey also highlighted problems with the communication of information about, for example, visiting times or ordering food.[77]

Despite the money invested in mental health care in the NHS, the condition of premises for many mental health services remains poor. In particular:

- the environment on numerous inpatient wards remained poor, and many are in need of refurbishment, redesign or rebuilding[10]
- half of the staff working on wards for people with mental health problems and learning disabilities in England and Wales feel that there is not enough space[35]
- there is continuing concern about the number of mixed sex wards, despite guidance from the Government that they be eliminated.[79, 80] In an audit of mental health and learning disability wards, 23% of respondents reported sharing wards with members of the opposite sex when they did not want to.[35] This contrasts with the Government's figures showing that 98% of mental health trusts comply with guidance on single sex accommodation[10]
- there is a lack of suitable mental health facilities in A&E departments, which means that staff often have to carry out assessments of mental health needs in rooms designed for bereaved families or in rest areas for staff[22]

There are also poor conditions in some sexual health services. According to a report in 2003, 20% of NHS clinics were based in portacabins, and 80% of clinics needed to be refurbished and extended. Extra funding was allocated to sexual health services, but there have been reports from staff that funding did not always reach frontline services.[81]

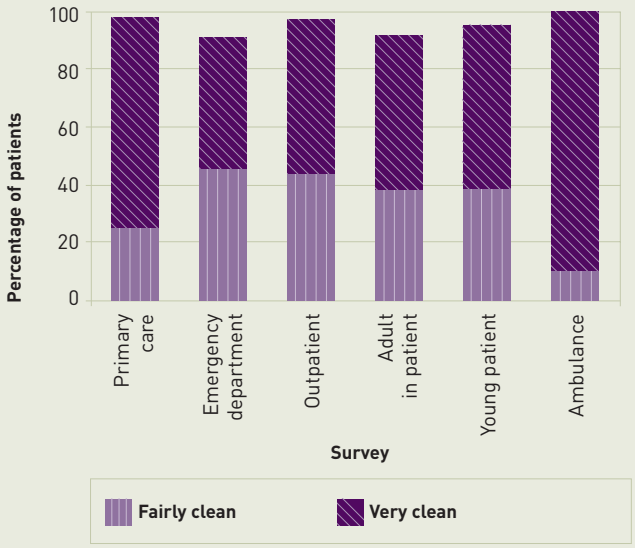
There are now around 1,000 independent healthcare facilities providing residential care for people with learning disabilities. A survey carried out by the Healthcare Commission and the Department of Health found that people using services were placed in facilities an average of 74 miles away from their home. The furthest distance a patient was placed was 385 miles away from their local community; for one facility the average distance was 194 miles. This makes it difficult for those managing an individual's care to monitor the quality and cost effectiveness of the service, and can put an individual's relationship with family and friends at risk. The Government has now issued a note clarifying that inspections can challenge developments of services that are not in line with the Government's policy or good practice in this respect.

The Healthcare Commission's work in the independent sector also found that some private doctors are operating in premises that are unsuitable for clinical treatment, and do not comply with standards in relation to fire and access by the disabled.

Cleanliness

Overall, people are quite positive about the cleanliness of NHS facilities. In 2004/2005, the majority of people surveyed by the Healthcare Commission said that facilities were clean or fairly clean.

Figure 12. Cleanliness of healthcare settings - results from national surveys of patients in England



Source: Healthcare Commission - surveys of patients in England 2004/2005

These views have not changed significantly in recent years, although there are some signs of decline in recent surveys of patients in A&E and outpatient departments. This could be the result of greater public awareness of hospital acquired infections.

In 2004, assessments of NHS facilities carried out by patient environmental action teams found that standards of cleanliness were acceptable or better in 97.7% of cases. Patient environmental action teams comprise volunteers, from NHS managers, nurses, patient and patient representative organisations to members of the general public.[3]

In response to recent concerns, the Healthcare Commission will carry out an audit of cleanliness in hospitals in England this summer. The audit will involve a series of unannounced visits to NHS and independent hospitals (acute, community and mental health hospitals[5]) to assess the cleanliness of areas used by patients and members of the public.[5, 82]

Food

Food in NHS hospitals has improved since the introduction of the Better Hospital Food programme in 2001, which aims to ensure that patients receive good food and accompanying services. Many patients are now able to get food 24 hours a day. A survey carried out by the Patients' Association and a hospital caterer also found that food in hospitals met or exceeded patients expectations 80% of the time.[77]

However, findings from the Healthcare Commission's national surveys of patients in the last 18 months show that patients' views on food vary widely. On average, 15% of people rate their food in hospital as poor. One survey showed that one in four patients had not received the food they ordered and half of patients thought that their food was the wrong temperature.[77] The Government has highlighted the need for improvements in the nutritional standards of food in hospitals and in the way in which meals are distributed within hospitals.[83]

Conclusion

There is evidence that many aspects of healthcare are improving. People are not waiting as long for care in hospital, and new places and ways to deliver services, such as walk-in centres and NHS Direct, have played a key part in improving the effectiveness of services. Improvements in care have also led to better outcomes for people with cancer and coronary heart disease.

The number of NHS staff who report seeing errors and accidents is still high. It is encouraging that there is a culture of reporting errors and accidents among NHS staff so that lessons can be learned. However, services do not always follow good practice to improve the safety of patients. Trusts also need to improve their ability to adopt good practice in relation to the effectiveness of care.

Progress in improving the way in which different healthcare organisations and different parts of the NHS work together is patchy. To people who use the services, they often still seem fragmented and planned according to the needs of those delivering them, rather than of the people needing them. If this is to change, managers need to give a higher priority to developing the skills of staff relating to communication and care.

There are particular concerns about services that do not enjoy a high public profile or which are not the subject of national targets, such as sexual health services, maternity services, NHS dentistry and mental health services. The experiences of people using these services are often negative, with problems of accessibility, safety and the quality of the environment of care. Similarly, people from a range of seldom-heard groups consistently report problems with gaining access to services and with their treatment by staff. Even in areas of priority, such as access to primary care, there are signs that some areas not covered by national targets, such as the ability to book appointments with a GP in advance, may be neglected.

Chapter 2

Do people have enough control over the care they receive?

Eye Clinic & West Wing
Endoscopy
Fracture Clinic
Surgical Assessment Unit
X-Ray Dept
Lifts to Wards B2-B17
Please report here for:
Prof. N. Davidson
M. Watson

The previous chapter focused on traditional aspects of performance in healthcare. Here we look at how the relationship between healthcare services and the people using them has changed in response to pressures to give people more influence and control over the delivery of services. We also look at how services have responded to these pressures.

Information for those using services

People need information to help them to make choices and get more involved in decisions about their care. Some people may not want to get involved, but they still need to gain access to information which lets them know what is going to happen to them and why, to address any concerns they may have, and to make them aware of any warning signs that they should watch out for.

Pressures to give people more control over healthcare services

- Concerns over safety - for example, adverse drug reactions
- Less trust as a result of scandals
- Need for clearer processes to get informed consent about treatments
- Increasingly complex medical choices
- Desire for choice when making appointments
- Pressure to cut waiting lists
- More people living with long term conditions
- Desire to build patient-centred services
- Rising public expectations over involvement in their healthcare
- Need for greater public engagement in healthcare

- For more and better information – to inform, assure and help people to make choices
- For patients to get more involved in decision making about their care
- To give people more control over and responsibility for the services they receive
- For greater influence and control for patients and the public over the design and delivery of services

Improving the quality of information for patients is a key theme of the national service frameworks and other guidance for healthcare services, such as the Cancer Plan.

In 2004, 77% of A&E patients and 80% of outpatients surveyed by the Healthcare Commission said that they felt that they receive enough information about their condition and its treatment. However, the survey's findings also point to problems with how information is being delivered and what type of information they are receiving. In particular:

- a third of patients said results of diagnostic tests were not explained in a way that they could understand
- four in 10 patients reported that they did not receive information about the possible side effects of their medication, or advice on how to monitor their condition
- a fifth of patients who received medication when they were discharged from hospital said that they were confused about what the drugs were for
- 31% of inpatients, 11% of outpatients and 16% of A&E patients said that they received conflicting advice from different healthcare professionals

For people using cancer services, there are some signs of improvement. More patients now receive printed information when they are diagnosed than was the case five years ago. A survey by the National Audit Office also showed that 80% of patients were content with the information they received about the outcome of their treatment. However, patients with a diagnosis of breast cancer, and those living outside London, are more likely than others to receive information at the time of diagnosis.[20]

When patients with coronary heart disease are asked which aspect of their care is most important to them, the majority identify issues related to information. Despite the introduction of national guidance on the provision of information for patients with coronary heart disease, the quality and accessibility of information given to patients still varies.[19]

Information available from the Healthcare Commission

The Healthcare Commission's website (www.healthcarecommission.org.uk) contains a great deal of information for patients and the public, including:

- information about local NHS providers of services and their performance, the results of surveys of NHS patients and staff, and other relevant reports such as the findings of any investigations of serious failures
- national reports on many aspects of healthcare services, such as cosmetic surgery, coronary heart disease, A&E services and safety in mental health units
- information about all registered independent providers of healthcare services, including details about the services for which they are registered and the latest inspection reports

Over the next year, the Healthcare Commission will increase the range of information on its website and explore ways to make this information more accessible.

Ninety-seven per cent of patients surveyed by the Healthcare Commission in 2004 felt that staff had given at least some explanation of why they were having an angiogram (x-ray of the blood vessels). However, 10% of those undergoing heart bypass operations reported that they did not understand the explanation they received about the outcome of their operation.

People are also seeking information from a range of different sources. The internet has played a large role in this, with an increasing number of people turning to it for information and support on different treatments and conditions. While much of the information they find can be very useful, sometimes it is placed in the public domain unchecked and is potentially misleading and possibly even dangerous.[84, 85]

Involvement in decision making

Market research company, MORI, found that more than 75% of people (including healthcare staff and members of the public) thought that patients should be more involved in decisions about their care and treatment.[86] Medical professionals also agree that decisions about care and treatment should take account of the views of patients or people using services. Involvement in decision making is also a necessary part of the process through which patients are able to give their informed consent to treatment.

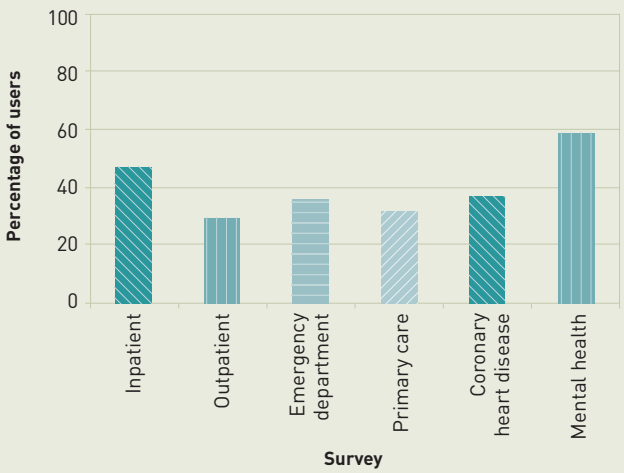
However, progress in this area is limited. A major international review comparing healthcare systems in five countries concluded that, in many respects, the involvement of patients in healthcare in the UK was lower than in the other countries.

For example, fewer patients in the UK:

- said that they were told about choices in their care and treatment, or were asked for their ideas and opinions
- were offered advice on choices for healthy living (such as on diet or exercise)
- reported that they had a care plan to help them manage their care at home
- had, or wanted to, gain access to their medical records (28% of people had access; of those who did not have access, 59% wanted it)[87]

The findings from surveys of patients show that between three and six in 10 patients (depending on the type of trust) felt involved in decisions about their care. From the information available, this situation does not appear to be improving.

Figure 13. Percentage of patients who would like more involvement in decisions about their care



Source: Healthcare Commission – national surveys of NHS patients in England 2004/2005

In primary care, surveys carried out by the Healthcare Commission show that, although there have been improvements since 2003, there is still scope for better involvement of patients in decisions about their care, in particular:

- 32% of patients visiting GPs wanted more involvement in decisions about their care and 31% wanted more involvement in decisions about their medication
- there was a decline in the involvement of dental patients in their care with 31% wanting more involvement, compared with 25% in 2003

Patients can only consent to a treatment or procedure if they are informed about the risks, benefits and possible side effects. The Healthcare Commission's survey of patients with coronary heart disease found that between 90% and 95% of patients who were about to have an operation said that the risks had been explained to them. However, far fewer patients (42% of patients undergoing angioplasty and 22% of patients undergoing coronary artery bypass surgery) were told about different treatments that could achieve the same result.[19]

There are some signs of progress involving people with long term conditions. For example, there is evidence of better use of care plans for people with cancer and diabetes, which indicates that they are discussing their care with their doctor. A survey by Asthma UK in 2004 found that, although 77% of sufferers from asthma had discussed and agreed with their doctor how to manage their care, only half had a full discussion about their medication.[89]

There is also some improvement in the involvement of people with mental health needs, but there is still some way to go.[10] Thirty one per cent of patients surveyed by the Healthcare Commission did not have a copy of their care plan††, and consultation with people using these services reveals that they do want to take more control over their care, beyond just seeing their care plan.[11]

The amount of involvement that carers have in decisions varies, depending on which part of the system of health and social care they are involved with. In 2002, the Princess Royal's Trusts for Carers found that only 20% of British carers were asked to give their views about NHS services used by those they cared for, compared with 50% of carers in social care.[90]

New techniques and tools are being developed to help people to understand the risks and benefits of decisions about their care.[19] Patients' groups and the National Institute of Health and Clinical Excellence have jointly produced publications to explain decisions and guidelines to patients with conditions such as multiple sclerosis, epilepsy and eating disorders.

†† This percentage relates to those on an enhanced care programme approach. This means that they should all have a copy of their plan. Of those who did, nearly half said that they could not understand it.

Control and responsibility over services

Some people want to take more control of decisions about where, when, and how their care is provided and who provides it.

One way in which people can take some control over their care is though the use of improved systems for booking appointments. For example, nine out of 10 day surgery appointments are now booked from a choice of different dates. This is a considerable advance over the last four years. However, only 44% of day surgery patients are offered an admission date within 24 hours of deciding that an admission is needed.[92]

A choice for patients

Many people are now being given more control over where they go for treatment. In England, this choice was recently offered to a wider range of patients, depending on how long they had been waiting and what treatment they required. All patients who have waited more than six months for an operation should be able to choose an alternative provider. By December 2005, the Government wants all patients to be offered a choice of four or more providers (including, when relevant, independent sector treatment centres) as soon as a decision to refer them for treatment is made.[93]

In Wales, there is a centrally run scheme, known as the 'second offer' scheme, to ensure that people do not wait more than a year for treatment without the opportunity to receive care at an alternative hospital.

A number of lessons can be drawn from the introduction of these schemes, as well as from surveys of people's views on choice.

Surveys generally show that people support the idea of choice in healthcare. A survey by the Department of Health found that 80% of people welcomed choice and 60% of people said that they would switch to an alternative provider to get quicker treatment. However, some people, particularly older people, do not welcome greater choice of healthcare provider, and prefer to be treated in their local hospital.[96, 119]

Of those people already able to choose an alternative provider, between 50% and 70% took up the offer of quicker treatment elsewhere. Latest figures show that 52,817 patients in England (21% of those eligible) have taken up the option for faster treatment, although there are early signs that proportions vary across the country.[3]

In Wales, almost 11,500 people took up the offer for faster treatment at an alternative hospital.

There are important lessons to be learnt from schemes already in operation. For example, payment of travel costs emerged as a concern for some patients, others also wanted more choice over matters such as who would treat them. Healthcare services are finding that they need to make sure that they have the facilities, staff and administrative systems in place to cope with these new schemes.

Studies also show that not enough information is available to help people to make a choice. The information that exists mainly covers matters such as waiting times, locations and opening times, but patients wish to know about the quality, outcomes and safety of care.

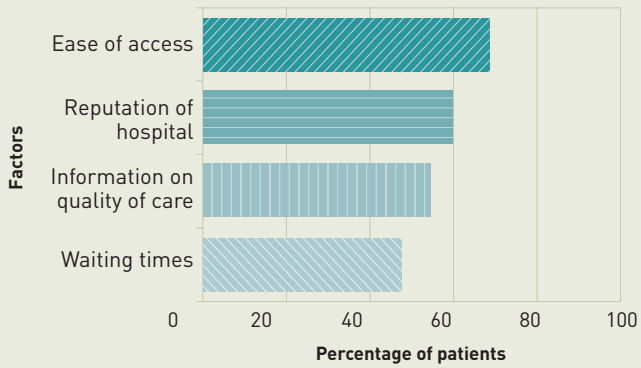
There has been some progress in developing ways of measuring outcomes of healthcare, but it is limited. For example, some information is available on rates of surgical mortality

Some measures of the impact of treatment on the quality of life of patients have also been developed and are being used in a number of settings in the NHS and independent sector.[95]

The new policy of offering patients a choice when they are referred for treatment, mentioned earlier, has been piloted in some areas. The findings from these pilots show that patients rate convenience of access and quality of care more highly than waiting times in terms of importance. They also show that one in five GPs said that they already offered patients a choice of which hospital they should be referred to before the study began. Although patients welcome extra involvement, the proportion of people who were treated in their local hospital was no different when compared with people who were not involved in this decision.[96]

There are concerns that the type of people who take up the offer of choice will primarily come from more educated and affluent social groups, widening inequalities that already exist in health and healthcare. There is evidence, for example, that people from these social groups are more articulate, persistent and confident in their dealings with healthcare services and that people who are better off financially are more likely to prepare a list of questions to ask during their healthcare appointments.[97, 98, 93] These findings underline the importance of providing effective advice to support people who are less confident in dealing with healthcare services.

Figure 14. Factors that influence NHS patients' choice of referral site for day surgery



Source: Study by Dr Foster and the University of Nottingham [96]

Control over services

Opportunities to increase the level of control that people have over their healthcare extend beyond choice of provider. Some people are taking greater control and responsibility through initiatives such as direct payments, which give them control over a budget to purchase social care. The number of older people taking up direct payments has increased, although overall take up remains low.[60, 99]

However, policies to give people more control are less developed in mental health services and for people with learning disabilities. Mental health services are not included in current policies to extend choice, and the take up of direct payments among people with learning disabilities, although increasing, remains low.[100, 10]

Success of the Expert Patient Programme

The Expert Patient Programme is an NHS initiative, which highlights the real benefits of patients taking more control over their healthcare. The programme offers courses to help people living with long term conditions to take more effective control over their health and to manage their condition better on a day to day basis.

The programme was introduced in England in 2001 and in Wales in 2003, with full implementation planned for 2008. It already involves 17,000 patients in England and 250 patients in Wales. The views of participants from 245 courses in England highlight the benefits of the programme for patients and for the NHS, including:

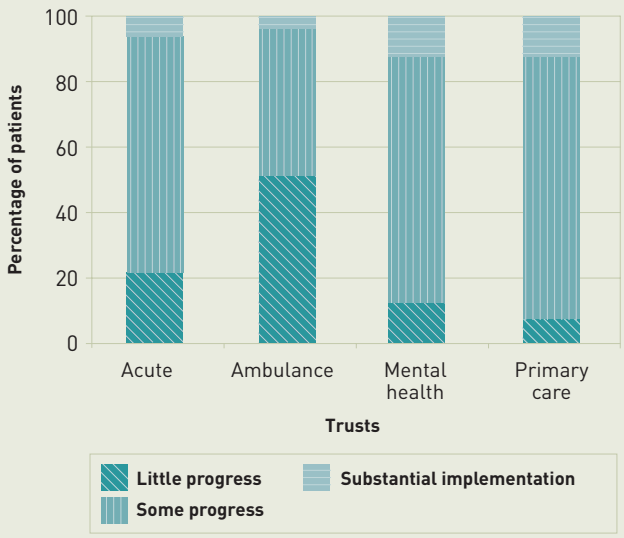
- people feeling more confident in managing pain, tiredness, depression and breathlessness
- more effective use of healthcare services (7% fewer GP consultations, 10% fewer outpatient visits, a 16% reduction in attendances at A&E, and a 13% reduction in admissions to hospitals)
- an 18% increase in the use of pharmacy services such as advice and support
- better partnership working with professionals (33% of participants felt better prepared for consultations with healthcare professionals)

Influence and control over the design and delivery of services

Patients and the public can also play a part in helping providers of services to understand local priorities and to see the service from the point of view of the person using services. In England, the Government recently set out its ambition that the NHS should be 'patient-led', giving people who use healthcare services real influence and control over how services are run.[101]

Clinical governance reviews in English trusts over the last three years have painted a mixed picture on involvement of patients and the public, with many trusts still in the process of identifying ways to involve them in the development of services. However, recent reviews, particularly in mental health trusts, show more positive results, as do the findings of our work with community mental health services.

Figure 15. Clinical governance review scores for patient and public involvement



Source: Healthcare Commission's and CHI's clinical governance reviews of NHS trusts

Patient forums have been set up in every NHS trust in England to monitor and strengthen the accountability of services in local communities by, for example, contributing to reviews of hospital cleanliness. A member of staff in each NHS trust has also been given responsibility for ensuring that patients and the public are involved in services.

Similarly, an evaluation of arrangements for involving patients and the public in Wales found that there has been significant progress in setting up the required foundations for greater involvement, such as focus groups, panels of patients and regional networks, but it is too early to assess the impact on services.

The organisation of these forums, as well as the national system to support them, is currently under review. The Healthcare Commission has a particular interest in these changes because we think that contributions from the public and patients should play an important role in our new annual health check. As part of the design of our new annual health check, we are examining how we can improve the involvement of patient forums in decision making, as well as involvement by other groups, such as local voluntary organisations and the overview and scrutiny committees of local authorities.

One interesting development in involving local people in the provision of healthcare in England is the introduction of NHS foundation trusts. These are designed to be more accountable to their local communities. The Healthcare Commission recently published a review of experiences in these trusts.

We found that the status of NHS foundation trusts provided new opportunities to involve patients and members of the public, but there was some confusion over the respective roles of existing patient forums and the trusts' new governors. Overall, we found that it was too early to say what effect these developments will have on services.[29]

Learning from the pilot improvement review of community mental health services

An improvement review is an in depth study of a particular health topic, often focusing on how healthcare is delivered across and between organisations. A number of reviews are currently being developed jointly with the Commission for Social Care Inspection, including a review of community mental health care for adults.

During the summer of 2004, we asked people using mental health services, carers, professionals, research organisations, representatives of black and minority ethnic communities and others to identify the main areas of importance in providing community mental health services.

A major theme to emerge was the extent to which those using services and carers were involved in decisions about their individual care and wider questions about how services were run. People who use services highlighted a range of matters on which they felt their perspective could help trusts to ensure that services were designed around their needs. Suggestions included:

- redesigning systems so that they feel less overwhelmed, for example, by redesigning forms to be more user friendly
- helping providers of services to 'see the whole person' by taking account of cultural and other differences
- understanding the differing needs of different ethnic and cultural groups
- designing systems to support the extension of direct payments by, for example, identifying how to support people who are less likely to be able to cope on their own
- making those who use services aware of their rights
- involving those who use services and carers in planning care
- identifying what information people using services need by, for example, ensuring that care plans indicate where day centres are and how people can get to them
- overcoming perceptions that consultation with those using services is superficial
- improving how clinicians and people using services communicate by, for example, identifying the best way in which to explain the risks and side effects of drugs
- developing strategies for evaluating the performance of clinicians

These, and other suggestions, are now being used to help to shape the improvement review.

Conclusion

There are good signs that people are getting more information about healthcare, particularly about those areas of care targeted for national action, such as cancer. However, people are still not being told enough about aspects of their care, such as what the results of diagnostic tests mean and the possible side effects of medication. The UK still lags behind other countries, despite widespread agreement about the potential benefits of involving people in decisions about their healthcare. And while some people who use healthcare services feel that they have enough say in decisions about their care, for many there is still a long way to go.

Giving patients control over when and where they receive their care has helped to cut waiting times and made services more convenient. Initiatives such as the Expert Patients Programme have shown how giving people control over their care can benefit the individual as well as the NHS. However, these initiatives are still in their early stages. There is not enough reliable information to allow people to get more involved in their care and to help them to make choices in and between hospitals. They especially need more information about the quality and outcomes of care. Nationally, policies to give more power to people through greater choice need to look beyond the choice of who provides care to wider choices about how care is provided. Improvements are also required in the level of support and information provided to people who want to take greater control in managing their own long term care.

Achieving these aims without widening the gap between those who get the most out of the system and those who may be missing out will not be easy. It will require extra support for people who may otherwise be left behind. These include older people, people needing mental health care and people less confident or able to deal with providers of healthcare. Additionally, achieving these aims involves more than merely systems and policies. It also involves changing the attitudes of staff and those who use services. In order to realise the full benefits of greater involvement of patients in their healthcare, underlying attitudes to people's ability to take part in managing their own health and healthcare need to change.

Chapter 3

Do some people get a better deal from healthcare services than others?

Not all people's experiences of healthcare services are the same. Sometimes there are differences which are sensible, based, for example, on the fact that different individuals or groups have different needs. However, many of the differences in experiences of healthcare that are evident today are not based on sensible grounds. This section of the report looks at how people's experiences of healthcare vary. In particular, we examine whether some people are getting a better deal than others.

Differences in the design and delivery of services

Variations in the way that providers of healthcare design and deliver services mean that different people have different experiences of healthcare. For example:

- some can book GP appointments a week in advance
- some are told how to look out for problems regarding their medication
- some children in A&E departments receive drugs promptly to help them to manage pain
- some people in stroke units receive an assessment of their ability to swallow food properly
- some older people have a good chance of returning to their own home when they are discharged from hospital

Some people, however, have the opposite experience. Of course, in an organisation as big as the NHS, some differences are to be expected. In fact, they should be encouraged so that services can be free to develop. But differences should not result in services for some falling below acceptable standards.

Under the Government's new standards of healthcare, published in England and under development in Wales, all services must meet certain core standards. This should help to reduce variations in the performance of healthcare organisations.

An important starting point is to make sure that funding for different services is in line with the needs of the people they serve. Last year's *State of Healthcare* report raised concerns about the gap in England between the levels of funding provided for services and local needs. Analysis of more recent data shows that there has been some progress in closing this gap in England and Wales, although we still have some concerns.

Does funding for services reflect the needs of local communities?

The Government takes the view that the funds made available for healthcare should be controlled locally. So, most of the NHS budget is shared out among PCTs in England and local health boards in Wales.

For these funds to be distributed fairly, the amount of funding required to meet local needs must be estimated. The approaches taken in England and Wales differ somewhat. Both examine the size and age of the local population, but they use different approaches to assess some aspects of need. In England, the method takes account of how deprived an area is and other indications of need, such as how many people have long term health problems. For Wales, the needs of a local population are measured directly by surveying people about their state of health, and with reference to other relevant information.

Although the methods result in a figure for how much funding each area should get (a 'target allocation'), this is not necessarily the amount that each PCT or local health board actually gets. What the organisation received in the past is also taken into account. This is done to avoid problems that might follow a sudden increase or decrease in funding.

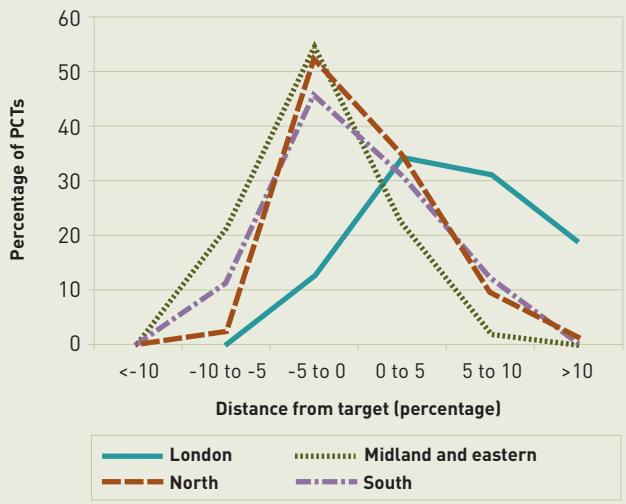
Last year's *State of Healthcare* report raised concerns over differences between the 'target allocations' and the amounts that PCTs in England actually received. In particular, the report pointed out that PCTs with high levels of deprivation tend to fare worse than others. For this year's report, we have studied the latest allocations of funding to see what progress has been made in increasing the funding of PCTs which have the highest levels of deprivation. We found that in England:

- the total level of variation has decreased, with 88% of PCTs getting within 5% of their target allocation in 2006/2007
- there was evidence that extra funding was going to PCTs in deprived areas. For example, PCTs in 'spearhead areas' (the 88 local authority areas assessed to have the highest levels of need) were now more likely to get at least their target allocation
- the distribution of funding was more in line with levels of deprivation

While some PCTs in London are funded below their target allocations (including some of the poorest parts of London), others (including some of the richest areas) get significantly more.

Concerns have also been raised that a lack of transparency in funding allocations in England has led to increasing variations of spending on different services.

Figure 16. PCT funding allocations in England 2006/2007: Distance from target



Source: Healthcare Commission analysis of Department of Health data

The latest report on progress in implementing the NSF for Mental Health found significant differences in the amounts that PCTs spend on mental health care, including a widening gap between spending in the north and south. It also found that PCTs could spend either more or less than needed because the allocation for spending on mental health and learning disabilities was not published, and that current spending patterns were determined more by historical spending than local needs.[10]

Progress has also been made in Wales, with the redistribution of £41 million. For example, the five areas most distant from their target allocations in 2003/2004 (by 10.8% on average) were now getting closer to their target allocations (on average 6.6% below).

Allocation of PCT funding

Ten PCTs with 2006/2007 allocations most below target

	Distance from target	
	2006/2007 %	2006/2007 £m
Easington	-8.2	-13.9
Tendring	-6.6	-8.3
Knowsley	-6.3	-12.0
Barking and Dagenham	-5.4	-10.3
Ashfield	-5.3	-5.5
North Liverpool	-5.1	-11.4
Central Liverpool	-5.1	-10.0
Heart of Birmingham	-5.1	-12.1
Tower Hamlets	-5.1	-6.8
Basildon	-5.1	-12.2

Ten PCTs with 2006/2007 allocations most above target

	Distance from target	
	2006/2007 %	2006/2007 £m
Westminster	8.5	17.9
Richmond and Twickenham	9.5	27.4
Cambridge City	9.8	29.9
Kensington and Chelsea	10.6	19.5
Wandsworth	12.1	42.8
Oxford City	12.7	43.9
Trafford south	13.3	54.7
Rushcliffe	14.5	28.5
St Albans and Harpenden	14.8	47.3
Sheffield south west	16.0	21.4

Experiences of people from different communities

While we know that many of the variations in people's experiences of healthcare relate to differences in how trusts design and deliver services, there is also evidence that some variations depend on the characteristics of the people who use the services. There is evidence that specific groups of patients, particularly those in poorer areas, experience difficulties gaining access to effective services. For example:

- more than a quarter of homeless people are not registered with a GP, compared with 3% of the population as a whole [103]
- homeless people are five times more likely to go to an A&E department because of problems encountered trying to register with a GP [104]
- women from minority ethnic groups are less likely to go to prenatal classes – for example, because they are not told about them or because they are uncomfortable that men may be present [74]
- people with learning disabilities experience problems gaining access to healthcare [105] (including some accounts of people with learning disabilities being refused access to primary care) [70]
- middle aged women and people over 70 years of age are less likely to be diagnosed or identified as having diabetes. This means that they may fail to receive support that will help them manage their condition [57]
- take up of immunisation services is lower in poorer areas, and there is a similar pattern in the take up and success of screening and services to help people to stop smoking [102, 19]
- analysis of regional variations in the use of implantable cardiac defibrillators shows that areas with the greatest need receive the fewest treatments [106]
- the National Audit Office's report on cancer services found that, on average, cancers were diagnosed at a more advanced stage in patients living in poorer areas [54]

Problems of mental health affect people from all social groups and of all ages. But some disadvantaged groups are more likely than others to fail to receive services. For example, unmet needs are a common finding of reviews of youth offending teams, while the Government's social exclusion unit estimates that almost three quarters of those in prison have two or more mental health disorders. [13, 107]

Learning from surveys of patients

An important part of the Healthcare Commission's role is to coordinate surveys of the experiences of people who use healthcare services. In the last year, more than 310,000 people took part in surveys across 568 NHS organisations. The results are reported to each organisation and made available to the public on the Healthcare Commission's website. To ensure that the results are reliable, we set strict rules governing how and when the surveys are carried out.

The surveys can tell us a great deal about how people experience healthcare services. For example, we have examined the way in which people's views of care vary depending on their age, gender and ethnicity, where they live and how sick, or well, they are.‡ In particular, we found that:

‡ The full report of this analysis will be published by the Healthcare Commission shortly.[103]

- there were indeed significant differences in the experiences of different groups (although only about 10% of all variation is explained by the factors mentioned above)
- older people, other than those with stroke or coronary heart disease, tend to answer questions more positively than others
- people in London generally respond more negatively than those living elsewhere
- people from black and ethnic minority groups tend to respond more negatively (particularly on questions about access to care, information and relationships)

The differences exposed may be due to a range of factors. These include the experiences of different groups, varying expectations about what constituted good service, or differences in the type of care received by different groups. Further work is required to unravel these issues.

Healthcare Commission's surveys of patients

Survey	Sample size	Response rate
Coronary heart disease 2004	3,784	75%
Emergency department 2004/2005	55,339	44%
Outpatients 2004/2005	84,280	59%
Young patients 2004	62,277	50%
Ambulance services 2004	12,282	51%
Mental health 2004	27,398	42%
Adult inpatients 2004	88,308	63%
Primary care 2004	249,538	49%
NHS staff survey 2004	363,072	60%

All surveys were carried out in England only

Seldom-heard groups

An important finding from earlier sections is that the experiences of people from seldom-heard or disadvantaged groups (such as travellers, people with learning disabilities and homeless people) can be significantly worse than those of others who use services. Our own consultation with seldom-heard groups, as well as other research, has shown that, in many cases, services treat people according to stereotypes, rather than as individuals with individual needs.

One reason for this could be that listening and responding to the needs of these groups requires extra effort. These groups are much less likely to respond to surveys. Many of these groups are also too small to show up in any analysis of surveys, even if they do respond. As a result, there has only been limited research with such groups, and much of that research has been carried out with limited resources. Local and national agencies need to gain a better understanding of these groups and do more to meet their needs.

An important part of the development of our annual health check is listening to the views of these groups, and identifying their key concerns about the state of healthcare services.

Learning from the consultation on the new annual health check

From November 2004 to February 2005, the Healthcare Commission consulted on its plans for a new annual health check. As part of this consultation, many events were held with patients, members of the public, clinicians and other healthcare staff. This included events for people from seldom-heard groups, including people with physical and learning disabilities, asylum seekers, homeless people, lesbians and gay men, travellers and people from different ethnic and cultural groups.

One of the main themes to emerge from discussions with these groups concerned problems in gaining access to services. Obstacles in the way of these groups included:

Physical barriers

"We often have no choice about whether or not to come in a car, and then we have to pay to park."

"We need risk assessments from entry to the car park to access in surgeries ... there are dropped curbs, shrubs, it may be difficult for motorists to see low moving people in wheelchairs and many (services) don't have wide bay parking."

"Just because you can manage on your own at home, doesn't mean you can manage on your own in hospital. You are familiar with your own home and you will have had it adapted."

Disabled group

Attitudes of staff

"You can't get past the secretary [at the general practice]. They think she's a gypo, sorry love we're full."

Irish and travellers group

"The receptionist at the general practice said that we don't have any gay people."

Lesbian, Gay, Bi-sexual and Trans-gendered group

The way systems work

"To get an appointment you have to ring before 8.30am that day. For many disabled people, even physically getting out of bed in the mornings is a problem. Assuming you manage to do this, they then give you an appointment, but you can't get there as you have to arrange community transport several days in advance."

"Making people phone on the day for an appointment. If you have speech problems, doesn't take this into account, very difficult."

Rural disabled group

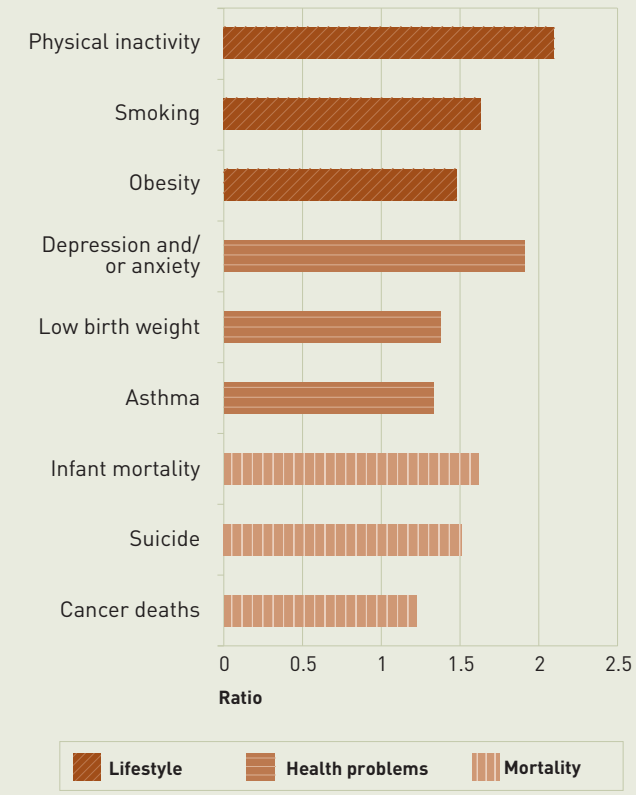
Wider variations in health

The question raised in this section is whether some people are getting a better deal out of healthcare than others. The 2004 *State of Healthcare* report discussed this question in some detail. The report highlighted significant variations, for example, in:

- overall health – with people in poorer areas having worse health in general, with shorter life expectancy and more time spent living with long term health conditions
- common health problems – with higher levels of obesity in poorer areas, higher suicide rates among young Asian women, some people (including older people and Asian men) more likely to have diabetes, and higher levels of hypertension and stroke among people of African Caribbean origin
- aspects of lifestyle known to affect health – with people living in poorer areas less likely to exercise regularly and more likely to smoke
- a range of other issues, including rates of teenage pregnancy and the chance of children being killed in accidents, both of which were higher in more disadvantaged areas [102]

A recent report showed how some of these issues also vary between richer and poorer parts of Wales.

Figure 17. Health and lifestyle indicators in most deprived and most affluent fifths of the Welsh population



This chart shows how indicators of public health vary between rich and poor areas in Wales.

Source: National Public Health service for Wales [109]

Disparity in life expectancy

Rather than trying to provide a full picture of variations in public health, in this report we focus on important trends, particularly the disparity in health status between those living in rich and poor areas. This disparity is especially important because of the link between deprivation and other health inequalities. It is also the subject of a number of Government targets in England and Wales.[110, 24]

Life expectancy across England and Wales has steadily increased for many years for those living in both rich and poor areas. However, it is not clear whether the gap in life expectancy between people living in these areas is widening or narrowing. A study by the Office for National Statistics found that there was no change in the disparity of life expectancy between the most and least deprived areas between 1994 and 1999. It also found that there were still differences in how long people were living with poor health.[120] However, a more recent examination of information up to 2003 found that the difference in the life expectancy between the richest and poorest areas of England had widened.[111]

The picture also varies between different conditions. A review of recent trends in rates of survival from cancer in England found that the difference between those living in rich and poor areas has widened.[54] However, the latest review of the NSF for Coronary Heart Disease found that the difference in mortality rates between areas with high deprivation and poor health and the average for England has narrowed.[53]

Inequalities in health

One positive development is that health improvement in England is now being highlighted. New targets to reduce differences in health and the publication of the White Paper, *Choosing Health*, are both aimed at tackling problems in public health. In Wales, public health has had a high profile for some time. For example, in 2001, the National Assembly set up an 'inequalities in health fund', which focuses on addressing underlying problems of health associated with coronary heart disease, such as diet and exercise, and improving access for disadvantaged groups.[112] A major review in 2003 concluded that Wales was ahead of the rest of the UK in terms of its approach to addressing inequalities in health through joint action across policy areas.[113]

Successful work in improving health relies upon developing a good understanding of the communities being targeted. For example, 'health literacy' as it is known, varies according to how well educated people are. This means that efforts to involve people in decisions about their health are likely to be more successful in more affluent areas and therefore greater effort is needed in deprived areas.[114]

Providing information about healthy eating and increasing opportunities to purchase nutritious food are also important. Obesity among children, which has increased significantly in recent years, is highest in deprived areas.[115] A recent study by the National Consumer Council found that supermarkets with customers from more affluent areas are more likely to offer advice on healthy eating, while promotional offers in supermarkets often involve less healthy foods.[116]

These factors are likely to explain, at least in part, some of the more worrying trends in public health. For example, while rates of smoking show some decline, rates among some groups (such as routine manual workers) remain much higher than average.[4]

Successful action to tackle problems of public health often requires a number of agencies to work together, including local councils, NHS bodies, and different government departments. It also needs to be recognised as a long term approach.

Deciding what action to take involves working out where best to intervene: for example, whether to try to address economic inequalities or whether to concentrate on explaining the risks of a particular type of behaviour. Campaigns to increase awareness about health and related primary care services are also important. Making these choices is made more difficult because there is little consensus of how inequalities in health are created or what solutions work.[117] Another problem is the commonly held view that issues of public health are separate from the provision of healthcare services. Recent developments, such as the introduction of national service frameworks, have helped to address this.

There are some new ideas that could make a significant contribution to tackling problems of public health. Health equity audits are a way of finding out more about public health in a particular area of the community. They are increasingly part of local planning for healthcare. Ways to gather more detailed information about health are also being developed. The Healthcare Commission will be assessing the extent to which the NHS is meeting local targets as part of the new annual health check and will be developing improvement reviews targeted at public health and inequalities, such as 'stop smoking' services.

Conclusion

There are significant variations both within healthcare services and in relation to the wider aspects of public health. Some people do get a better deal from healthcare services than others. Too often, the care someone receives depends on which provider they go to. This is a particular concern when services fail to follow good practice, or when they fall below national standards. Progress in making sure that funding matches needs should contribute to resolving some problems, as should our new annual health check.

There are also notable differences in the experiences of people from different social groups, including evidence that people from some groups are not getting equal access to the healthcare that they need. The negative experiences of people from seldom-heard groups are particularly worrying, especially when those providing healthcare services fail to see beyond stereotypes to people's individual needs. If people from these groups are to get a fair deal from healthcare services, greater effort is required locally and nationally to understand and respond to their needs.

Providing effective healthcare to people from disadvantaged groups is particularly important, as these groups are often also those with the greatest need. Commitment to long term action is required to tackle inequalities in health.

Chapter 4
Lessons

The aim of this report is to describe the state of healthcare from the point of view of people who use healthcare services. However, it has also raised several questions about how healthcare services are managed and led. In this section, we highlight what needs to be done by providers and commissioners of services, Government and other organisations to address these questions and to improve people's experiences of healthcare. We also identify how the Healthcare Commission will play its part in meeting these challenges.

Do people receive effective healthcare?

Improving how services are assessed

National targets have clearly played a major role in driving improvements in healthcare in the last few years, particularly in reducing long waiting times for people from referral to treatment in hospital. They have also helped to focus attention on areas of healthcare that the Government has identified as priorities for improvement. The National Audit Office's report on emergency care concluded that the extra motivation provided by targets have had at least as much effect on healthcare as the extra resources that have been put into the service. In the same way, targets for reducing inequalities in health are helping to highlight the importance of public health.

However, the introduction of targets has also had some unintended consequences. For example, focusing on one area of access to primary care – the 48 hour target for making an appointment with a GP – may have contributed to a fall in performance in other aspects of care in some PCTs.

Investigations by the Healthcare Commission reveal a link between aspects of care where there are often failures to provide good service and those that receive little local or national attention. This may be one of the reasons that this report has consistently found examples of poor experiences in relation to sexual health, mental health and maternity services. It could also account for the fact that features of services that are less easy to measure, such as communication and establishing good relationships with patients, often seem in need of development.

There is also a risk that targets may lead to distortions, for example, by admitting patients into a hospital from an A&E department before the expiry of the four hour target, and before the need for admission is fully established, or by discharging someone from hospital before the right support is in place. While there is no evidence that this is occurring, the possibility of distortions needs to be recognised and monitored.

Another criticism of targets is that simple numerical targets cannot reflect the whole picture of people's experiences of healthcare. It is these experiences, those of patients and of the people around them, which shape people's views about healthcare services. So, while targets are used to explain how services are changing, there is a danger that the limited information they give us does not match people's own views. This, in turn, could result in people becoming more cynical about, and less trusting of, messages from the Government or the NHS.

These problems can be overcome, in part, by improving the way in which aspects of healthcare are measured. More fundamentally, more comprehensive assessments of performance that go beyond simple statistical measures must be developed. The challenge for the Healthcare Commission will be to ensure that its new annual health check gets the balance right in terms of being comprehensive, without becoming too complex and difficult to take in. A further benefit of this approach will be to encourage healthcare providers to take greater responsibility for the whole of the services that they provide, so they cannot make the excuse that one poor feature of a service is the result of the need to meet a target in another area.

Do people have enough control over the care that they receive?

Providing better information about services

Information about services, or rather the lack of it, is also a common concern. There continues to be little evidence with which to make judgments on a number of aspects of the state of healthcare – such as the effectiveness of primary care or waiting times for mental health services. There is also only limited information available about people's experiences of independent healthcare and of the experiences of people in Wales, in part because there is no equivalent to the Healthcare Commission's patient survey programme in place in Wales.

A concern raised by patients who were asked to make choices about where their care was delivered was the lack of good information on the quality and outcomes of care. This is an issue that the Healthcare Commission will address in its new assessment system, in consultation with clinicians, patients and the public. Related to this are concerns about some of the information on the internet. Similarly, the lack of an authoritative, trusted voice on healthcare issues has made it more difficult to address public concerns over the safety of healthcare services.

Efficiency and value for money

There is only limited data on the efficiency, productivity and value for money of NHS healthcare services. These have not been discussed in detail in this report because they do not tell us anything directly about people's experiences of healthcare. Problems with addressing these complex questions were discussed in last year's report, including how such calculations take account of long term investments (such as new IT systems) or changes in the quality of care. Another danger also identified was that a focus on measures of activity (such as numbers of operations) created an incentive to do more, rather than do what is appropriate, and could, therefore, undermine efforts to improve the public's health.

Some progress has been made in addressing these questions, with the development of a measure of efficiency that assumes that the benefits of long term spending will be spread over future years.[2] However, more work is needed to take account of other factors. In the meantime, measures that are specific to services, such as those identified in the acute hospital portfolio, can provide more targeted measures of the efficiency of services. Managers can use these measures to identify areas in which resources could be released. For example, recent topics examined in the portfolio have found wide variation in levels of sickness in staff and in the extent to which good use is made of operating theatres.

An important aim of the Healthcare Commission's annual health check is to provide better information to the public about the quality and outcome of healthcare services. Other parts of our work, such as the investigation of serious service failures, certainly have a role in providing greater assurance to the public about the quality of services. But the development of new sources of information to fill these gaps will need the efforts of more than the Healthcare Commission. It will require involvement from many more national agencies and local providers of services.

Involving patients in the design of services

There is also an opportunity to develop services around the needs of people using services through greater involvement of patients and the public in the design of services. The creation of local forums, and the recruitment of staff to lead them, can also help providers to improve services from the point of view of those who use them. This could be of particular value in developing links between different aspects of services and improving aspects of care for patients in a wider sense. However, gaining a better understanding and meeting the needs of people from seldom-heard groups is a challenge, which may require national coordination and further research.

Giving people more control

This report has highlighted a number of lessons about the potential benefits of giving people greater control over the services they receive. In particular, we found that people prefer to have good local services, but many are willing to be treated elsewhere if this will reduce the time that they have to wait.

We also found that giving people more control over the services they receive, as demonstrated in the Expert Patients Programme, can also produce wider benefits for patients and for the NHS. To make this happen, the Government needs to ensure that the extension of policies to promote choice form part of a wider agenda to improve outcomes through greater involvement and empowerment of those receiving healthcare.

Providers of services also need to enable patients to take more control and responsibility over the care that they receive by providing better information and support to allow them to make choices about where, when and how care is delivered.

Do some people get a better deal from healthcare than others?

Developing and spreading good practice

Another theme of this report is the variation in people's experiences of healthcare when standards and good practice are not followed. This is a particular concern when quality of care and safety fall below the standards set for them. But variations are not limited to quality and safety. They can also be seen in aspects of services, such as managing relationships, communication, how well different services work together and how services meet the needs of disadvantaged groups.

For many, if not all, of these aspects, standards exist or good practice examples are available. However, service providers often fail to implement or learn from them. One possible reason for this is that systems to improve healthcare are often focused on preventing failure rather than improving.[118]

The Healthcare Commission can help trusts to overcome these problems by ensuring that its new annual health check takes account of existing standards (although the challenge will be to keep this manageable). Those involved in managing the performance of trusts will also need to direct attention to how well their work supports improvements in services.

For the Healthcare Commission, local reviews provide an opportunity to highlight and spread good practice. Existing and planned reviews will cover topics such as maternity services, healthcare acquired infections, services for older people, services for children and community mental health services. A planned review of public health should also help to identify good practice in meeting the needs of people from particular sections of the community.

Action on wider inequalities in health

Better information is required to understand wider inequalities in the health of different groups. However, addressing these will require a range of organisations to work together, along with a long term commitment to see actions through to their conclusion. For the Healthcare Commission, the development of local targets provides an important opportunity to include measures that take account of local circumstances and priorities in our annual health check. Both of these will play an important role in addressing inequalities.[118]

In order to prevent policies to extend choice from widening inequalities, the Government and local organisations will have to ensure that adequate support is provided to those less confident in taking advantage of these choices.

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