Inspecting Informing Improving

State of Healthcare Report 2004

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STATE OF HEALTHCARE REPORT
FOREWORD

The Healthcare Commission must present annually to Parliament, a report on "the provision of healthcare by or for NHS bodies". This State of Healthcare Report is our first.

In operation only since April 2004, we must rely largely on evidence collected by others. That said, we are able to add our contribution. The report is organised around themes and areas which will figure prominently in our work. We also draw attention to the aims and ambitions of the Commission in relation to these various themes.

It is tempting to offer some pithy, over-arching assessment: that the NHS is this or that. This is a temptation which we should avoid. The NHS is very large and complex. It does not lend itself to some general judgement.

The NHS serves a huge range of people, from pregnant mothers, to newborn babies, the chronically ill, those with acute illnesses, whether physical or mental, and those at the end of their lives. It must serve the whole nation, not just those who live in certain areas, or those best able to demand healthcare of good quality.

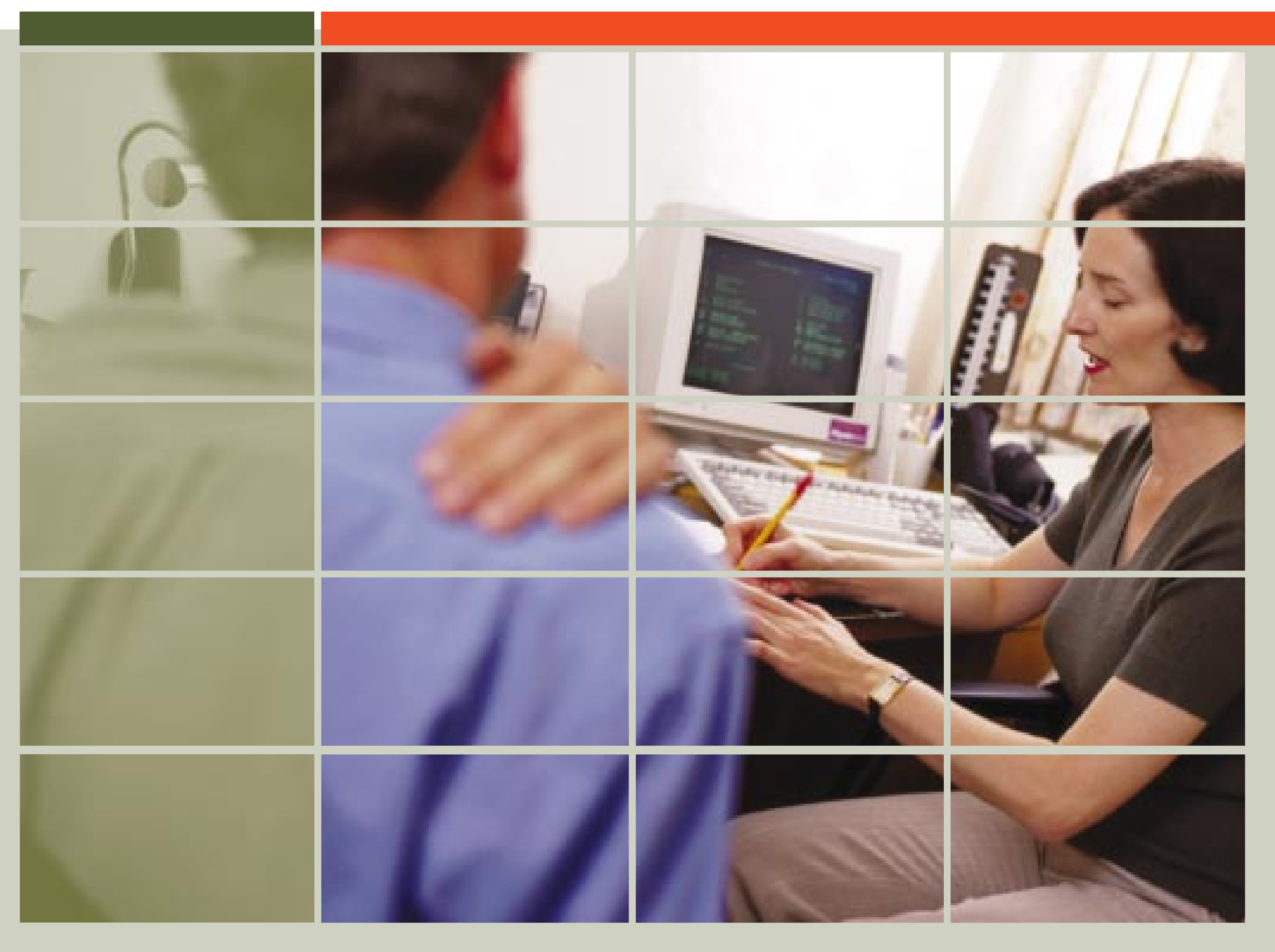
The NHS is the GP's surgery, intensive care unit, community care, hospital ward, and clinic treating those addicted to drugs. Those who work in the NHS bring vastly different skills and backgrounds: not just doctors, nurses and managers, but cleaners, physiotherapists, accountants, pharmacists, counsellors, technicians and drivers. United by their shared sense of purpose and commitment, they are vital: they should not be undervalued nor taken for granted.

The complexity and scale of the NHS means that judgements on its performance must be appropriately focussed. Clearly, we cannot report here how well a particular unit in a particular service is performing, although this is part of what members of the public want to know. We will seek to provide this information in our annual reviews of all NHS bodies. This report must provide a level of generality which neither over-simplifies or lumps together too many disparate elements of the NHS, nor drowns the reader in detail.

Who is our audience? While formally for Parliament, we have written our report with the general reader in mind. The NHS exists for all of us.

Our sincere thanks go to Robert Cleary and his team, and the staff of the Commission, all of whom have contributed to this report.

STATE OF HEALTHCARE REPORT
AN OVERVIEW



What is the State of Healthcare Report?

The State of Healthcare Report is aimed at all those with an interest in improving health and healthcare in England and Wales. It illustrates some of the key challenges we share and aims to give concise and useful background on the state of healthcare today. It draws together facts and analyses from reliable sources and highlights the complex pattern of factors which influence the health of the population and the provision of healthcare. This will be of particular interest to those charged with monitoring, holding to account, influencing and guiding local health services.

This State of Healthcare Report is the first in what will become an annual series from the newly established Healthcare Commission. The Commission's remit is to work with partners, within and outside the healthcare sector, to promote improvements in public health and in the quality and value for money of healthcare. We do so through our programmes of independent, authoritative, patient-centred assessments of the performance of those who provide healthcare services. We seek to coordinate inspections and are committed to reducing the burden of regulation.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and takes over some responsibilities from other commissions. The Healthcare Commission:

- replaces the work of the Commission for Health Improvement, which closed on 31st March 2004
- takes over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on 31st March 2004
- picks up elements of the Audit Commission's work which relate to efficiency, effectiveness and economy in healthcare

One of our key challenges is to provide patients, the public, policy makers and providers of healthcare with reliable and useful information. Each inspection, review, survey and other assessment that we undertake will be published, either in local reports on particular organisations or services, or in national

reports. Future State of Healthcare Reports will reflect on what these tell us from a national perspective. We will analyse trends and variations across the country, look at what has been achieved in return for the investment made and, where suitable means of making comparisons exist, assess how our healthcare services stand in international terms.

What does this report cover?

We use this report to explore a limited number of carefully selected topics in an accessible and focused way. Each topic reflects a different aspect of our role and an acknowledged priority for the health service. The topics we have chosen also allow us to highlight some of the areas on which we plan to focus our inspection efforts. In future years, we will cover a wider range of topics to provide a fuller picture of the nation's healthcare.

We set the scene by looking at **the health of the population**, not only because this is important as background, but also to reflect the new duty on us to scrutinise measures to improve public health, as well as healthcare. We explore the care of **children in hospital**, reflecting the duty laid on us by Parliament to give particular regard to the rights and welfare of children and the measures taken to safeguard them. An ageing population presents huge challenges in the provision of healthcare. We look at the issue from the perspective of **staying well in old age**. We are committed to promoting equal citizenship and human rights in healthcare: the experience of **black and minority ethnic people in mental health care** provides a stark illustration of the reasons why we have emphasised this commitment.

With the task of promoting improvement comes the challenge of establishing whether improvement is actually taking place. One nationally important measure examines how long patients are **waiting for care**. It is also crucial to continue to refine ways of measuring what some call productivity, or what is achieved in relation to what is invested. Equally, we must find better ways of **learning from patients' experiences**. We need to improve the way in which we approach the task of **auditing clinical quality** at a national level, by giving

clinicians the tools necessary to compare practice and improve care. These tasks reflect our concern for the quality of care being provided, but we are also concerned with whether patients and the public are getting value for money. **Decisions on spending**, both local and national, are important influences on both quality of care and value for money.

Over time, the Healthcare Commission aims to create a system of inspection and assessment that will apply regardless of whether healthcare is provided by the NHS or the **independent sector**. At present, though, our regulation of the independent sector continues to be based upon separate national minimum standards and a discrete framework for inspection and enforcement.

Themes and highlights

Real achievements that are benefiting patients...

In recent years, patients have experienced some substantial improvements in care. For example, the proportion of hospitals with dedicated stroke units has risen from 45% to 73% since 1998, supporting better outcomes for stroke patients. The significance of this lies in the fact that stroke is a leading cause of death and the largest single cause of severe disability in England and Wales. Another notable achievement is the significant progress made in England in cutting long waiting lists for admission to hospital: from 47,000 people waiting 12 months or more five years ago to fewer than 25 now.

...but the headlines do not tell the whole story...

In order to assess properly the extent of the improvements being made, it is necessary to go beyond the figures in the headlines. For example, we know that more than 90% of patients can now be offered an appointment with a GP within 48 hours, following the introduction of that as a target. But, to what extent has this been achieved by denying patients the opportunity of booking appointments further ahead than 48 hours? And how has this affected patients' overall experiences of the service? To understand progress from the patient's point of view, we need information that gives a fuller picture, rather than just 'progress towards the target'.

...and we need better information.
We are conscious that in many areas there is simply not enough information, or not enough complete, reliable and relevant information, to help us really to understand and describe the full picture. For example, whilst we have data telling us that there are fewer delays in discharging patients from hospital, we know less about how well the process of discharging patients is planned. Are patients being discharged 'quicker and sicker'? We need to get behind the raw statistics and gather information which helps us to understand the experiences of patients in such situations.

Greater emphasis on public health can have a huge impact...
The developing emphasis on improving the health of the population has the potential to influence greatly the state of healthcare in the longer term. The proportion of resources devoted to primary care, health promotion and the prevention of ill health is being reexamined. People will be expected to become more engaged in maintaining and even improving their health and to respond to initiatives aimed at reducing the risks they take. A wide range of agencies beyond healthcare will work together in this endeavour.

...but how best to measure the gains in health?
One of the major challenges engaging us is how best to measure the impact of this shifting emphasis. Current methods for measuring what is achieved can be perverse. At the moment, for example, a successful clinic aimed at reducing smoking should mean fewer hospital admissions for heart disease or lung cancer. However, such success could actually be counted as a reduction in productivity. If we are going to have healthcare services that invest for health, we must find new ways of assessing their achievements in improving health.

Variations in health and the provision of healthcare services are striking...
The national state of healthcare is notable for its local variability. People who are less well-off tend to have poorer health. Life expectancy and the incidence of long term illness vary between regions in England and Wales. There are

variations in health across different ethnic groups: diabetes, for example, is six times more common amongst South Asians. There are differences in people's experiences of health services: for example, it is striking that compulsory admissions to mental health units appear to be disproportionately high for some black and minority ethnic groups. There are also inconsistencies in the provision of services: for example, the proportion of older people receiving flu vaccinations varies from 78% to 49% across primary care trusts.

...but we will stress the equal entitlement of all groups to the same standard of healthcare.
We are committed to the principle of equal citizenship. Where there is evidence of inequalities in access to, or the provision of, healthcare, we will stress the equal entitlement of all groups to the same standard of healthcare. In so doing, we will recognise and seek to understand the particular challenges presented by different sections of the population. We will also examine and comment on the allocation of resources across the NHS in relation to the needs of local populations.

Conclusion
As we made clear at the outset, this, our first State of Healthcare Report, is illustrative rather than comprehensive. This is inevitable: we have only just begun our work. Over time, we will be able to build up a richer picture of the state of healthcare. We expect in future to issue a linked report that focuses on healthcare in Wales, its particular context and issues. We will also be in a position to look in more depth at the state of the provision of healthcare in the private and voluntary sectors.

SETTING THE SCENE: HEALTHCARE SERVICES

THIS SECTION DESCRIBES THE ORGANISATION OF HEALTHCARE IN ENGLAND AND WALES, INCLUDING NHS AND INDEPENDENT PROVIDERS

NHS activity

The NHS in England is a large and complex organisation. It employs around 1.3 million people – more than any other organisation in Europe.

- on average, men consult their GP four times a year, women five.[7] In England alone, patients consult GPs around 220m times each year[8]
- across England and Wales, over 660m NHS prescription items are dispensed in the community annually[8,9]
- in England there were 6.3m calls to NHS Direct in the year to March 31st 2003 – a rise of just over 20% on the previous year.[8] In Wales, 2% of NHS Direct's 303,000 calls last year were in Welsh[10]
- there are around 15m visits to accident and emergency (A&E) departments a year in England and Wales[11,9]
- in England in the year to March 31st 2003, the NHS ambulance services made 3.2m emergency journeys. This figure has risen for each of the last eleven years and is now about 60% higher than it was in 1992[12]
- the NHS in England and Wales has nearly 200,000 hospital beds[13,14]
- people suffering from some form of mental illness account for around 200,000 inpatient admissions to NHS hospitals each year in England and Wales[15,16]
- across England, nearly 12% of outpatient appointments are not kept by the patient[17]
- the NHS delivers around 600,000 babies a year in England and Wales – over 1,600 a day[18,19]

Figure 1 shows the main organisations that make up the NHS in England. The full picture is more complex than can be shown here. For example, the figure does not show either the important relationships between the NHS and other agencies such as local authorities, or regulators such as the Healthcare Commission.

Department of Health

Manages the NHS, develops policy, sets national standards and allocates resources

21 special health authorities

are organisations providing a specific national service to the NHS or the public, eg. the National Blood Service and the NHS Direct telephone help line

28 strategic health authorities

act as the link between the Department of Health and NHS locally. They develop the strategy for improving NHS services within a region, make sure that national priorities are translated into local plans and monitor the performance of local services

300 primary care trusts (PCTs)

plan and manage NHS services locally, either by commissioning services from other organisations (eg. hospital care from an NHS Trust), or by providing them directly (eg. health visitors, community midwives or mental health services for older people)

Primary care

usually a patient's first point of contact

Secondary care

specialised treatment usually provided by hospitals

32,593 GPs

work with nurses and other staff to treat patients or, when necessary, refer on for more specialised care

43 walk-in centres

A new type of health centre: open early until late seven days a week, offering treatment for minor conditions and advice on other local services

20,857 dentists

9,748 community pharmacies

8,096 ophthalmic opticians

209 NHS trusts

Hospitals are run by NHS trusts. Most trusts provide a wide range of services, while some focus on a particular specialised area of care – eye or heart hospitals for example. Ten trusts are now foundation trusts and have additional devolved powers to manage and develop their services

23 mental health trusts

provide specialist mental health services, in hospitals and the community

30 Ambulance trusts

provide emergency access to healthcare and, in many areas, patient transport services

8 care trusts

A new kind of organisation which provides both health care and social services for one or more groups of patients/clients – older people or people with mental health problems, for example. Some take on the role of a PCT as well.

Figure 1. The NHS in England.
Sources: Department of Health and NHS Information Authority[1,2,3,4,5,6]

The NHS is also Wales' largest employer. It has over 81,000 staff, representing more than 7% of the Welsh workforce. Responsibility for the NHS in Wales is devolved to the Welsh Assembly Government and the service has a slightly different structure to the NHS in England.

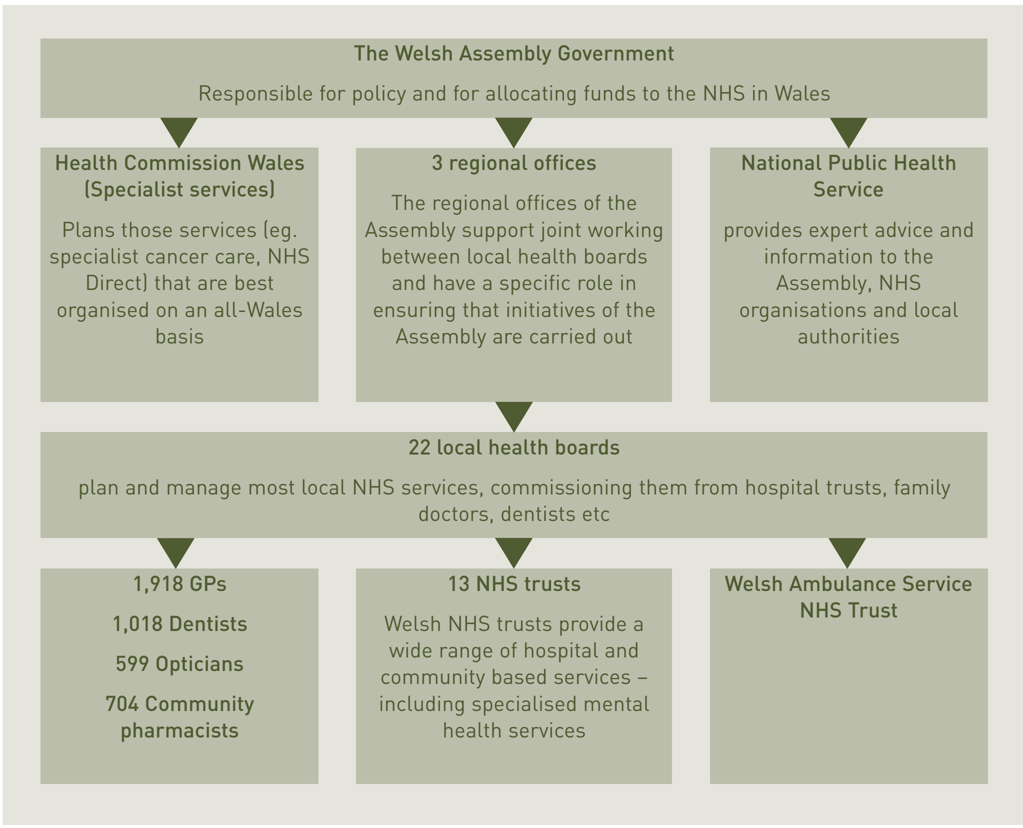


Figure 2. The NHS in Wales.
Source: Health of Wales Information Service[20,21]

Independent healthcare

In England, the Healthcare Commission is also the regulator for independent healthcare providers – those that operate hospitals and clinics in the private and voluntary sectors. On taking over this responsibility on April 1st 2004, the official register of these providers included 914 services (table 1).

<table>
<tr><th colspan="5">914 healthcare services, comprising:</th></tr>
<tr><th colspan="2">246 Acute hospitals</th><th>482 clinics and other facilities</th><th colspan="2">186 mental healthcare establishments</th></tr>
<tr><td>205 with inpatient facilities</td><td>41 with day care facilities only</td><td rowspan="2">Establishments providing medical treatment in clinics – hair and tattoo removal by laser for example. Other services provided include: kidney dialysis; in-vitro fertilisation; and abortion</td><td rowspan="2">175 able to treat patients detained under the Mental Health Act</td><td rowspan="2">11 able to treat voluntary patients only</td></tr>
<tr><td colspan="2">Providing a range of investigations and treatments, including surgery and specialist palliative care</td></tr>
</table>

Table 1. Registered independent healthcare providers in England as at 1st April 2004.
Source: Healthcare Commission.

The role of the Healthcare Commission in the private and voluntary sector is described in the section Independent but regulated. While the integration of regulation of NHS and independent healthcare is new, public and private providers already work together and share facilities. Some facts and figures about these links, within England, are shown below.

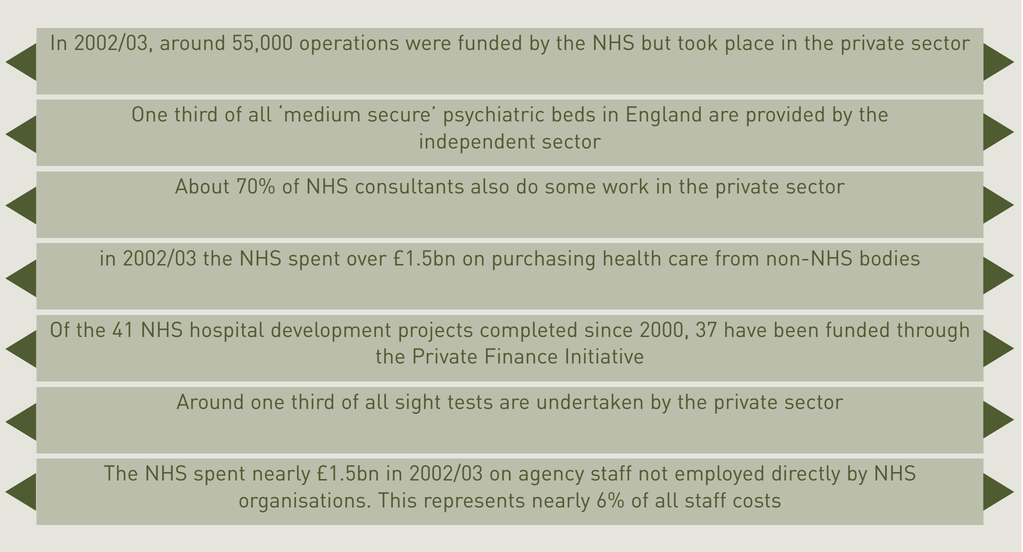


Figure 3. Examples of links between the NHS and the independent sector in England. Various sources[8,22,23,24,25,26,27]

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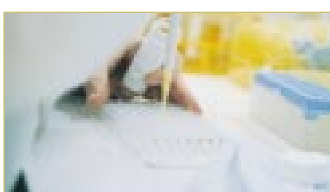
STATE OF HEALTHCARE REPORT
SETTING THE SCENE: THE PUBLIC'S HEALTH

WHO WE ARE CAN INFLUENCE OUR HEALTH NEEDS AND OUR EXPERIENCE OF HEALTHCARE SERVICES. THIS SECTION LOOKS AT THE PUBLIC'S HEALTH.



The previous section outlined the scale and organisation of healthcare services across the country. This section sets the context for the rest of the report by looking at some of the major health problems that face those services. The provision of healthcare alone cannot solve these problems. The section ends by considering how the contribution of healthcare fits into the bigger picture.

Health in England and Wales

Health is influenced by a wide range of issues, including age, economic status, education, ethnic origin, and where people live.

Population trends

The population is growing older. This has implications for how healthcare is organised and how health services act to prevent disease and prolong good health.

There are 52.4 million people in England and Wales. For the first time, there are more people (21%) aged over 60 than there are children under 15 (19%).[1,2] But the pattern is different in different parts of the country (see box 1).

Box 1: Population variation

- in Newham in east London, 12% of the population is over 60; in east Devon the figure is 33%.[1]
- in Newham 61% of the population comes from black and minority ethnic communities (including people of mixed origin); in east Devon less than 1% does.[2]

Social and economic issues

People who live in deprived areas and who are less well off generally have poorer health and lower life expectancy than the better off living in wealthier areas. Poverty, poor housing and lack of education all affect people's health. There is more about this later in this section.

There are large variations in life expectancy across regions in England and Wales

Black and minority ethnic communities

Black and minority ethnic groups, including people of mixed origin, make up 9% of the population of England and 2% in Wales.[2] Black and minority ethnic communities are geographically concentrated – for example 29% of London's population is from black and minority ethnic groups – and tend to be younger than the white population.

Black and minority ethnic groups are likely to experience greater socio economic disadvantage, worse access to healthcare services and poorer health than white communities. For example:

- people of African Caribbean origin have a higher prevalence of hypertension and stroke than the general population[3,4]
- diabetes is up to six times more common in South Asian people and three times more common in Black Caribbean people than in the general population[5]
- diagnoses of schizophrenia are several times higher among African Caribbean groups than the white population[6]

In some instances, however, black and minority ethnic communities have better health. For example, of women living in England and Wales those born in the Caribbean and South Asia have lower mortality from breast cancer than the national average[7] and Indian, Pakistani and Bangladeshi women are less likely to smoke than women generally (although Bangladeshi men are more likely than average to smoke).[5]

Long term illness

In England and Wales, 18.2% of people have a long term illness or disability that limits their daily activities, or the work they can do.[2] Such problems are more common among people with lower incomes. The highest proportion of people with such long term illnesses (23.3%) is in Wales, while the lowest (15.5%) is in the South East and London.[2]

Life expectancy

Life expectancy is an indicator of the overall health of the nation and the differences in health experienced by particular groups. Life expectancy at birth in England and Wales is almost 76 years for men and just over 80 for women.[1] It increased by 2.4 years for men and 1.6 years for women over the 1990s.

However, there are large variations in life expectancy across regions in England and Wales. Taking the extremes of this variation:

- a baby boy born in Manchester has a life expectancy of 71 years – it would be 79.5 years if born in Rutland
- a baby girl born in Manchester has a life expectancy of 77.3 years – it would be 84 years if born in Kensington and Chelsea[1]

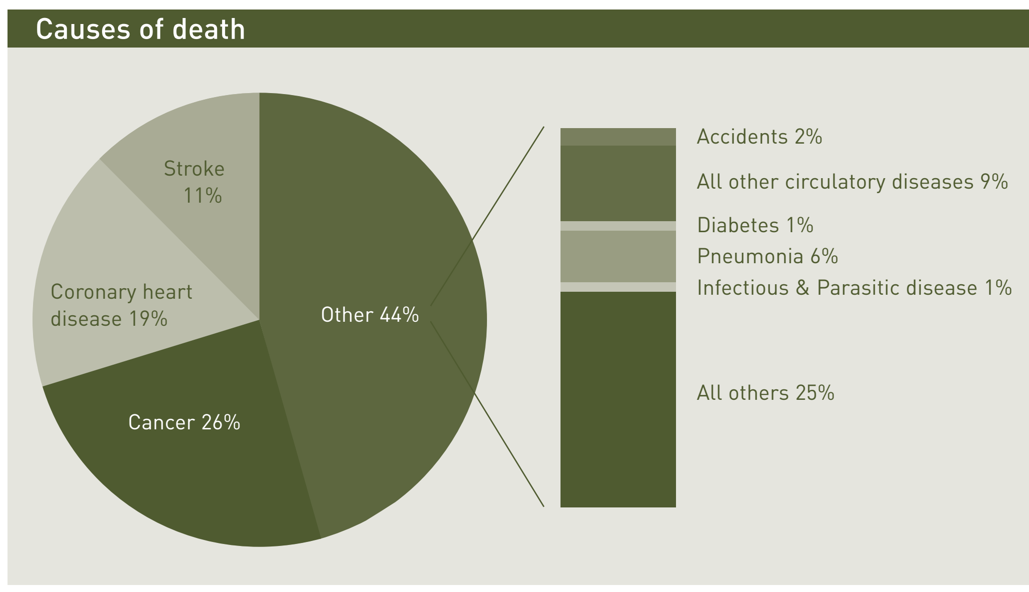


Figure 1. Percentages of deaths due to particular causes in England & Wales 2002.
Source: Compendium of clinical and health indicators[1]

“ In addition to being a major cause of death, stroke is the largest single cause of severe disability in England and Wales

Causes of death

Cancer

In 2002 there were over 136,000 deaths from cancer.[1] Mortality from all cancers fell by 13% between 1993 and 2001. However, there are wide variations with respect to social class and geographical area – for example, mortality from all cancers is about 60% higher in Tower Hamlets and Liverpool than in east Dorset.[1]

Coronary heart disease

Deaths from coronary heart disease have been falling steadily in recent years,[8] although in 2002 (the latest year for which figures are available) about 103,000 people died from coronary heart disease in England and Wales.[1] There are significant differences in coronary heart disease mortality with respect to gender, socio-economic status, geographical area and ethnic origin:

- death rates in men under 75 are almost three times higher than in women[1]
- Coronary heart disease is more common in people of South Asian origin and this community has an almost 50% higher coronary heart disease mortality rate than the general population[7]
- there are social class differences, with death rates in affluent areas such as Guildford, Kensington and Chelsea being half those in deprived areas such as Manchester, Tameside and Liverpool[1]

Stroke

In addition to being a major cause of death, stroke is the largest single cause of severe disability in England and Wales, with over 300,000 people being affected at any one time.[10]

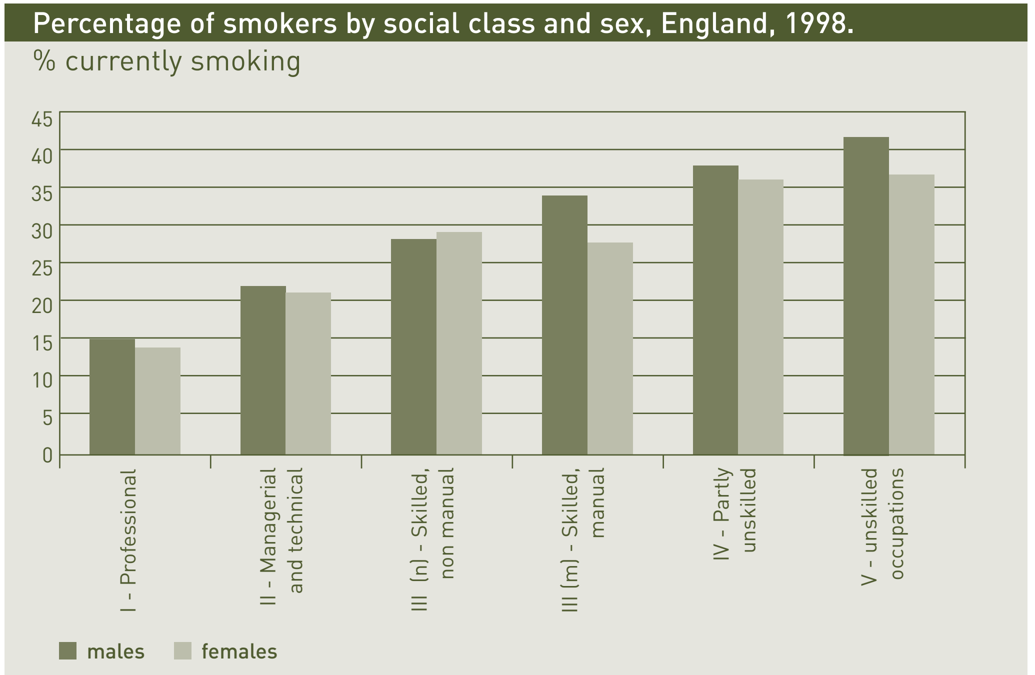


Figure 2. There are significant differences between social classes in the case of smoking – a major risk factor for coronary heart disease, cancer and stroke. Smoking rates are highest among unskilled workers and lowest among professionals.
Source: adapted from Wanless (2003)[9]

Health from youth to old age: some examples

Children

Infant mortality: About 3,100 babies under the age of one die each year – a rate of 5.3 deaths for every 1,000 births. Another 3,300 are stillborn.[1]

Low birth weight: About 8% of babies weigh less than 2.5kg when they are born. Low birth weight is linked to infant mortality and to problems with health later in life.

Breastfeeding: Although 73% of mothers start out by breastfeeding their babies, only 47% continue to do so for at least a month.[11]

Measles, mumps and rubella (MMR): The proportion of children in England immunised against MMR fell to 82% in 2003/03.[12]

Obesity: About one in five boys and one in four girls aged two to 15 is either overweight or obese, with obesity more common in deprived areas.[11]

Healthy eating: Consumption of fruit and vegetables by children increases with household income.[11]

Physical activity: Around a third of children fail to reach recommended levels of physical activity of at least an hour a day.[11]

Accidents: The injury rate for children from unskilled families is five times that of children from professional families.[13]

Asthma: Asthma is one of the most common chronic diseases in children, with about a fifth of children reporting a medical diagnosis of asthma.[14]

Young people

Sexual health: Between 1991 and 2001, new cases of sexually transmitted infections (STIs) seen in clinics specialising in genito-urinary medicine in England, Wales and Northern Ireland doubled from about 670,000 to 1.3 million. Chlamydia, the most common STI, is a cause of pelvic inflammatory disease, ectopic pregnancy and infertility. The rate of chlamydia has increased since the mid 1990s and is highest among 16 to 19 year old women.[15]

Teenage pregnancy: The mortality rate for babies born to teenage mothers is 60% higher than for older mothers. Rates of conception among under-18s vary from less than 30 conceptions for every 1,000 girls aged 15 to 17 in relatively affluent areas to more than 90 in some deprived inner London areas.[16] Over a third of all pregnancies (35.8%) in women under 25 in England and Wales end in abortion.[17]

Smoking: A third of 16 to 24 year olds smoke.[11]

Obesity: One in ten young people is obese, while about one in three is overweight or obese.[11]

Suicide: In England and Wales in 2002, 1,479 people aged 15 to 34 committed suicide. Suicide accounts for over 20% of all deaths for males in this age group.[1] Suicide rates in young Asian women are almost double those for young women generally.[18]

Adults

The risks of disease and early death are increased by unhealthy behaviour, much of which starts when people are young.

Smoking: About a quarter of men and women smoke.[11] Despite a decline in cigarette smoking up to the late 1980s, since about 1990 the prevalence of smoking among adults has fluctuated between 25% and 30%, without a clear trend.

Although there are clear links between low birth weight and smoking, around 18% of mothers smoke during pregnancy. The percentage of mothers who smoke decreases as income increases.[11]

Physical activity and healthy eating: Six out of 10 men and seven out of 10 women are not active enough to benefit their health. Men from low income households are twice as likely to be insufficiently active, compared to those in the most affluent households.[19]

Twenty two per cent of men and 23% of women in England are obese. Another 43% and 34% respectively are overweight.[11] Roughly twice as many adults in higher income groups eat five or more portions of fruit and vegetables a day compared to those in lower income groups.[9]

Alcohol: Around 30% of men and 20% of women drink more than the recommended weekly limits for the consumption of alcohol.[11]

Older people

Coronary heart disease: Coronary heart disease is a major cause of death among older people. Almost 21,000 people aged 65 to 74 years in England and Wales die every year prematurely from coronary heart disease, accounting for about 22% of all deaths in this age group.[1]

Stroke: Seven thousand five hundred older people in England and Wales die prematurely (between age 65 and 74) from stroke each year.[1]

Diabetes: Older people are more likely to get diabetes. One in 20 people over 65 in the UK has diabetes – one in five in the over 85s.

Mental health: Depression is the most common mental health problem in older people, with women more likely to be depressed than men. The rate of suicide among older people is relatively high, and the rate for men over 85 is amongst the highest.[20] The rate of depression in some groups, such as older black African and particularly Somali people, is higher than for white British people.[21]

Falls: Up to 14,000 people a year die in the UK as a result of osteoporotic fractures of the hip. After an osteoporotic fracture, 50% can no longer live independently.[22]

The NHS has a role as a leader and a partner in improving health

The wider determinants of health

A wide range of factors influence health and health inequalities. These include:

- **personal** – age, sex, ethnic origin and genes
- **socio-economic** – education, employment, economic status, housing, where someone lives
- **lifestyle** – diet, physical activity, tobacco and substance misuse
- **environmental** – pollution

The NHS cannot directly influence many of these wider factors which affect people's health. Many opportunities to have an effect on these lie elsewhere – in local government, for example, which has a primary responsibility for housing, environmental, educational, leisure and social services.

That said, the NHS can play an extremely important role in improving health and reducing health inequalities in a sustainable way, by:

- ensuring healthcare services are cost effective and achieve a good balance between health promotion, prevention of disease, treatment, and care
- joining up or linking services across organisations – for example linking hospital discharge with home help
- attending to the health and well being of its staff, and as a corporate citizen recruiting staff and purchasing goods and services locally to benefit the communities in which it operates

Nationally, the Government is placing increasing importance on improving public health (see Box 2), as demonstrated by the Wanless report *Securing good health for the whole population*[23] and the Department of Health's *Choosing health?* consultation document.[19] The House of Commons Select Committee on Health echoed this shift in emphasis in its recent report on sexual health, which urges that sexual health be recognised as a major public health priority.[24]

Box 2. Public health

Public health is the "science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals."
Wanless Report 2004

Public health professionals are concerned with:
• improving health and protecting against illness, for example reducing heart disease and providing immunisation
• health inequalities – reducing the gap between those with good health and those with poor health
• planning for major incidents or outbreaks

Locally, the NHS has a role as a leader and a partner in improving health. In order to make sure that its services meet local needs, to contribute to the work of other local organisations and to take on this broader leadership role, the NHS needs to work with a range of partners such as:

- those engaged in area wide planning of services, such as local strategic partnerships that include local authorities, the police, and other local organisations and groups
- 'issue focused' bodies such as drug action teams
- area based initiatives such as SureStart programmes for children

The role of the Healthcare Commission

The Healthcare Commission has a new role in reviewing the capacity of healthcare organisations to improve the health of the population. This includes the examination of aspects of public health services, such as the assessment of local needs, the commissioning of services to meet those needs, programmes to promote health and prevent disease, and emergency planning. There will also be a focus on major challenges to the health of the population – initially sexual health and smoking. Future reviews will address other health priorities.

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STATE OF HEALTHCARE REPORT

WAITING FOR CARE

WAITING FOR HEALTHCARE SERVICES IS A MAJOR CONCERN FOR MANY PATIENTS. THIS SECTION DESCRIBES WHAT IS BEING DONE TO REDUCE WAITING.

Why this topic?

When diagnosis or treatment is delayed, the result can be frustration and anxiety for patients (see Box 1). For some conditions, waiting for treatment is also potentially life threatening.[1]

Reducing the time that patients have to wait for treatment remains a key priority for the Government's programme of investment and reform for the NHS.[2,3]

Box 1. What patients say about waiting[4]

when the delay is long...

"I was horrified to hear about the length of the waiting list, the thought of having to endure this severe pain was too much to bear."

"The condition I have is uncomfortable and without high dose medication would be unbearable, but I have to wait at least six months for the operation."

"The worst thing for me was the delay (10 days) waiting for a brain scan."

"The treatment I got was perfect. I can only find fault with the waiting times. For old people it is very worrying, 12 months waiting is a long time."

"This [the waiting] makes a mockery of all the good work which has been carried out beforehand."

...and when things move faster

"My initial appointment came within three weeks of seeing my GP. I had surgery about three months after the initial consultation and the results of this are excellent."

Reducing delays – the Government's targets

The Department of Health has set a range of targets aimed at tackling waiting times in England. These are a major part of the star rating system, currently used to assess the performance of NHS organisations.[5] Some current targets and the progress being made towards meeting them are shown below.

Target to be achieved by March 2004[2]	Current position
No one should wait more than nine months to be admitted to hospital.	The figures for March 2004 record fewer than 50 patients waiting more than nine months.[6]
	This contrasts with the situation five years ago, when approximately 131,000 people had been waiting for nine months or more – and of these 47,000 had been waiting more than a year.[7]
No one should wait more than four months (17 weeks) for a first outpatient appointment.	Eighteen months ago more than 111,000 patients had waited more than four months.[7] The total number reported in March 2004 was 18.[6]
At least 90% of people going to accident and emergency (A&E) for treatment should be seen, treated and discharged, or admitted to a ward, within four hours*.	Final figures for March 2004 were not available at the time of writing, but results from earlier in the year show the target as having been reached – if minor injuries units and walk-in centres are included in the figures.[6,7]
Ninety per cent of patients should be able to see a GP within two working days. The target is 100% from December 2004.	Figures for March 2004 indicate that 97% of patients can be offered an appointment within two working days.[6]
Patients referred urgently to specialists in cancer should be seen within two weeks.[12]	Latest figures show that 98.9% of patients referred urgently to specialists in cancer are seen within two weeks.[13]

* For hospitals that have completed the NHS Modernisation Agency's emergency service collaborative scheme, the four hour target applies to all patients (excluding clinical exceptions) rather than 90%.

Waiting in Wales

The improvements in waiting times reported in England are not echoed in Wales. At the end of March 2004, 8,457 patients (about 11% of those waiting) had been waiting more than 12 months for admission to hospital. Of these 1,401 had been waiting more than 18 months.[8]

However, the NHS in Wales has had some success in reducing waiting times for particular operations. There are now no patients waiting more than 12 months for heart surgery, or more than 18 months for orthopaedic surgery, such as hip and knee replacements. Furthermore, when the Audit Commission reported on A&E in 2001 it found that waiting times for medical attention were shorter in Wales than any region of England.[9] For patients referred urgently to specialists in cancer, the intention has been that patients are seen within 10 working days,[10] but no routine statistics are available to measure performance against this standard.

Nevertheless, the general picture on outpatient waiting times (where 10% of those referred to a specialist have been waiting more than a year[8]) is, like that for inpatients, one of patients encountering longer delays for care in hospital in Wales than in England.

The reasons for this difference demand careful examination – levels of ill health (see previous section – The public's health) are known to be relatively high in Wales. A less healthy population will make greater demands on health services. However, Wales and the north east of England have populations that are similar in many ways and, in addition, Wales spends more money per person on healthcare.[11]

In the end the difference in waiting times may be due to a combination of reasons including differences in the population and in the way the health service in Wales is run. For example, compared to England, Wales has not adopted as strong an emphasis on targets for reducing waiting lists.

The National Audit Office Wales is currently conducting a study of waiting times in NHS Wales, and the Healthcare Commission will return to this theme in future national reviews of healthcare in Wales.

“ There are now over 380,000 nurses, midwives and health visitors working in the NHS

Targeting delays: solutions

Delays in treatment can occur through a lack of resources, or their inefficient use.[14,15] A lack of resources might include shortages of staff, too few operating theatres, or not enough beds. Efficient use of those resources requires that services are planned and organised effectively; that the right equipment is in the right place at the right time, and that staff are adequately trained, for example.

Action is being taken within the NHS to increase the resources available and to improve the efficiency of their use. Below are some examples.

Increasing capacity – facilities

Specialised treatment centres are being set up to cut waiting times for some of the more commonly needed operations such as hip replacements, hernia repairs and the removal of cataracts. Treatment centres also carry out a range of investigations, such as endoscopies.[16]

Treatment centres aim to contribute to reducing delays because they increase the resources available for certain treatments and are able to plan the use of those resources better. They can take advantage of economies of scale, and planning is not disrupted by the need to respond to emergency admissions – one of the factors that complicates planning in traditional hospitals. Operations, therefore, are less likely to be cancelled or rescheduled. By the end of 2005, the Department of Health intends that there will be 80 treatment centres, treating 250,000 patients a year. Twenty nine are already open. Of the 80, it is intended that a proportion will be run by the private sector, but all treatment centres will have to offer free care and be subject to national standards as regards the services provided, covering matters from cleanliness to clinical practice.

Treatment centres must be judged not only on the quality of the care they provide, but also on their ability to offer value for money. It is too early to judge the success of this new venture, but the Audit Commission has highlighted a number of questions that are likely to be pertinent to any evaluation.[15]

- will treatment centres be able to attract and retain additional clinicians and support staff without 'poaching' resources needed at existing NHS hospitals?
- can treatment centres establish working practices that maximise the benefits of their being specialised and make efficient use of their resources?
- if patients transfer from existing waiting lists in NHS hospitals to fast track treatment at treatment centres, will this cause financial problems for these hospitals – with detrimental effects to their other services?

Increasing capacity – staff

In 2000 the Department of Health identified shortages in staff as the biggest constraint facing the NHS, and set targets of an extra 20,000 nurses, 7,500 consultants and 2,000 GPs for the NHS by April 2004.[17]

The target for nurses was met by 2001 and there are now over 380,000 nurses, midwives and health visitors working in the NHS. Many of the new staff have been recruited from abroad – new overseas registrations have more than doubled from their 1999/2000 level to around 13,000 in 2002/2003[18] – while others include UK trained staff who have been encouraged to return to the NHS.[19]

Progress is also being made on increasing the number of doctors. For GPs the target was achieved in December 2003. For consultant staff, however, the December 2003 figures show that 21% of the target increase over the 1999 baseline of 23,321,[20] remains to be achieved.[21]

Nurse practitioners can carry out some of the tasks that used to be done by doctors

Further increases in the numbers of staff are regarded as essential by the Department of Health.[22] However, there are difficulties ahead that may reduce the impact of the growing numbers. For example:

- there are increasing restrictions, such as the European Working Time Directive,[23,24] on the number of hours that junior hospital doctors can work. As new recruits arrive, they and existing juniors will on average work fewer hours than was the norm in the past
- more GPs are choosing to work part time, meaning that the increase in numbers will be in part offset by the shorter hours worked[25]
- there is a risk that the rate at which nurses leave the profession will increase. A third of all qualified nurses, midwives and health visitors in the NHS are aged 45 or more and the proportion likely to retire in the next few years (i.e. aged 55 or more) is increasing.[26,27] Concerns have also been raised about how long nurses recruited from overseas will stay in England.[19]

Managing resources – making the best use of staff time

In addition to the introduction of new resources, there remain opportunities to develop new ways to organise services, based on the needs of patients, that make delivery of these services more efficient.

For example, a recent review by the Audit Commission focused on the efficiency with which operating theatres are used in NHS hospitals.[28] It found that one in four trusts failed to use at least 35% of the time scheduled for operations. It appeared that at some hospitals operating sessions were being cancelled because of problems which could have been predicted, such as a surgeon being away on annual leave. Better planning would have allowed the time to be offered to another surgeon, rather than being wasted.

Other initiatives focus on staff, such as extending their skills so that they can undertake new activities. For example, nurse practitioners can carry out some of the tasks that used to be done by doctors. Moreover, this can have a substantial impact on the overall capacity of a department.[14]

Managing resources – the patient choice initiative

Official figures show that waiting times for admission vary from hospital to hospital. Longer waiting times are not confined to any one part of England, although some areas, such as the south east, exhibit the problem more acutely.[15]

This kind of variation is one of the main reasons for the Department of Health introducing the patient choice initiative, which makes the following commitment: by the summer of 2004, all patients who have been waiting six months for surgery will be offered the chance to choose to be treated at another hospital. From the end of 2005 the scheme will be extended to offer a choice of hospitals and treatment centres to all patients when they are referred for treatment by their GP.[29†]

One objective of the scheme is to help hospitals that have spare capacity take the pressure off those that do not. Pilot schemes have been testing this plan and, although not all the statistics are available yet, it appears that between a half and two thirds of patients who have waited six months take up the offer of faster treatment at a different hospital.[29] More research and development needs to be carried out to find out why some patients turn down the offer and to make sure that all sections of the population can exercise the choice offered.[30]

Targeting delays: problems

Quick fixes

The Audit Commission's 2003 report on hospitals' progress towards meeting the Government's targets concluded that most would achieve the targets relating to waiting times. However, auditors expressed concerns that some of the methods used might not be sustainable.[31]

While gains achieved by making more efficient use of operating theatres, or cutting out administrative delays, were judged to be potentially long lasting, some other methods were considered less robust. The report asked: "Will trusts that achieved targets by special measures such as paying consultants to do extra sessions, or paying private providers, be able to repeat this year after year?"

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† In Wales, the Second Offer Scheme offers treatment at another hospital, which may be in England, to anyone either already waiting or likely to wait over 18 months for an operation.

It will remain important for services to consider the whole of the patient's journey

Seeing the whole of the waiting time

Government statistics divide waiting times among different parts of the healthcare system – waiting to see a GP, waiting for an outpatient appointment and so on – but for the patient this is all part of one journey.[14]

Problems can arise when only one part of this journey has a target. For example, a maximum of two weeks delay for patients referred urgently to a cancer specialist may help to speed up diagnosis, but there is a risk that if resources are disproportionately deployed to achieve this target, then the actual treatment for the cancer, if needed, may not start sooner than it would have done, and could even be delayed further.

Steps have been taken to try to prevent this by adopting more sophisticated targets. For some cancers, targets have been introduced that measure the time between referral by the GP and the point at which the first treatment starts. These targets will cover all types of cancer by 2005.[1] However, it will remain important for services to consider the whole of the patient's journey. Patients will want to be sure that concentration on the target for first treatment does not delay follow up treatment to any extent that puts recovery at risk.

Getting the priorities right

In 2001 the National Audit Office reported the results of a survey of hospital consultants which suggested that just over half felt that the need to meet waiting list targets had meant that they had treated patients 'in a different order... than their clinical priority indicated'. More recent anecdotal reports of waiting time targets having adverse clinical consequences, such as those reported to the Public Accounts Select Committee last year,[32] give cause for concern but do not provide a systematic basis for assessing the extent of the problem within the NHS.

Hitting the target but missing the point

Waiting time targets can be hit without producing any gain for patients. The Audit Commission's spot checks of waiting lists (see Box 2) detected practices such as offering patients appointments at very short notice, and then resetting their waiting time to zero when they are unable to take up the offer. This helped trusts avoid having patients who have waited longer than the maximum, but did nothing for the patients concerned.

Box 2. Can the figures on waiting list reductions be trusted?

There have been a number of media stories about waiting lists being 'fiddled' to make the performance of hospitals look better, perhaps meeting targets that would otherwise have been missed. Independent spot checks found weaknesses – mostly inadvertent, a small minority deliberate – in how waiting times were recorded and calculated in some English NHS trusts.[33]

It was concluded that while these could cast doubts on whether all patients were treated within target times, the level of accuracy was good enough to establish the kind of broad trends discussed here. Evidence from more recent spot checks continues to support this conclusion.[34] The official figures on large reductions in long waiting times for admission can be believed; they represent an impressive achievement compared to how long people were waiting for hospital care five years ago.

Problems can arise when there is too narrow a focus on achieving a particular target. The Secretary of State for Health, John Reid, recently tackled this issue with respect to the 48 hour target for appointments with a GP.[35] There is anecdotal evidence that to help achieve this target, some practices have restricted patients' ability to book an appointment with a GP further than 48 hours in advance.[36] The Health Secretary made clear that he wanted all patients to have the option of seeing a GP at short notice, or booking a later appointment: the goal of the 48 hour target was "meeting the needs and aspirations of NHS patients, not shoehorning their expectations into pre set systems and targets."

> The goal is not 'hitting the targets' – it is to put in place lasting solutions that meet the needs of patients

The point made by the Secretary of State applies generally to targets relating to access to healthcare. The Government has focused its efforts on waiting and the NHS has been very successful in reducing a problem that causes misery for many people. As this chapter has shown, the work to cut waiting times continues. An important part of the task ahead, however, is to keep in mind that the goal is not 'hitting the targets' – it is to put in place lasting solutions that meet the needs of patients.

What will the Healthcare Commission do?
In view of the importance of waiting times to many patients, access to NHS services will be an important component of our assessments.

In our first year, for example, a national review of A&E services will assess waiting times for triage, medical attention and admission.

In the longer term, as we develop our approach to annual ratings of the performance of NHS organisations, while it is likely that waiting times will remain an important component, we intend that they will be only a part of a richer picture of performance than is available from the current set of star rating indicators.

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STATE OF HEALTHCARE REPORT

STAYING WELL IN OLD AGE

OLDER PEOPLE MAKE MORE USE OF HEALTHCARE SERVICES. THIS SECTION LOOKS AT THEIR NEEDS AND THE SERVICES DESIGNED TO MEET THEM.

Why this topic?

Healthcare services make an important contribution to the health, independence and well being of older people. Improvements in the quality of life and in the degree of independence of older people are a priority for the NHS.[1] The National Service Framework for Older People,[2] published in 2001, sets standards for "...better, fairer and more integrated health and social care services for older people."*

Positive developments in services for older people are important for today's elderly population. They also contribute to an effective response to the needs of an ageing population. Within approximately 15 years the proportion of the population aged 60 or over will have risen from 20% to 25%, with further increases expected.[3]

Healthcare – part of a bigger picture

As people get older, they make more use of healthcare services. For example, the 20% of the population aged 60 or over accounts for more than 40% of the people cared for in NHS hospitals.[4] But staying well in old age is not simply a matter of treatment in hospital and may involve assistance from agencies other than healthcare services.

For example, an elderly man with recurrent chest infections may need a range of help that does not come under the heading of healthcare, such as reliable heating and the income to pay for it, help in his home and opportunities to get out and about, stay active and meet people. As a result, the necessary package of care may involve social services, the housing department and voluntary organisations that can provide a range of services such as lunch clubs and benefits advice.

Notwithstanding this bigger picture, we begin by focusing on some of the specific contributions healthcare makes to the well being and independent life of older people.

* The National Service Framework for Older People relates to care in England. A comparable framework is being developed in Wales, with publications planned for 2005. This section of the State of Healthcare Report focuses on England.

“ Patients in their 70s were the group most likely to seek advice on healthy eating and exercise

Care close to home

While treatment in hospital is an important part of the healthcare of older people, most of the contribution made by the NHS to help them stay healthy and independent takes place in local GP surgeries, health centres and in their own homes. Older people make more use of these services than do others.

For example, people aged 75 and over make up around 7.5% of the population,[5] but account for half of those treated by community nurses.[6] More than half of the population aged over 85 are being cared for by community nursing services.[6]

In addition to treating illness as it arises, the community team provides preventative care, including:

- **advice and help on exercise, diet and smoking**
- **monitoring of blood pressure to help prevent diseases such as strokes**
- **immunisation against influenza**
- **helping patients live fulfilling lives despite problems with their health**

Advice on diet, exercise and smoking

According to a survey carried out by the Commission for Health Improvement (CHI), patients in their 70s were the group most likely to seek advice on healthy eating and exercise – and the group most likely to report that they received the help they needed.[7]

Figure 1 shows the results for advice on healthy eating. A similar pattern of results was found for advice on exercise.

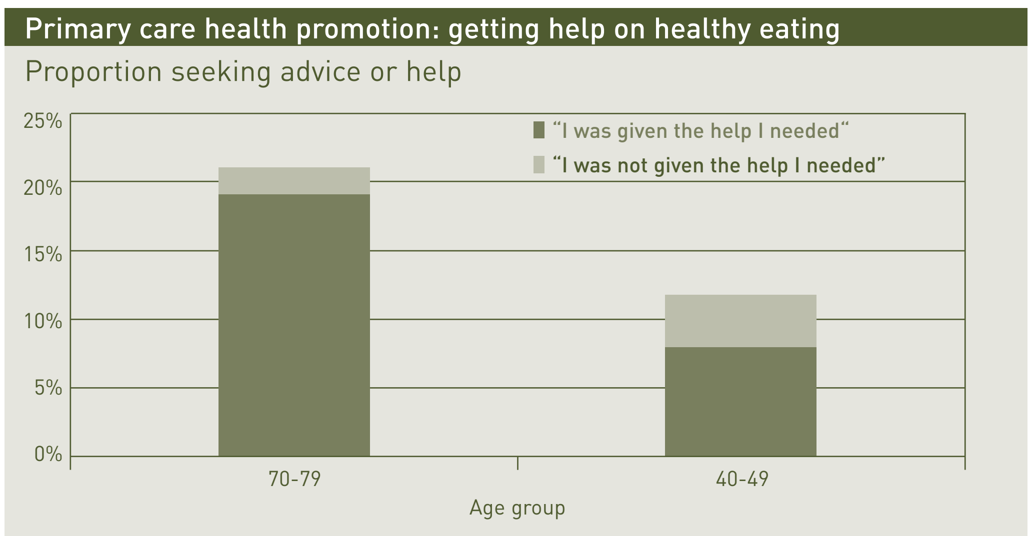


Figure 1. Compared to patients in their 40s, patients in their 70s were more likely to seek advice on healthy eating, and more likely to be satisfied with the help they received.
Source: CHI[7]

For those seeking advice, receiving "...the help I needed" is a subjective measure of success. The younger age group may have had higher expectations of the advice they sought, and as a result could have been more difficult to satisfy.

However, objective measures from the NHS stop smoking services also show older people being reached and helped by activities focused on health promotion.[8] Eighteen percent of those using the services are aged 60 or over – a proportion which reflects the age pattern of smokers in the population.[9] The 60 and over group also have the best rate for stopping smoking. In this group, 63% report giving up for at least four weeks, compared with 51% of those under 60.

Monitoring of blood pressure

In CHI's 2003 national survey of health service users, 78% of those aged 60 and over reported that their blood pressure had been taken by someone at their GP surgery or local health centre during the last 12 months.[10]

“ Influenza vaccinations for older people are a cost effective way of saving lives

This apparently high level of monitoring contrasts with research that suggests that older residents in nursing homes may not receive the same level of care. An investigation of the care received by a sample of older people living in nursing homes in Bristol reported that only 53% of patients aged over 65 and previously diagnosed as having high blood pressure had had their blood pressure measured in the previous year.[11]*

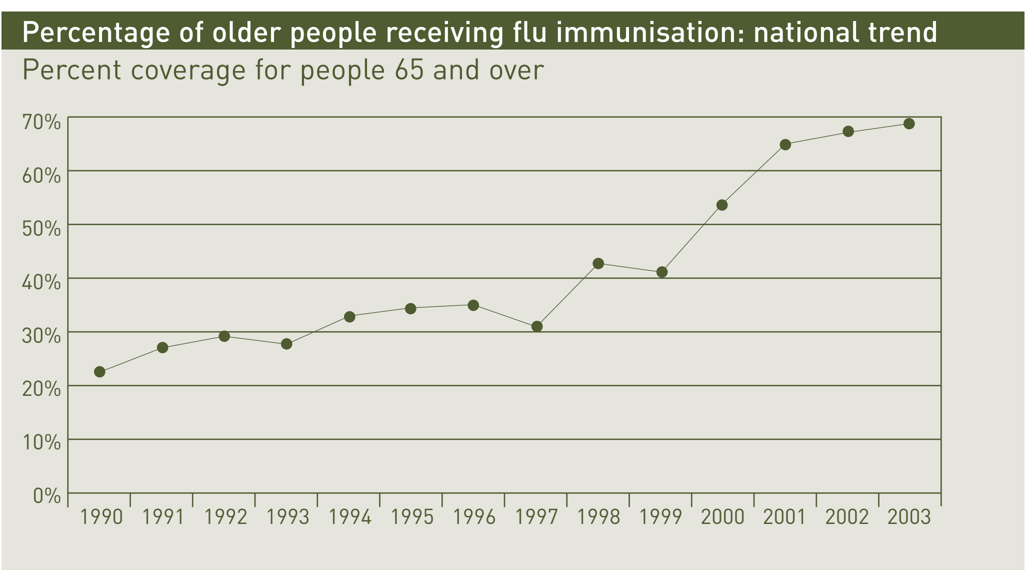
Immunisation against influenza
If older people get influenza, they are more likely than the young to suffer complications such as pneumonia. Thousands of emergency admissions and deaths among older people can be traced back to a bout of influenza. Influenza vaccinations for older people are a cost effective way of saving lives, preventing serious illness and hospitalisation.[12] If all older people were immunised against influenza, nearly 5,000 lives could be saved each year in England.[2]

The number of older people who are offered and accept immunisation against influenza has risen steadily in recent years[13,14] and the Department of Health campaign to promote immunisation is now aimed at reaching everyone 65 and over.[15] The aim is for 70% of this age group to be offered and accept immunisation and nationally this target has recently been reached.[16]

However, there is a large variation in rates of immunisation between primary care trusts. As figure 2 shows, while the 10 best rates are all well above 70%, the 10 worst are in the region of 50%. The latter PCTs are all within big cities and for the most part serve populations with high levels of deprivation and large minority ethnic communities. These demographic factors may make it more difficult to provide immunisation as extensively as is desirable.

Getting more out of life – in spite of COPD
Illnesses such as chronic bronchitis and emphysema, sometimes referred to as chronic obstructive pulmonary disease or COPD, can cause serious difficulties in breathing. COPD is particularly common among older people.

* National research has uncovered a similar picture among other primary and community services for residential and nursing home residents. The National Primary Care Research and Development Centre reported particular concerns about residents' access to physiotherapy, speech and language therapy and occupational therapy,[17] for example.



PCTs with the 10 lowest rates in 2003	
Greenwich	59%
Central Manchester	58%
Islington	56%
Lewisham	56%
Hammersmith & Fulham	54%
City & Hackney	53%
Westminster	51%
Heart of Birmingham	50%
Lambeth	49%
Southwark	49%

PCTs with the 10 highest rates in 2003	
North East Oxfordshire	78%
Hambleton & Richmond	76%
Trafford South	76%
Selby & York	75%
South East Oxfordshire	75%
Mid Sussex	75%
South Warwickshire	74%
Colchester	74%
Daventry & S. Northants	74%
Greater Derby	74%

Figure 2. By 2003 the NHS was very close to the target of 70% flu vaccination coverage for people aged over 65. However there were large local variations within this national figure.
Source: Department of Health[14]

Everyone over 75 should have their medicines reviewed once a year

Researchers from the Audit Commission recently studied a service set up by GPs for patients at risk of serious COPD. It brings together family doctors, community nurses and physiotherapists to identify at risk patients early, organise sessions offering exercise, and give advice on staying active. The medical and nursing staff who set up the scheme have shown that by helping patients to both exercise and learn more about their condition, the service helps elderly people with COPD get more out of life.[18]

Currently there is no means of knowing how widespread practice of this high quality is around the country. With the introduction of the new general medical services contract, however, NHS GPs will receive extra payments when they have done more to diagnose and help those with COPD[19] and a range of other chronic conditions. As a result of the data collected as a consequence of the new contract, more will be learned about the services being provided for older patients in primary care.

Checking on medicines

In addition to health promotion, the care provided by GPs for older people involves treating existing and new illnesses, often by prescribing medicines. eighty percent of people over 75 take at least one prescription medicine; 36% take four or more different medicines,[20] reflecting the fact that many older people suffer combinations of illnesses.

Compared to someone taking just one medicine, a person taking several different sorts of medicine is at greater risk of having a bad reaction to either one medicine, or a combination of them. Many emergency admissions to hospital among older people are the results of adverse reactions to medicines.[20] For example, if a combination of medicines caused dizziness, this could lead to a fall and a serious injury.

Because the number of medicines taken by a patient may increase gradually as new illnesses emerge and because people may become less able to follow the instructions on a prescription, a regular review of all the medicines prescribed for a patient should be carried out.

The doctor, pharmacist or nurse uses the review to consider whether the prescription should be changed or stopped, whether the combination of medicines and their side effects are safe, and whether the patient has all the information they need about their prescriptions. These reviews usually lead to fewer drugs being prescribed. The cost of the review is likely to be more than met by the money saved on medicines that were doing no good, or perhaps even harming patients.[20]

The National Service Framework for Older People required that, by April 2002, everyone over 75 should have their medicines reviewed once a year; every six months for those taking four or more drugs. However, there has been no system in place to establish whether this has been happening nationally. Some figures are available for patients aged 65 and over, which suggest that the best that is achieved for this group is an annual rate of review of 50%.[21] A survey of reviews of medicines prescribed for the over 75s, originally announced by the Department of Health as planned for 2003,[13] will now take place in 2004.[21]

Gaining access to care in hospital

Many older people will need care in hospital at some time. In the past, some hospitals had policies that denied particular treatments to people because they were elderly. This kind of policy is now very rare[22] and it appears that older people are now getting greater access to some important treatments such as coronary artery bypass surgery.

Patients should be discharged to a setting that offers the maximum independence appropriate to their circumstances

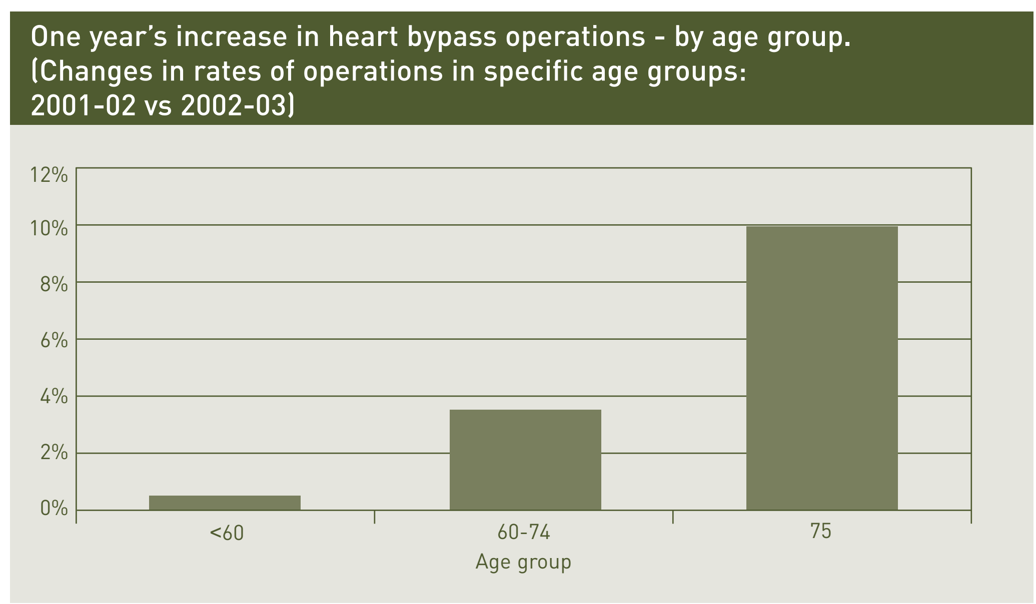


Figure 3. The proportion of people having bypass surgery is growing faster among those aged 75 and over than within other age groups.
Source: Department of Health[23].

Figure 3 shows how rates for coronary artery bypass surgery have changed for different age groups. While, in every age group, more people are having this type of surgery, the proportion of those over 75 operated on has increased more than the proportion in other age groups, suggesting that older people may now be more likely to be offered this operation if they need it.

While such national trends for treating older people are encouraging, it is also important to make sure that individual NHS hospitals are tackling discrimination on the basis of age. To this end, the Department of Health has provided hospitals with a means of checking whether their operation rates for different age groups are in line with other hospitals.[24]

Leaving hospital...

Once someone is ready to leave hospital, they should be discharged promptly, not least because:

- hospitals pose their own risks to health – the risk of infection, for example
- hospitals are largely designed for people who cannot look after themselves, not those who are able to be more active
- beds should be available for people who need care in hospital

Patients should be discharged to a setting that offers the maximum independence appropriate to their circumstances. For some this will be a care home, for others it will be intermediate care provided in their own home or in a community hospital. The NHS has been investing in intermediate care and, for example, came within 10% of meeting a target to provide an extra 5,000 intermediate care beds by March 2004.[25]

Most people discharged from hospital will return to their own home, but for many older people this is not possible until arrangements have been made to provide any help they might need. This could be something as simple as a bath rail, or more complicated arrangements for home based care.

...when the time is right

Whatever their destination, most patients will need some arrangements to be in place to support them when they leave hospital. Because the planning of this support is not always completed in time, on any one day around 3,000 older people are unable to leave hospital even though they are well enough to do so.

The NHS and social services have made great efforts, by increasing capacity and improving their ability to work jointly, to try to tackle this problem of delayed discharge. As a result, the proportion of patients aged over 75 who have to wait unnecessarily to be discharged fell from 12% to 6.5% between September 2001 and March 2003.[26]

Across the country, however, there are substantial variations in the proportion of discharges that are delayed.

“ Older people must not be rushed back to independent living before they are ready

Figure 4 plots the percentage of patients aged over 75 whose discharge is delayed in each of the 28 strategic health authority areas in England for the year to March 2003.[27] These rates vary from 3.2% to 15.4%. It can be seen that areas with the lowest rates are mostly concentrated towards the north of the country, with delays being more frequent in the south, particularly in Hampshire, Surrey and Sussex. The Government has recognised that the boom in the property market in the mid 1990s, particularly in the south of England, contributed to a reduction in places in institutions offering residential care. This reduction has exacerbated one factor in the delays for older patients who need to move to residential care.[28] Additional funding has been directed at those areas of the country with the greatest problems,[29] but the most recent national figures show a delayed discharge rate for the over 75s of 6.7% in September 2003 and suggest that in some areas performance is still significantly behind that of the best.

The downward national trend in delays in discharging patients is welcome, but older people must not be rushed back to independent living before they are ready. If they are, there may be a greater risk that they will need to be quickly readmitted to hospital. There is some evidence that this may indeed be happening with increasing frequency. Between September 2001 and March 2003, during the biggest recent fall in delays in discharges among over 75s, the percentage of this age group needing emergency readmission within 28 days rose from 7.1% to 8.2%.[30] If the trend continues, the reasons will need to be identified and the effects on vulnerable older patients assessed.

Beyond timeliness

A full consideration of the quality of the plans made for the discharge of patients must go beyond the issue of timeliness, discussed above and analysed in detail by the National Audit Office last year.[31] As the Health Select Committee's 2002 report on delayed discharges noted, the key objective is ensuring "...the right care in the right place at the right time...."[32] Although research has shown that good planning can reduce rates of readmission,[33] there is not, as yet, a clear national picture of the everyday quality of discharge plans in the NHS.

Proportion of patients aged over 75 whose discharge is delayed 2002-2003

- 11.3 - 15.4%
- 7.3 - 11.2%
- 3.2 - 7.2%

Figure 4. There are clear regional variations in the proportion of patients aged 75 and over for whom discharge from hospital is delayed.
Source: Department of Health.

“ We will need to review how the whole system works, not just the performance of individual organisations

The 2001/02 National Acute Inpatient Survey, however, provides one insight. While nearly two thirds (64%) of hospital patients aged 70 and over felt that there should have been a discussion with staff about the health and social care they would receive after leaving hospital, in almost a quarter (23.8%) of these cases the patient said that these arrangements had not been discussed with them.[34] The National Sentinel Stroke Audit has also highlighted circumstances in which communication about discharge could be improved. In 43% of cases examined, patients (the great majority being 60 and over) were discharged before their GP was informed that they would be leaving hospital. Furthermore, in 39% of the cases, the information supplied to the GP on discharge did not include details of the patients' ability to look after themselves on leaving hospital.[35]

Integrated care

The National Service Framework for Older People aims to improve the way in which the care of older people is planned by introducing joined up assessments of their needs for care. In the past, different professionals such as social workers, doctors, nurses and therapists carried out their own assessments and often none of them had a complete picture of the circumstances and needs of the patient. The practice could be frustrating for those being assessed, as they had to give the same information to a number of different professionals.

In April 2004 all local NHS organisations and social services departments were required to start using the single assessment process. This process aims to make sure that nothing is missed and that all the information about the patient is available to the whole team. It is also hoped that it will save older people from having to repeat their story several times.

Given that older people have sometimes been excluded from the planning of their care, as evidenced by the result of the survey quoted above, it is encouraging to note that a key requirement of the process is that “individuals are placed at the heart of assessment and care planning.”[36] This welcome focus on assessment from the patient's perspective will also need to recognise the varied needs of the diverse communities in society.[37]

The single assessment process and the rest of the NSF are part of a wider recognition of the need to join up services where the often complex needs of older people are concerned.[38,39,40] Intermediate care services – which, through an emphasis on rehabilitation, can help avoid admissions to hospital and premature moves to residential care – are an important example of how this approach is being developed. These services are typically constructed from components of primary, secondary and social care, with the aim of providing timely access to a service that brings together all the relevant professionals.

There is a lesson here for inspectorates such as the Healthcare Commission: if we want to understand fully the quality of care provided from the perspective of the patient, most of whom receive care from more than one service, we will need to review how the whole system works, not just the performance of individual organisations.

What will the Healthcare Commission do?

This section has discussed a range of indicators of the state of healthcare for older people. This is a large topic, and there is clearly a need for a richer and more comprehensive account than is available from currently available information. In collaboration with the Audit Commission and the Commission for Social Care Inspection, we will in our first year begin joint reviews of the implementation of the National Service Framework for Older People. By reviewing performance with reference to patients' pathways through health and social care within a sample of 12 to 15 local communities, we will build a national picture of the care available to older people and provide a basis for spreading good practice between providers. Our national report on the National Service Framework for Older People will be published in 2005.

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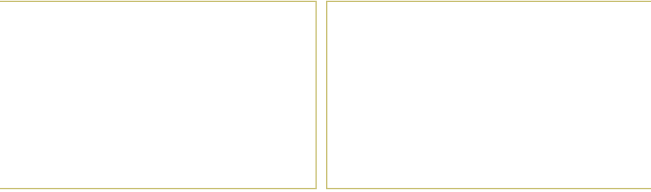
STATE OF HEALTHCARE REPORT
LEARNING FROM PATIENTS' EXPERIENCES

DESIGNING HEALTHCARE SERVICES TO MEET THE NEEDS OF PATIENTS REQUIRES PATIENTS' VIEWS TO BE SOUGHT, UNDERSTOOD AND ACTED UPON. THIS SECTION DESCRIBES THE EXTENT TO WHICH THIS CHALLENGE IS BEING MET.



Why this topic?

A patient-centred healthcare service can only be achieved if the needs, concerns and views of patients are taken into account. The views and priorities of patients may be different from those of clinicians and providers of services. In recent years there has been guidance and advice for the NHS about how to get feedback from patients and involve them in improving services.[1,2,3,4,5] Private healthcare organisations also carry out patient satisfaction surveys and have begun to involve patients in assessing services.[6]

However, learning from the experience of patients is complicated[4] and subject to barriers that include professional and organisational resistance to the involvement of patients and the public,[7] a failure to accept the validity of patient views,[8] and the powerlessness of the staff who collect information from patients to make changes.[9]

In addition, there has been very little evaluation of the impact of using information from patients to influence change,[10,11] so there is not a great deal of evidence available about which approaches are the most effective.

This section examines methods that have been tried and assesses the progress in different parts of the health service. The word 'patient' is used to cover patients, users of services and carers.

Learning within the clinical team

Individual doctors, nurses and other NHS staff who deliver healthcare are in the best position to learn from patients about how care could be improved. Although examples of this learning are not generally recorded, more systematic approaches to encouraging and recording learning by clinical teams are being established across the NHS. For example:

- the Essence of Care toolkit provides guidance and standards to help clinical teams assess the care they provide[12]
- the General Medical Council recommends that, under some circumstances, the process of demonstrating that doctors remain fit to practice should make reference to evidence from questionnaires completed by patients[13]

> “Using the expertise of patients and supporting them to manage their own care has been shown to lead to improvements in health

- GP practices covered by the new General Medical Services contract will receive additional payments if they carry out an approved annual survey of their patients[14]
- involvement of and learning from patients is a key element of programmes to redesign and modernise services[4]

There are examples of how initiatives of this kind have led to changes in services[9,15] (see box 1). However, there has been little systematic evaluation of whether these are leading to improvements in patients' experiences of services.[16]

At the level of the individual consultation, the patient may also be an expert, particularly if they have a chronic disease. Using the expertise of patients and supporting them to manage their own care has been shown to lead to improvements in health, and the NHS is investing in a national programme to develop expert patients.[17]

Box 1. Acting on feedback from patients in primary care

Four primary care trusts in the South West invited GPs to carry out a survey of their patients. Practices were encouraged to invite a small group of patients to discuss the results of the survey and look at how services could be redesigned from the perspective of patients.

What was done? Patients were given a one page questionnaire after they had seen a doctor or nurse. They were asked to rate various aspects of their care. Responses were analysed by an independent organisation, and the results passed back to practices. The information allowed practices to see how they compared with each other. Practices then invited patients to discuss the results.

What was the outcome? One practice scored quite low on 'waiting time in the surgery'. When staff met patients they said that it was difficult to improve waiting times. However, one of the patients said that it appeared that waiting was not the issue – the problem was not being told how long the wait would be. This left patients feeling they were not valued. Patients suggested that staff could do more to tell patients how long they would have to wait. This was agreed as a new initiative for receptionists at the practice.

Source: Modernisation Agency[4]

Learning across each organisation

Information is available to help organisations learn from the experiences of patients. It includes, for example:

- information collected routinely across the NHS about issues that directly affect the experience of patients, such as waiting times, cleanliness or complaints
- results from national surveys of patients in England[18,19] and local surveys in Wales
- feedback from comment cards (see box 2), which will be available for all inpatients and analysed by Patient Advice and Liaison Services (PALS)[20]
- local analysis of complaints and other sources of feedback from patients
- information collected by individual trusts, as part of clinical audit, redesign of services, local clinical governance and work on involving patients.

Box 2. Comment cards

University College London Hospitals Trust is introducing a scheme to record the comments of patients and visitors across the trust. A pilot of the scheme resulted in improvements such as more fresh fruit being available for patients, repairs to bedside panels, and easier access for patients to bedside items. Ward staff saw all the comments (good and bad) and worked together to respond to the issues that had been raised.[21]

However, it seems that the potential learning from these sources is not being fully realised. A review by the Commission for Health Improvement (CHI) of the implementation of measures to involve patients and the public found that learning from patients was seldom integrated into the management of NHS organisations.[9] For example, although resolution of complaints within specified timescales is a national performance indicator,[22] it is rare to find any formal system in organisations to ensure that complaints are reviewed and acted upon, and that lessons are learned for the whole organisation.[23]

Feedback from patients can provide a different perspective from other information about performance

The results from national surveys of patients are published for each organisation, alongside a comparison with other trusts, and advice on making use of survey results.[15] Feedback directly from patients can provide a different perspective from other information about performance, and may even have a different message for a particular organisation. For example, inpatients' views of hospital cleanliness are not closely aligned with ratings of cleanliness produced by the inspections carried out by the Department of Health's Patient Environment Action Teams (PEAT) (figure 1).

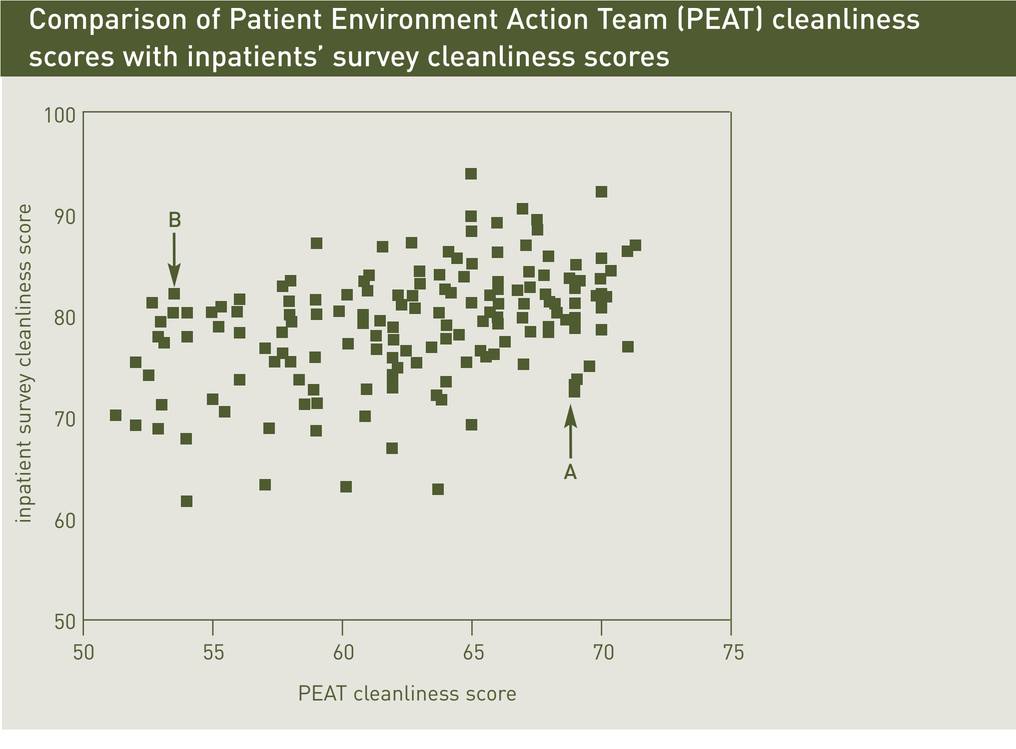
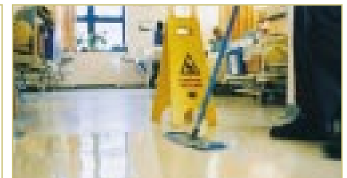


Figure 1. Overall there is only relatively weak agreement between cleanliness scores produced by official inspections of NHS trusts, and patient survey results on the cleanliness of, in this case, the inpatient facilities of those trusts. Trusts A & B are discussed in the text.
Sources: Healthcare Commission analysis of data from national inpatient survey (November 2003) and PEAT inspections[24] from March 2003.



Each point on the graph compares two scores for a single NHS trust. Some trusts with above average PEAT scores (e.g. trust A) have below average assessments of cleanliness from inpatients. For other hospitals the reverse is true (e.g. trust B). Overall there is only relatively weak agreement between the two sets of scores. It is true that the PEAT score refers to the whole hospital, and it might be that inpatient wards, bathrooms etc are generally unrepresentative of standards elsewhere in a hospital. However, CHI's survey data also show that patients give relatively consistent judgements of cleanliness across A&E, outpatient departments and inpatient settings. It seems that the ratings of cleanliness derived from the official PEAT inspections do not always give an accurate guide to the standards of cleanliness experienced by patients.

The national surveys of patients help to describe the experiences of patients, monitor change over time, and allow comparisons of organisations' performance. However, other methods that are tailored to the needs of the local population and particular groups of users of services should also be used to ensure that the views of all patients are considered. For example, response rates to national surveys are known to be low for some age and ethnic groups.[25]

In Wales, over the last four years, there has been explicit guidance on involving the public and patients. This has included:

- tracking complaints and aggregating data
- making available details of networks, contacts and resources in communities
- storing information on initiatives designed to improve involvement
- providing information on good practice as regards approaches, methods and techniques
- providing and documenting plans for patient and public involvement in health services
- helping to assure the quality of information about healthcare and healthcare services[2]

“ The review found only two PCTs with arrangements to ensure routine reporting of issues relating to quality of care

Learning across communities

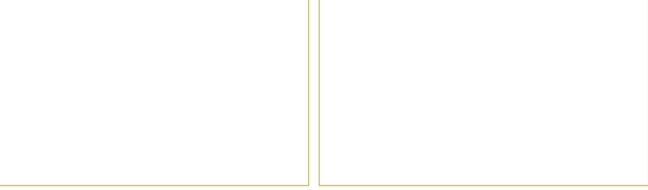
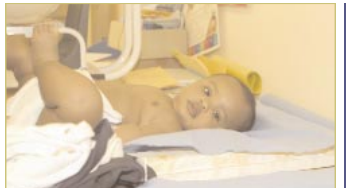
Patients use services provided by different health and social care organisations in the NHS, the private sector and voluntary organisations. Patients may often be receiving care from more than one organisation simultaneously, particularly if they have complex needs and long term conditions. It is important, therefore, to look at the experience of patients across these organisations. For example, for a person with diabetes, typical measures of patient experiences, such as waiting times, may not be relevant, but coordination of care between providers of services is critical.

Capturing this aspect of a patient's experiences is particularly difficult. Information collected by individual organisations does not generally deal with how care is delivered at the boundaries between organisations. For this to be done, organisations need to take steps such as coordinating the collection of information and making sure that there is clear accountability for addressing issues that are raised.

Information on the experience of patients at a community level is also important. It helps to ensure that services are provided equitably and that views from all sections of the community are taken into account. Finding out about the experiences of people with learning difficulties, for example, requires targeted methods and the gathering of views about the whole healthcare system, not just a single provider (see Box 3).

Box 3. Transferring learning across health and social care

In the Bro Morgannwg NHS Trust in Wales, the 'inclusive communications' initiative provides training and support for patients and carers of people with learning disabilities. It has included work on the trust's complaints procedure and the production of West Glamorgan's Housing Tenants' Charter in symbol form.[2]

Primary care trusts are responsible for driving improvements in services across the healthcare system in their area. A review of PCTs by the Commission for Health Improvement found that few organisations are collecting or using information about services and the needs of the population to do this. The review found only two PCTs with arrangements to ensure routine reporting of issues relating to quality of care. It also noted that patient and public involvement and local needs assessment seldom informed commissioning decisions.[26]

National learning from patients' experiences

It is vital to ensure that learning from the experience of patients is used nationally:

- to ensure that national policy and systems of performance management deliver the improvements that matter to patients
- to ensure that themes and issues which are common across the NHS can be identified and acted upon
- to address issues for specific services or sectors and analyse trends and variations
- to enable independent assessment of the experience of patients.

Key sources of information include the results of national surveys of patients, routinely collected information on performance and information gathered as part of national studies[27] and consultations (see Box 4). Information gathered locally, such as reasons for complaints or feedback from PALS, is not recorded in a standard way, making it hard to aggregate.

Box 4. National consultation

National consultations, such as those for the NHS Plan[28] and on patients' choice,[29] or those on particular issues by national patient groups, provide the NHS with a view of what matters to patients. This information is used to target improvements locally. When coupled with central government policy, patients' views can produce change. The idea for modern matrons, for example, flowed from the consultation on the NHS Plan.

Analysis of the results of patients' surveys at a national level has shown variations by region, age, gender, ethnic group, level of deprivation and patients' self reported health status.[25] For example, patients from different ethnic backgrounds report different experiences of the same issues. White British and Irish respondents are generally the most satisfied, while those of South Asian origin, particularly Bangladeshi and Pakistani respondents, tend to be the least satisfied. This type of analysis is essential if the NHS is to meet its commitments to address inequalities in health.

What will the Healthcare Commission do?

The Healthcare Commission has two important roles in promoting improvement in the way healthcare organisations learn from the experience of patients:

- firstly, through its assessments, it will hold organisations to account for the way in which they obtain and use feedback from patients and for how they involve patients in improving the quality of care. As it develops its approach to annual ratings of NHS organisations, it will continue to use feedback from patients, as well as assessing how organisations learn from patients

- secondly, the Healthcare Commission will lead by example, by reviewing and improving its own methods for learning from patients' experiences in a robust and systematic way, disseminating information to healthcare organisations and the public, and working with others to make greater use of existing sources of feedback from patients. For example it will:
  - develop a strategy for capturing and using learning from patients about their experiences
  - evaluate and improve the current programme of surveys of patients, including carrying out research into why people do not respond to surveys
  - analyse and disseminate information about the experience of patients from the NHS complaints system for which it is responsible

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CHILDREN IN HOSPITAL

THE NEEDS OF CHILDREN IN HOSPITAL ARE NOW A RECOGNISED PRIORITY IN HEALTHCARE. THIS SECTION EXAMINES THE EXTENT TO WHICH THEY ARE BEING MET.

Why this topic?

The well being of children and young people is now at the heart of the Government's policies. Inquiries, such as those into the events at the Bristol Royal Infirmary[1] and the death of Victoria Climbié,[2] highlighted systematic and repeated failings in how public services respond to the needs of children.

One of the Government's responses has been to develop new standards for health and social care services for children and young people. These will be set out in the Children's National Service Framework (NSF). The first part of this framework, published in April 2003,[3] deals with the care of children in hospital.*

This Standard for Hospital Services recognises the scale of the changes that are needed. It sets out a 10 year programme but also stresses that healthcare organisations need to be taking action now.

Children are major users of hospital services...
There are more than 9.25 million children aged under 15 in England, around 19% of the population.[4] This age group accounts for a large proportion of what is done in hospitals. For example, under 15s make up approximately:

- 25% of those visiting A&E[5]
- 13% of all inpatient cases[6]

...and they have particular needs
Children's physiology differs from that of adults and changes as they grow and develop. They suffer from a different range of diseases and disorders from those commonly seen in adults and their mental capacity and level of understanding also change as they develop.

* The NSF Standard for Hospital Services relates to care in England. Comparable Standards are being developed in Wales, with publication planned for 2005. This section of The State of Healthcare Report focuses on England.

Hospital staff have a responsibility to help to protect children from harm

Children rely more than adults on the support and care of others. Decisions about treatment, including consent, will primarily be the responsibility of parents or guardians. Carers will also have their own needs for information, explanation and support.

Additionally, there is a particular need to safeguard children from any danger of abuse or neglect. As with others working with children, hospital staff have a responsibility to help to protect children from harm.

How do hospitals respond to the needs of children?
The Bristol Inquiry and Climbié report highlighted failings of health services in relation to the needs and protection of children:

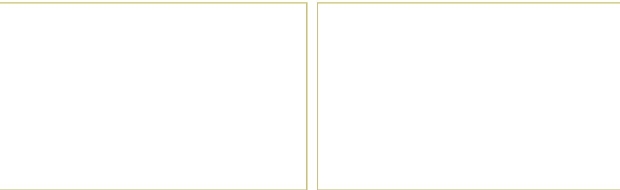
- in Bristol it was found that a failure to recognise and respond to the particular needs of children contributed to the tragedy
- the Climbié report drew attention to poor practice in child protection in the hospitals in which Victoria was seen

The NSF hospital standard emphasises the need for hospital services that treat children to take account of the physical, intellectual and emotional characteristics that make children different from adults.

Hospitals generally respond to the particular needs of children in two ways:

- by providing facilities or settings for care that have been designed or adapted with children in mind
- by having staff who have specialist skills in the care of children

Responding to children's needs: facilities
Although a few big cities in England have hospitals that just treat children, most children are cared for in hospitals that also treat adults. Most of these hospitals have dedicated facilities for children, such as children's wards and special care units for newborn babies. Some also have specialist services for children requiring intensive care (see Box 1). Many hospitals also have places set aside for children in more general areas, such as the accident and emergency (A&E) department.



Box 1. Intensive care for children

A small proportion of children admitted to hospital – those with the most serious illness or injury, and some who have undergone major surgery – will need to spend time in a paediatric intensive care unit. In 1997, the Department of Health published new recommended standards for children's intensive care. These recognised that nationally this specialist service had developed in an unplanned way, and that this had sometimes meant that children needing intensive care had not had access to a paediatric intensive care unit without travelling long distances.

The new standards recommended that in each part of the country hospitals should organise themselves into a paediatric intensive care network. In each network a lead hospital with a paediatric intensive care unit would serve the needs of the other local hospitals in a coordinated way. In this model, the local hospitals would retain responsibility for the less intensive category of 'high dependency care', request the transfer of a child to the lead hospital's paediatric intensive care unit if necessary, and have sufficient intensive care facilities to 'stabilise' the patient's condition before they travelled.

Since the 1997 report there has been further investment in the paediatric intensive care service – currently an extra £25m per year – and additional beds for intensive and high dependency care have been provided.[7] However, there is as yet no clear national picture of the operation of the paediatric intensive care networks. This may begin to change this year as the Department of Health Paediatric Intensive Care Audit Network – which collects data from each of the 24 hospital trusts with paediatric intensive care units in England and Wales – is due to begin reporting in 2004.

“ I’d prefer to be with people of my own age group so that I can communicate with them

However, when children are in hospital they are not always cared for in children’s wards or other dedicated facilities. Over the last three years reviewers from the Commission for Health Improvement (CHI) have visited nearly all NHS trusts in England that care for children. They found that around one in four hospital trusts do not have enough separate facilities for treating children.[8] This means that children are sometimes placed on adult wards, which affects their care. For example, they may be frightened to be surrounded by adults whom they do not know. Moreover, being away from the wards in which expertise in the care of children and appropriate facilities are concentrated may lead to delays or failure to provide the best care.

CHI identified similar problems in psychiatric hospitals. There are particular concerns when the treatment is compulsory as is the case when young people are detained in a psychiatric hospital under the Mental Health Act (see Box 2).

Box 2. Young people detained on adult psychiatric wards

The Mental Health Act Commission (MHAC) reviews the care of all patients compulsorily detained under the Mental Health Act. Between 1999 and 2001, more than 1,000 young people were detained in psychiatric hospitals; over 40% of them were under 16.

Guidance from the Department of Health states that the placement of young people on adult wards should be exceptional. However, MHAC reports that the majority are admitted to adult psychiatric wards. While most of these are aged 16-18, MHAC has in the past found children as young as 12 being admitted to adult wards. MHAC requires psychiatric hospitals to notify it within 24 hours if a young person is detained on an adult ward. This leads quickly to a visit by an MHAC commissioner to check that everything is being done to care for the patient appropriately.

Moreover, as regards those detained on adult wards, the most recent data (for the year to April 2003[9]) reveal that in the majority of cases no programme of activities suitable for the patient's age had been provided, leading to boredom and frustration that cannot assist with recovery:

"I'm on my own for most of the time but I want to talk to people."

"I'd prefer to be with people of my own age group so that I can communicate with them."

Children are not a uniform group. Accommodation in hospital has to take account of the age range of children, from newborn to teenager. CHI reviewers have reported that even in specialist children's hospitals, where all the wards are children's wards, adolescents report being unhappy about being treated on wards with children much younger than themselves. Getting the environment right for the age group is necessary, not just because it is important for young people to mix socially with others of their own age, but also because there must be appropriate privacy and dignity. CHI has raised particular concerns about the failure of some hospitals to provide bays and wards for adolescents which are solely for one sex.

The need to get the right facilities for the right age group applies throughout the hospital, wherever children are treated. In A&E, for example, cubicles may be decorated and equipped for children. But, it may be hard to ensure these are dedicated facilities. If they also have to be used for adults when the A&E department is under pressure, it may not be ideal either for the adults concerned, or for those children not able to use them because they are occupied.

“ The RCN’s report estimates that the NHS in England needs around 15% more children’s nurses

Responding to the needs of children: staff

The need for specialists in the care of children was emphasised by a comment to the Bristol Inquiry from a nurses’ leader:
“...the majority of adult qualified nurses and doctors see children as small adults, who simply need smaller beds and smaller portions of food.”

Nurses

According to a survey conducted by the Royal College of Nursing (RCN) two years ago, NHS hospitals employ around 12,000 registered children’s nurses.[10] Most of these work in dedicated children’s services and on children’s wards. However, children also receive many general hospital services. The RCN’s survey found that:

- of over 150 NHS hospitals trusts, more than one in ten had no registered children’s nurses working outside dedicated children’s services
- for the other trusts, five or six was the typical number of registered nurses working outside children’s services (but these nurses would have to cover all the general services of the trust 24 hours a day, seven days a week – and this could include more than one site)

This level of staffing may well make it difficult to provide round-the-clock cover wherever it is needed. Given the number of children visiting A&E it is particularly important that there should be children’s nurses in this department. The Royal College of Paediatrics and Child Health recommends that an A&E department should have *“...at least one registered children’s nurse on duty at all times....”*[11] When compliance with this recommendation was checked in 2000 it was found that, on average, child specialist nurses were only present for around one third of the time, including nights.[5]

The RCN’s report estimates that the NHS in England needs around 15% more children’s nurses than it has at the moment. Having considered this result, a recent report to the Department of Health by the Children’s Care Group Workforce Team has advised that an increase in the number of training places for children’s nurses is now required.[12]

Doctors
While most children under 15 (70%) who are admitted to hospital are under the care of a consultant who is a paediatrician or paediatric surgeon,*[6] surgery on children is often carried out by surgeons who also operate on adults. These may primarily be specialists and many may have added to their skills through training in operating and caring for children. However, a report from the paediatric forum of the Royal College of Surgeons showed that, in 2000, this was not always the case.[13] The more recent report of the Children's Care Group Workforce Team, referred to above, recommends that the relevant specialist skills of surgeons operating on children be "certified and validated."

In some clinical areas there may simply be too few specialists. For example, an expert group set up by the Department of Health has advised that the current number of paediatric cardiologists (there are currently around 60 consultants in post) should be increased by around 50%.[14]

In other specialties, the estimated shortfall (in percentage terms) is much smaller. For example, the Children's Care Group Workforce Team report also considered the need for increasing the number of paediatricians in the NHS. There are currently around 1,500 consultant paediatricians who work wholly or mainly in hospitals. The report recommended that an additional 100 specialist training places should be created.

Getting the overall total right for the country as a whole is one task, but it is also important to consider the availability of skills in different parts of the country. In reporting the results of their 2001 census of the workforce, the Royal College of Paediatrics and Child Health calculated for each region the number of consultant paediatricians per 100,000 children aged up to 15 (figure 1).

* Based on inpatient and daycase consultant episodes

“ Staff with appropriate training will be better able to focus on the needs of children and young people

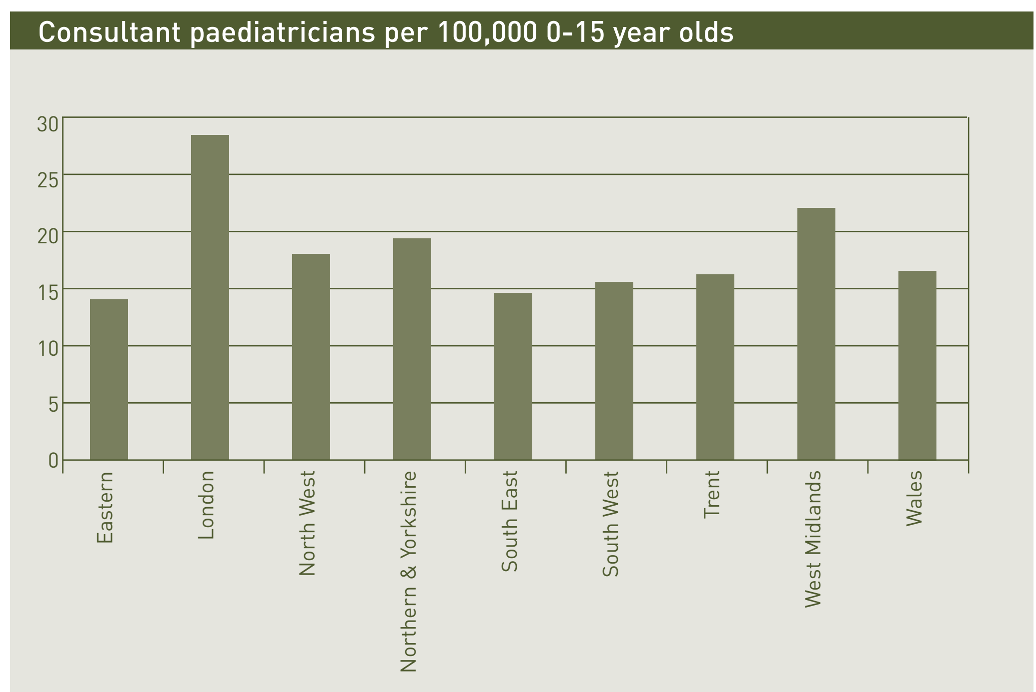


Figure 1. The ratio of consultant paediatricians to the size of the child population varies across the country.
Source: Royal College of Paediatrics and Child Health[15]

The fact that London has a ratio of consultants to child population that is around twice as high as that in the eastern or south eastern regions can be at least partly explained by the concentration of teaching hospitals in the capital. However it is unclear from the available evidence whether all the variation in levels of staffing can be accounted for by the needs of the populations served, or whether a more even distribution would be appropriate.

All staff

The issue of specialist training goes beyond doctors and nurses. Physiotherapists, dieticians, speech and language therapists, radiographers and pharmacists are just some of the professionals who are involved in the care of children in hospital. A key principle of the NSF hospital standard is that all staff caring for children should “...have appropriate training ... and should undergo regular updating and refreshment of skills.”

What this makes clear is that having the right staff is not just about ensuring that they have the right technical skills. Staff with appropriate training will be better able to focus on the needs of children and young people, making care which is safe and of high quality more likely. Following the Climbié Inquiry, NHS trusts were asked by CHI to rate to what extent their hospitals had achieved a child-centred culture – defined as one in which staff responded sensitively to the needs of individual children. While the majority of hospital trusts were positive about the progress they had made, 78 trusts (44%) only felt able to claim that this aim had been achieved 'somewhat' or 'slightly' (figure 2).

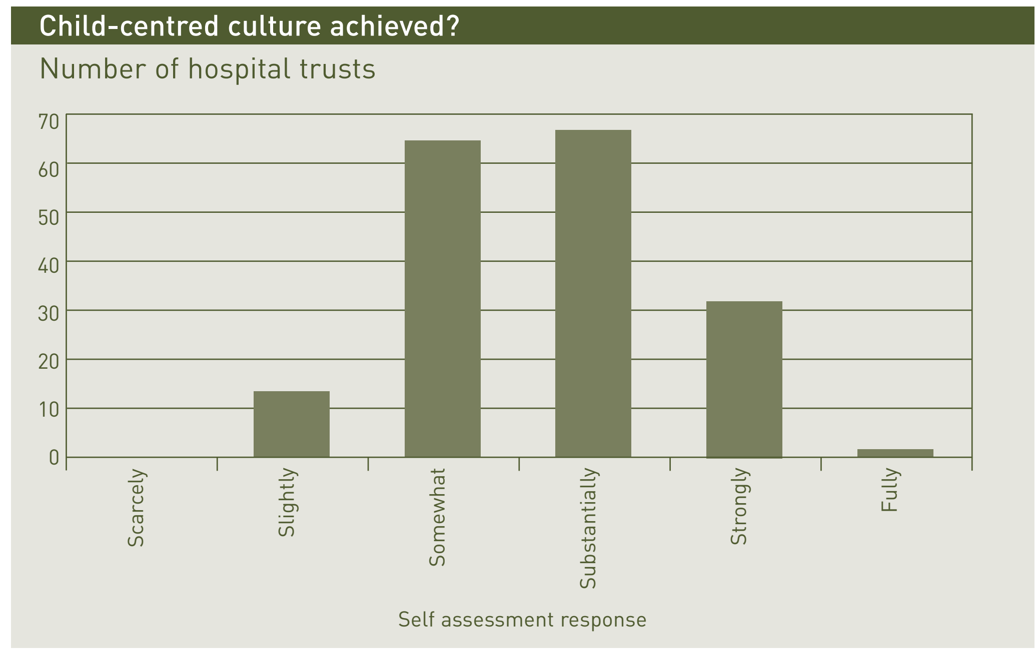


Figure 2. 44% of NHS Trusts reported that they had achieved a child-centred culture only somewhat or slightly. Source: Commission for Health Improvement.[16]

The standard to look for

The NSF standard for hospital services sets out what care of good quality for children in hospital should look like. It covers the matters discussed in this chapter as well as others such as consent to treatment, communication with children in hospital, and the need to involve children and their parents in the design of services.

It is also important to make sure that there are good standards for children treated in private hospitals

To help families understand the standards that they are entitled to expect, the Department of Health has published three guides to accompany the main document:

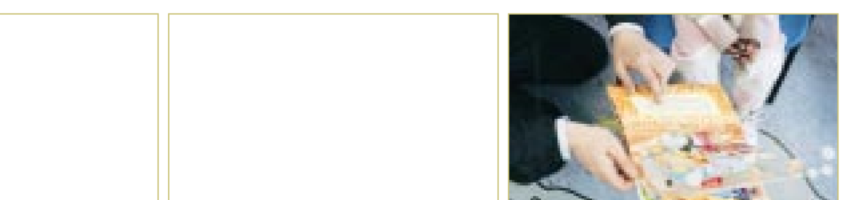
- one for children – *What should a really good hospital look like?*[17]
- one for young people – *What should a really good hospital be like?*[18]
- and *Standards for children in hospital: a guide for parents and carers*[19]

It is also important to make sure that there are good standards for children treated in private hospitals. The Healthcare Commission is responsible for inspecting private hospitals to determine whether they meet national minimum standards concerning specialised staff and facilities. The standards emphasise the need for a dedicated paediatric unit – rare in private hospitals – for all but straightforward cases. The standards are published[20] and can be seen by anyone considering care in a private hospital for a child.

Will the NHS live up to the new standard?

Clear recommendations have been made before about how hospitals should meet the needs of children. The Bristol Inquiry report described four earlier reports going back to 1959 that promoted principles similar to those underlying the standard for hospitals. But, good intentions have not been followed through.

One advantage of the current initiative is that the standard for hospitals is part of a wider NSF for children which, when it is published later this year, will go beyond hospitals to set standards across the NHS and social services. This joined up perspective is important because, as for other patients, children's experience of care in hospital will be influenced by what happens before (e.g. how and when they were referred to a specialist) and after (e.g. arrangements for continuing care) a stay in hospital. This broader perspective is also in keeping with the cross Government emphasis on children's issues (laid out in the recent Green Paper *Every child matters*[21]) which may help to keep attention focused on the task of implementing the NSF hospital standard.



There are, however, new barriers to overcome if the standard is to be delivered. For example, limits on the number of hours that junior doctors can work will be felt more keenly in children's services than in many others. The special training needed by doctors who treat children means that the opportunities for other doctors to fill in are limited and care in hospital for children is a 24 hour a day activity.

Nevertheless, the current large increases in general NHS funding provide a positive context for the NSF. Moreover, the Department of Health has made it clear that the implementation of the hospital standard is an important objective for the health service.[22] This push, combined with the capacity of the service to devise creative solutions, such as using the skills of different types of staff and linking services differently,[23] gives hope that services for children in hospital will improve this time.

What will the Healthcare Commission do?

The Healthcare Commission has a specific statutory duty to safeguard and promote the rights and welfare of children. In line with the NSF, our early plans focus on hospital care. In 2004/05 we will:

- publish the results of the first national survey of young patients
- conduct a national review of A&E departments, including specialised facilities and staffing for children
- develop and test criteria for measuring performance by reference to the NSF hospital standard

The rest of the NSF is due to be published before the end of this year. Our work will broaden as a consequence to take in the full range of children's healthcare. The development of the NSF is being coordinated with the Government's introduction of a Children Bill. This will place a duty on all children's services – in particular health, education and social services – to work together to reach five key outcomes for children: being healthy, staying safe, enjoying and achieving, making a positive contribution and economic well being.

In line with this integration, the Healthcare Commission, Ofsted and the Commission for Social Care Inspection will all contribute to local joint reviews of services, from 2005.

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STATE OF HEALTHCARE REPORT

COMPULSORY CARE: THE EXPERIENCES OF BLACK AND MINORITY ETHNIC GROUPS

PEOPLE FROM SOME BLACK AND MINORITY ETHNIC COMMUNITIES ARE MORE LIKELY TO BE DETAINED UNDER THE MENTAL HEALTH ACT. THIS SECTION LOOKS AT THIS ASPECT OF MENTAL HEALTHCARE IN OUR DIVERSE SOCIETY.

Why this topic

Each year in England and Wales there are about 200,000 hospital admissions relating to mental health problems.[1,2] Of those admitted, around one in five spend some of their time in hospital detained under the Mental Health Act 1983.[3] This kind of compulsory admission or detention may be necessary if a person has severe problems that risk their safety, or the safety of other people, and they refuse hospital care.[4]

Within a wider pattern of disadvantage with respect to health and healthcare, people from black and minority ethnic communities (see Box 1) tend to have a worse experience of mental health services than the white majority.[5] The Healthcare Commission is working closely with the Mental Health Act Commission (MHAC), the body responsible for safeguarding the rights of detained patients, to understand what this means and how to remedy it.

Box 1. Black and minority ethnic groups

People from black and minority ethnic groups have a range of religious beliefs, values, histories, cultures and socio-economic experience. Issues relating to the mental health of different ethnic groups reflect this diversity. There are differences between ethnic groups in the prevalence of mental health problems and the use and experience of mental health services.[6,7]

Detention of black and minority ethnic patients

Some black and minority groups are subject to high levels of detention. Figure 1 shows the rates of compulsory admission under the Mental Health Act for different ethnic groups in England and Wales. Compulsory admissions among some groups appear to be disproportionately high, when compared to their representation within the population. For example, Black Caribbean people make up just over 1% of the population, but they account for 2.5% of these admissions.

“ Black people on inpatient units were four times more likely to experience a compulsory admission compared with white people

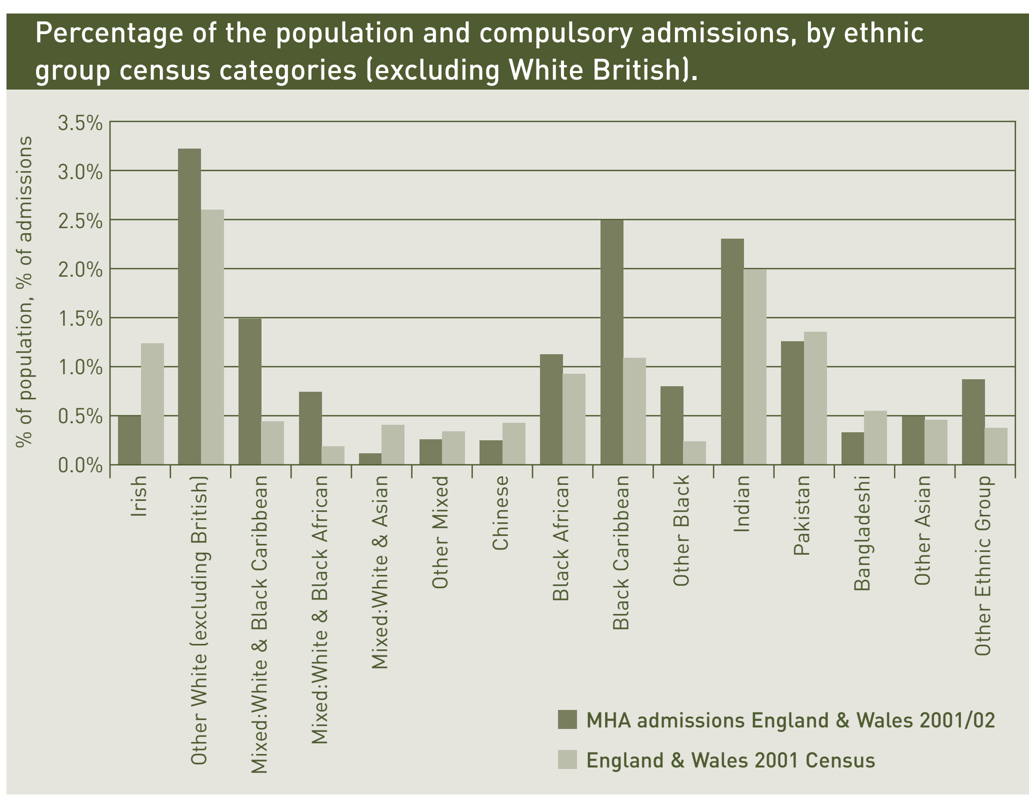

Figure 1: Compared to their representation within the population, some ethnic groups are subject to a disproportionately high rate of compulsory admission to hospital.
Sources: MHAC[8] and Office for National Statistics[9]

Research confirms the over representation of certain groups. One recent review found “black people on inpatient units were four times more likely to experience a compulsory admission compared with white people.”[7] Black people are also more likely to be compulsorily admitted through the involvement of police, or through the courts, and are over represented in special hospitals, secure institutions, medium secure units and prisons.[6]

Experience of black and minority ethnic groups admitted under the Mental Health Act

Research shows that some black and minority ethnic people suffer adverse experiences compared with others within mental health units. These include:[10,11]

- an increased risk of coercive care
- over diagnosis of schizophrenia and under diagnosis of depression or affective disorder
- decreased likelihood of receiving non-physical treatments such as psychotherapy, psychological treatments, counselling or alternative treatments
- overuse of psychotropic medication
- decreased likelihood of having social and psychological needs addressed by care planning
- more time, on average, in hospital
- a greater risk of readmission

These experiences and failures in care have led to tragic outcomes, such as the death of David Bennett (see Box 2).[12]

Box 2. Racial discrimination: David Bennett

David Bennett was an African-Caribbean man who suffered from schizophrenia. He died in a medium secure unit after having been restrained for 25 minutes, following an incident sparked by racial abuse directed at him by another patient. Recommendations from an independent inquiry into his death included:

- training in cultural awareness and sensitivity for everyone who works in mental health services. For managers and clinicians this should include training to tackle overt and covert racism and institutional racism
- all mental health services should have a written policy on racial abuse
- care plans should include appropriate details of each patient's ethnic group and cultural needs

Part of the problem of higher rates of detention relates to the previous experience individuals have had with mental health services

Why are there higher rates of detention?

Several issues have been identified as contributing to the experiences described above, although the relative weight of the contribution of these factors is unknown.[13]

- black and minority ethnic communities tend to be concentrated in inner city areas characterised by social deprivation, including poverty, educational disadvantage and discrimination in employment. "In inner urban areas at least, most patients with a psychotic illness are likely to experience detention under the Mental Health Act at some point in their illness. Many will come from the ethnic minorities more likely to live in such areas"[14]
- the age, gender, marital status and composition of the household varies between different ethnic groups and may have a bearing on rates of admission that make comparisons between ethnic groups difficult[8]
- research shows that there is a higher prevalence of diagnosed severe mental illness in African Caribbean people. The possible causes of this are not clear and have been the subject of contentious debate[5,6]

There is evidence that part of the problem of higher rates of detention relates to the previous experience individuals have had with mental health services. For example, the Sainsbury Centre for Mental Health reported that there are "circles of fear that stop black people from engaging with services" (figure 2):

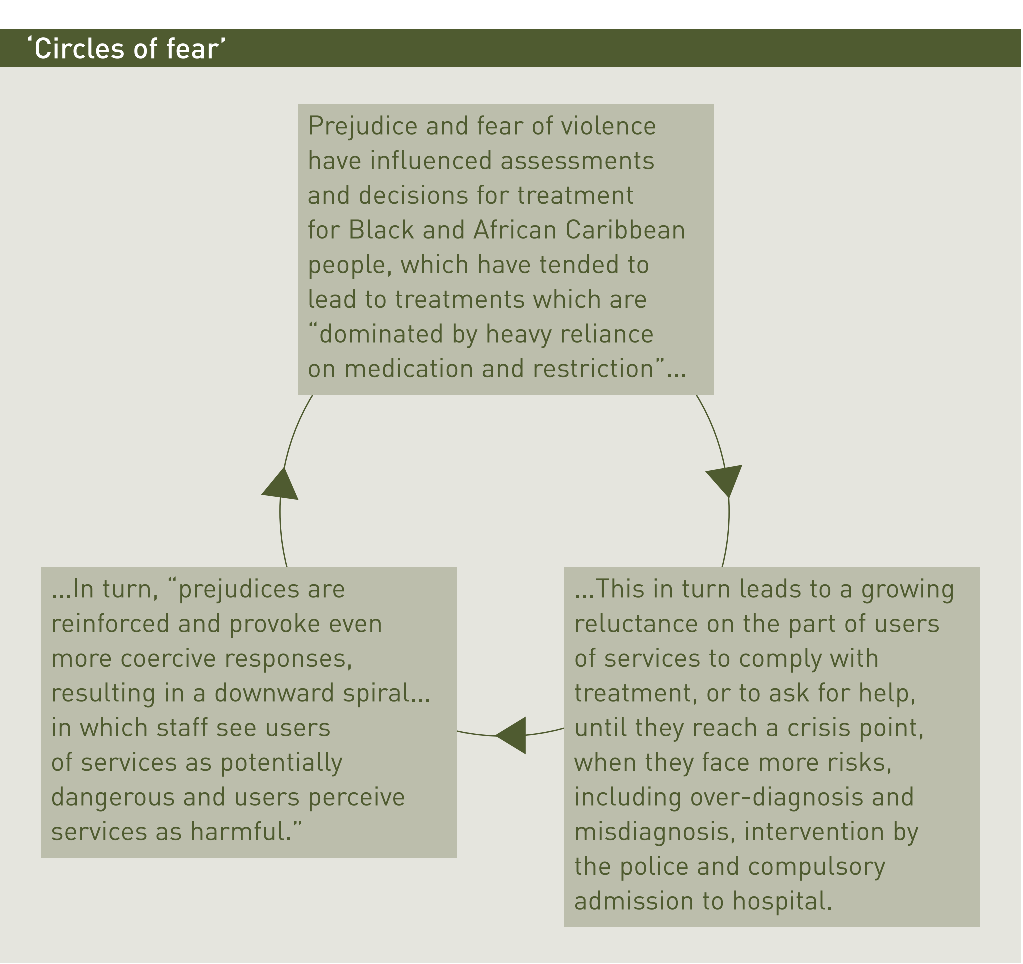

Figure 2. A 'circle of fear' is thought to discourage some Black and African Caribbean people from engaging with mental health care before they reach a crisis point.
Source: The Sainsbury Centre for Mental Health[10]

> “Services designed around the needs and wishes of service users cannot be achieved without listening to what communities want

What can be done?

The Department of Health, the National Institute for Mental Health in England (NIMHE) and others have been working on ways to tackle the problems described in this section. Below, we describe some of the important recommendations and findings arising from this work.

Improving patients' experiences of acute care

Training

Mental health staff need effective training in anti discriminatory practice, race equality and cultural diversity. Information packs on culture, faith and ethnicity should be available to staff, although these "must not take the place of asking the patient and carers about the patient's preferences."[15]

Protection from abuse and harassment

The Department of Health has set a minimum standard for psychiatric intensive care units and low secure units. They must have "a clear policy on equal opportunities and racial harassment which all staff and patients are aware of. The policy should cover staff/patient and patient/patient harassment. The trust board should sign up to the policy. There should be a system for monitoring adherence to the policy with a clear method of investigation."[16]

Providing culturally sensitive and appropriate care

Relatively simple changes can make an important difference to individuals. These include addressing patients' religious and spiritual needs, dietary requirements and any other personal needs. Organisations should consult their communities so that they can provide culturally relevant and sensitive care "services designed around the needs and wishes of service users cannot be achieved without listening to what communities want."[16] The National Institute for Mental Health (NIMHE) is leading a programme of engagement with black and minority ethnic groups; the aim of this is to empower and involve community organisations, so that they can help to develop locally responsive and appropriate mental health services.

Engaging with patients at an earlier stage than admission

The focus of this chapter has been on the experience of people as inpatients in acute hospitals, but the majority of mental health services are provided outside hospital. All of the recommendations outlined above apply equally to services in the community. It is these services that have an early opportunity to prevent crises developing to a point at which detention becomes necessary.

Assertive outreach teams have been set up in some primary care and community mental health services to engage with people who have severe mental health problems, but do not take up after care once they have been discharged from hospital. National guidelines for mental health services states that assertive outreach teams should:

- visit people at home, act as advocate, and liaise with other services such as the GP or social services
- help users of services with such issues as finding housing, getting enough income and the tasks of daily living such as shopping, cooking and washing[17]

In some parts of the country assertive outreach teams have been set up to work with specific black and minority ethnic groups. For example in Haringey the Antenna Outreach Service focuses exclusively on young men of African or Caribbean origin in early stages of mental health problems.[18] Research shows that assertive outreach teams have reduced admissions to hospital and improved the engagement of users with services.[17] An evaluation of outreach teams within three London boroughs found that the teams are having a positive effect and that "the people who use the services and their carers feel they have been helped in ways they have not experienced before."[18]

> Effective ethnic monitoring can have a real impact on the development of services

Monitoring of improvement

Effective monitoring needs to be in place to check whether the care for black and minority ethnic patients is improving. The recording of a patient's ethnic group has been mandatory for inpatient services since 1995, but many services are still struggling to collect this information. The importance of collecting such data is clear. Effective ethnic monitoring can have a real impact on the development of services and the delivery of comprehensive, holistic care programmes.[15] As well as affecting the experience of individual patients, ethnic data and information of good quality:

- are required to meet the duty of the Race Relations (Amendment) Act 2000 to monitor the effect of services on different racial groups[11]
- are necessary to identify trends within hospitals and the community and to highlight possible inequalities in the use of compulsion, seclusion, care and restraint, and to monitor incidences of harassment[15]

A dataset for mental health has been introduced by the Department of Health. The NHS will have to collect information on a range of care related variables, including ethnic origin. The dataset has been compiled centrally since the first quarter of 2003/04 and will provide comparative data, which will be the key to monitoring the implementation of recommendations such as those mentioned above.

What will the Healthcare Commission do?
The Healthcare Commission's work relating to mental health will, over time, examine a wide range of services. In our first year we will:

- carry out a review of mental health services for adults and services for those misusing substances, which will include assessing services for black and minority ethnic service users
- publish the 2004 NHS performance ratings, which include an assessment of the recording of ethnicity in datasets relating to patients and the workforce
- complete clinical governance reviews of mental health services, which include an assessment of patients' experiences from the perspective of black and minority ethnic users of services

In addition, the Mental Health Act Commission will undertake a census of black and minority ethnic patients in 2004, in conjunction with the NIMHE and the Healthcare Commission. The aims are to obtain a firm baseline of information and to develop performance indicators for the purpose of future monitoring.

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STATE OF HEALTHCARE REPORT
INDEPENDENT BUT REGULATED

FOR THE FIRST TIME, THE REGULATION OF PRIVATE AND VOLUNTARY HEALTHCARE SERVICES HAS BEEN BROUGHT ALONGSIDE REGULATION OF THE NHS. THIS SECTION LOOKS AT HOW REGULATION OF THE INDEPENDENT SECTOR WORKS.

Why this topic?

In England, the regulation of independent and NHS healthcare services has been unified under the Healthcare Commission. This section explains how private and voluntary healthcare (PVH) in England is regulated.

The PVH sector comprises providers of acute services (hospitals and clinics) and mental health services (see Boxes 1 and 2). They are regulated within the legal framework set out in the Care Standards Act 2000.[1] The quality of these services is judged by reference to explicit standards set by the Department of Health. In May 2004, the Department of Health completed consultation on a set of standards for NHS services.[2] Once in place, these standards will form the basis of the Healthcare Commission's reviews of services provided within the NHS.

Box 1. Acute services (hospitals, clinics etc.)

Independent acute services regulated by the Healthcare Commission are:

- acute hospitals
- hospices
- maternity hospitals
- private doctors
- walk-in medical centres
- establishments providing:
  - termination of pregnancy
  - treatments involving lasers and intense pulsed lights
  - hyperbaric oxygen therapy
  - dialysis
  - in vitro fertilisation
  - endoscopy
- agencies providing doctors to private patients at home

The Healthcare Commission also regulates the treatment centres[3] described in the section Waiting for care.

Box 2. Mental health services

Independent mental health services regulated by the Healthcare Commission include:

- specialist mental health services for all age groups
- services for people with learning disabilities
- 'low secure' and 'medium secure' mental health units
- services for people with eating disorders
- substance misuse services for people with problems, such as addiction, involving the use of drugs or alcohol
- services for people requiring rehabilitation following brain injury

National minimum standards

The national minimum standards for independent healthcare[4] are a crucial part of the regulation of PVH. The standards were set by the Department of Health in consultation with providers of independent healthcare and users of their services.

All providers of PVH must comply with the legislative requirements of the Care Standards Act 2000 and must meet or exceed the national minimum standards to ensure both the safety of users of services and the quality of care.

There is a single set of core standards, applying to all services, and seven sets of service specific standards, each applying to a particular type of service. Each of the standards has been designed with a particular outcome in mind. Some examples are shown in table 1.

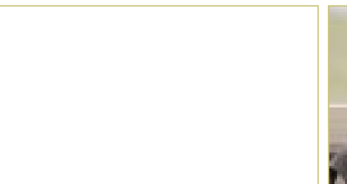


Table 1. Examples of the national minimum standards	
A given standard...	**...relates to a particular desired outcome**
Pre and post employment checks should be carried out before a health care professional is allowed to practise. For example, the practitioner should be interviewed and their references should be taken up.	That patients receive treatment from appropriately recruited, trained and qualified professionals.
Within mental health establishments: any factors that suggest a patient has been or might be a suicide risk ....are recorded in case summaries and discharge letters.	That patients are protected from self harm, including risk of suicide.
In establishments providing terminations of pregnancy, there should be procedures to allow for any personal wishes to be taken into consideration with regard to the disposal of fetal tissue.	That fetal tissue is handled sensitively.

Source: Department of Health[4]

The processes of regulation

The Healthcare Commission uses the national minimum standards, and the statutory requirements that accompany them, as the basis for regulating PVH. This is achieved through a set of linked processes, outlined in table 2.

Table 2. Processes for regulating PVH

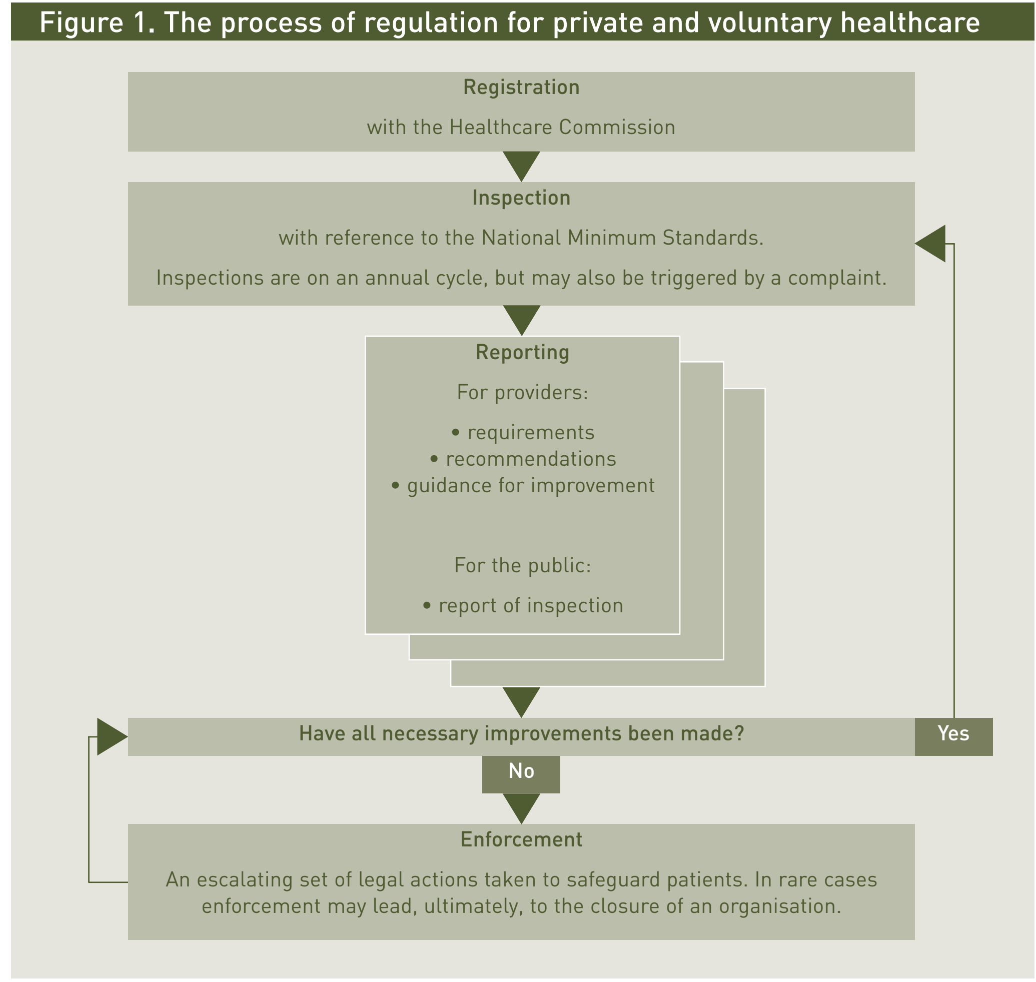
Registration and inspection	Enforcement
• registering independent healthcare services and checking their compliance with all statutory requirements and national minimum standards	• carrying out enforcement if necessary to require compliance with the regulations and standards • investigating when regulations may have been breached
Monitoring of complaints	**Reporting and guidance**
• requiring providers to investigate and respond to complaints • inspecting services where a complaint indicates that there may have been a breach of the regulations	• reporting information on independent healthcare to the Department of Health • supporting providers by offering guidance to help them comply with the standards • making the results of inspections available to the public

This regulatory system enables the Healthcare Commission to act on behalf of patients and users of services to:

- improve the quality of independent healthcare services
- improve the protection of vulnerable people using these services
- ensure that patients and their families know what standards to expect
- ensure that arrangements to assure safety and quality are in place

Each of the component processes is described in more detail below. Additionally, figure 1 illustrates how the processes are linked.

Figure 1. The process of regulation for private and voluntary healthcare



“It must also be publicly visible – displaying transparency in its practices and procedures

Registration and inspection

Registration

The Healthcare Commission registers PVH services in England. A service must be considered fit before it can be registered. This means that the service must have satisfied a range of requirements covering such areas as:

- probity – all people associated with the service must be honest, truthful and be of professional and ethical standing
- the service must be efficient and effective
- it must be possible to hold the service accountable for its activities. It must also be publicly visible – displaying transparency in its practices and procedures
- there must be good clinical governance, with systems in place to ensure that people are treated safely, effectively and appropriately

Before registration, the service is assessed by such means as site visits, interviews, checks through the Criminal Record Bureau and financial checks.

In May 2004 there were almost 1,000 independent healthcare services registered with the Healthcare Commission. At the same time the Commission was processing 722 new registrations for acute services and 19 new registrations for mental health. Recent changes in requirements for registration have triggered a large number of requests for registration, many from individual private doctors and clinics offering treatments involving lasers.

Inspection

When a service is registered, it is included in a programme of annual inspection. The Healthcare Commission is committed to working with providers to identify problems and find solutions during and following an inspection to ensure that the quality of the service is improved where necessary.

Annual inspection visits are undertaken by teams of specialist inspectors. Each team includes a range of professionals appropriate to the particular inspection: clinicians, nurses, pharmacists, mental health nurses, social workers, doctors and other health professionals could all be involved.

The duration of a visit varies according to the facility being inspected. A 500 bed hospital might require several days of inspection involving five or more inspectors. By contrast, the inspection of a smaller facility might rely on a shorter visit from a single inspector who has specialist knowledge of the service in question.

Following an inspection, a report is published and made available to the public.* The report summarises the results of the inspection and gives details of where regulations have been breached or standards have not been met. It also sets out guidance on the improvements needed, and the times by which changes should be made. In response, providers must produce a detailed action plan showing how they will meet the requirements of the report.

Monitoring of complaints

The Healthcare Commission deals with complaints about registered PVH providers. In the first instance, the provider is asked to investigate the problem, respond to the complaint and inform the Healthcare Commission of its response. The Healthcare Commission then considers the provider's response and determines whether the Commission needs to take action. It may, for example, undertake an inspection to establish whether there has been any breach of regulations, and to assist in the appropriate resolution of the complaint.

* The reports can be accessed via the Healthcare Commission's web site www.healthcarecommission.org.uk/YourLocalHealthServices/PrivateHealthAZ/fs/en

“Cancellation of registration is the ultimate sanction

Enforcement

If providers do not make the necessary improvements following an inspection, or where the Healthcare Commission thinks there is a risk to the health and welfare of patients and users of services, the Commission has legal powers under the Care Standards Act 2000 to act appropriately to safeguard patients. The Healthcare Commission has a range of actions relating to enforcement available to it. These actions are subject to the requirements of due process and to appeal.

Urgent requirements are usually dealt with on the day of an inspection. However, a provider may be notified in writing that immediate remedial action is needed to resolve a serious or potentially serious threat to patients and users of services.

Enforcement notices are issued where it is considered that a service has failed to comply with the regulations, and the risk to patients is such that the provider should be compelled to take action. The provider is given time to remedy the problem, but if the problem is not solved further action to secure enforcement can be taken. In some cases, this may lead to prosecution.

Prosecutions are launched when a previous enforcement notice has not been complied with, or when serious offences have been committed. Cancellation of registration is the ultimate sanction.

Activity relating to enforcement involving PVH in the year March 2003 to April 2004 involved 33 actions; 28 of these were recovery of debt and five arose from breaches of regulations, one of which resulted in a successful prosecution for the operation of an unregistered establishment (see Box 3).

Box 3. A prosecution

In April 2004 guilty pleas were entered by defendants at a Magistrates Court in London in a prosecution brought by the Healthcare Commission for operating an unregistered establishment, contrary to the Care Standards Act 2000. The defendants were ordered to pay fines and costs totalling £19,300.

The company that operated the establishment (a clinic), together with its former director and former manager, pleaded guilty to 14 charges originally brought against them by the Healthcare Commission's predecessor, the National Care Standards Commission. All of the charges related to a failure to register the clinic, which has ceased to operate as a result of the action taken.

Reporting and guidance for improvement

In addition to publishing reports of inspections, the Healthcare Commission has a duty to inform the Secretary of State about matters relating to independent healthcare services and a duty to support and provide guidance and recommendations to providers to ensure that standards are met.

Reporting: Information reported to the Secretary of State can include specific research on aspects of independent healthcare, such as cosmetic surgery. It may also consist of feedback on the general state of PVH and the standards used to regulate the sector.

Guidance: Inspectors offer guidance to PVH providers to help them to meet the national minimum standards and the regulations.

> We will also work to reduce the burden of inspection on providers so they can focus on caring for their patients

What will the Healthcare Commission do?

The Healthcare Commission will continue to apply the national minimum standards and regulations for independent healthcare. We will undertake a programme of inspections and reviews, and any necessary enforcement actions, to maintain and improve standards in the independent sector.

The greater use and further evaluation of data relating to clinical and operational performance and changes to the methods of inspection will be planned, consulted on and implemented to strengthen the programme of inspection. These developments aim to promote practice more strongly founded on evidence and enhance the impact of techniques for improving quality.

The Commission will provide a range of information and reports on compliance with standards and on performance for people working in the sector, for patients and the community.

We will also work to reduce the burden of inspection on providers so they can focus on caring for their patients. This work will include developing the methodology for robust inspection based on the assessment of risk.

We will work to bring together standards and criteria that will enable a similar approach to assessments and inspections to be adopted across all sectors of the health system.

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STATE OF HEALTHCARE REPORT

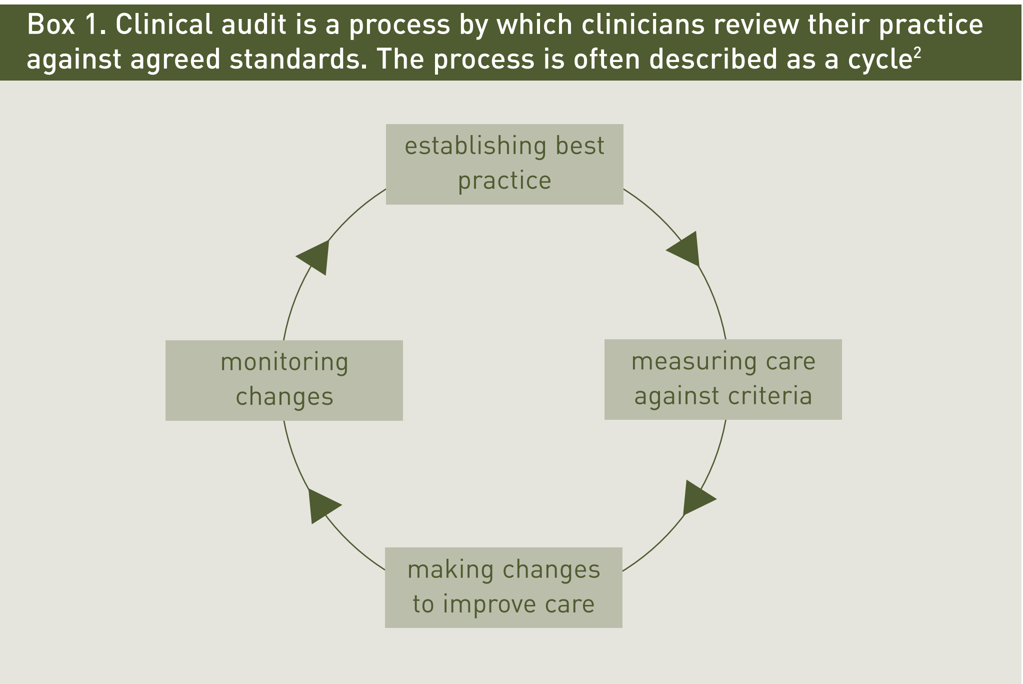
AUDITING CLINICAL QUALITY

AUDITING CLINICAL PRACTICE CAN DRIVE IMPROVEMENTS IN CARE. THIS SECTION LOOKS AT THE EFFECTS OF NATIONAL AUDIT PROJECTS.

Why this topic?

From the point of view of patients and the public, the quality of clinical care is of central importance. Trusting clinical staff to provide treatment of good quality is important to users of the health care services[1] and, individually, we all want to get good results from the treatment we receive.

Box 1. Clinical audit is a process by which clinicians review their practice against agreed standards. The process is often described as a cycle[2]



One of the main ways in which the quality of clinical care is checked is through clinical audit (see Box 1). When audits are carried out nationally, they enable clinicians to compare their practice with that of their peers. This can help services that are lagging behind the best improve by learning from good practice elsewhere.[3]

Current national clinical audits

From 2002 to April 2004 the Commission for Health Improvement (CHI) was responsible for sponsoring a programme of national clinical audits. These cover a range of conditions and services. Table 1 gives examples.

> The MINAP audit collects 87 pieces of information on each patient suffering a heart attack

Table 1. Examples of national audits in five clinical areas	
Coronary heart disease	The myocardial infarction national audit programme (MINAP) checks the management of heart attacks in hospital against the standards set out in the National Service Framework for Coronary Heart Disease. The audit currently covers all relevant hospitals in England and 17 out of 18 in Wales.
Services for older people	A national audit of care for those who have suffered a stroke began in 1998. It covers hospitals in England, Wales and Northern Ireland. The audit is explained in more detail later in this chapter.
Cancer	The national audit of bowel cancer has collected information on patients treated and results achieved from 261 surgeons in 73 hospitals in England, Wales and Northern Ireland.
Diabetes	The national audit of diabetes will start by collecting data in England. In 2004, it will track whether everyone with diabetes is recorded on a register held by a GP practice, and how often those with diabetes suffer complications of the disease. The aim is for the audit to develop so as to look at a wider range of standards of treatment.
Mental health	The national audit of violence in mental health settings is being set up to allow participating organisations in England and Wales to check their services against standards of provision and practice that have been shown to reduce the risk of violence.

A full list of the audits can be found at:
http://www.healthcarecommission.org.uk/AuditsNewCurrentProposed

Audits – aiming to improve patients' care

National clinical audits are large scale and complex projects. They require central resources to administer them and to analyse and feedback the results. They usually also need the involvement of clinical staff across the country to collect the data. For example:

- the MINAP audit collects 87 pieces of information on each patient suffering a heart attack
- in the most recent round of the national audit of stroke in 2001, 8,200 sets of case notes were examined by clinical staff

Once an audit is well established, it is a tool that can be used to improve the quality of care that patients receive. Below, we look at how one of the longest running national audits, the National Sentinel Audit of Stroke,[4] is contributing to improvements in care.

Stroke: a case study

The national audit of stroke is coordinated by the Royal College of Physicians. There have been three rounds of collecting and reporting data since it began in 1998; a fourth round began in April 2004.[5] A total of 235 hospitals took part in the third round of the audit. This represents over 95% of the trusts in England, Wales and Northern Ireland that provide care for those who have had a stroke.[6] Participation has increased from 80% in 1998.[7]

The audit enables hospitals to measure the quality of their services for people who have had a stroke by reference to the National Clinical Guidelines for Stroke[8] and to monitor their progress towards the milestones for such services set out in the National Service Framework for Older People.[9]

Although nearly three quarters of hospitals have stroke units, the majority of patients who have had a stroke spend no time in one

The standards for the care of patients who have had a stroke can be split into two main groups:

- those that focus on how such care is organised in a hospital
- those concerned with the care given to particular groups of patients

How is care organised?

Research shows that "outcomes for stroke patients are better when they are cared for by specialist stroke teams within designated stroke units."[10] Over the three rounds of the audit the proportion of hospitals that have dedicated stroke units has risen from 45% to 73% (figure 1).

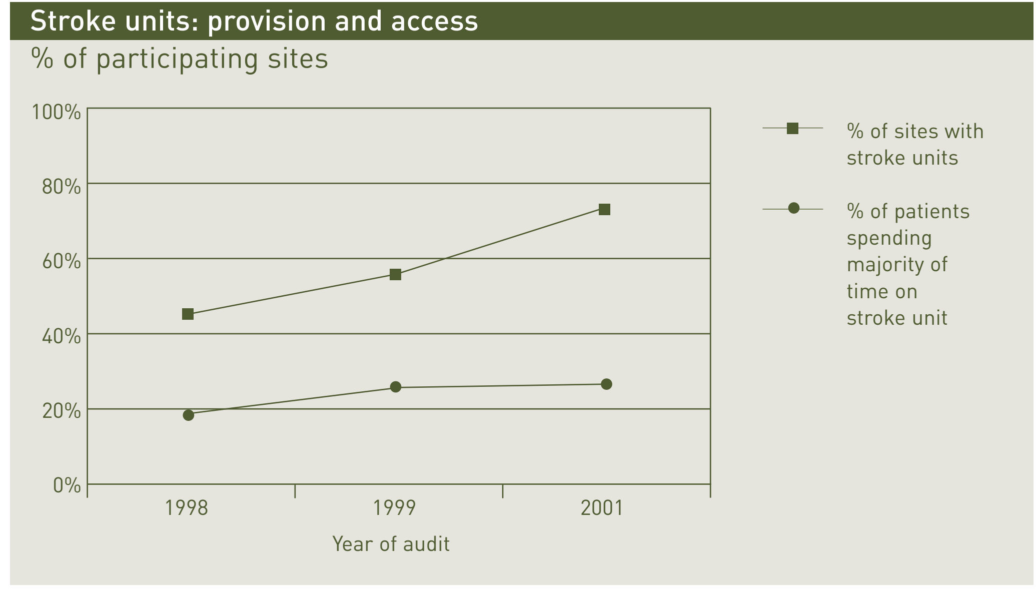


Figure 1. The proportion of hospitals that have dedicated stroke units has risen from 45% to 73%. However, the proportion of stroke patients spending most of their time on a stroke unit has remained below 30%. Source: Royal College of Physicians[6]

Having a stroke unit is only part of the story; the audit also underlines that units need to be big enough and be run efficiently if they are to cater for all the patients who might benefit from them. Although nearly three quarters of hospitals have stroke units, the majority of patients who have had a stroke spend no time in one. The 2001 audit found that, of the cases examined, only 36% of such patients spent any time on a stroke unit, while just 27% spent most of their stay on a stroke unit.

What care do patients receive?

By collecting information on a sample of cases from each hospital, the audit has been able to look at the care received by individual patients. It examines many of the minimum basic standards for care that are set out in National Clinical Guidelines for Stroke.[8]

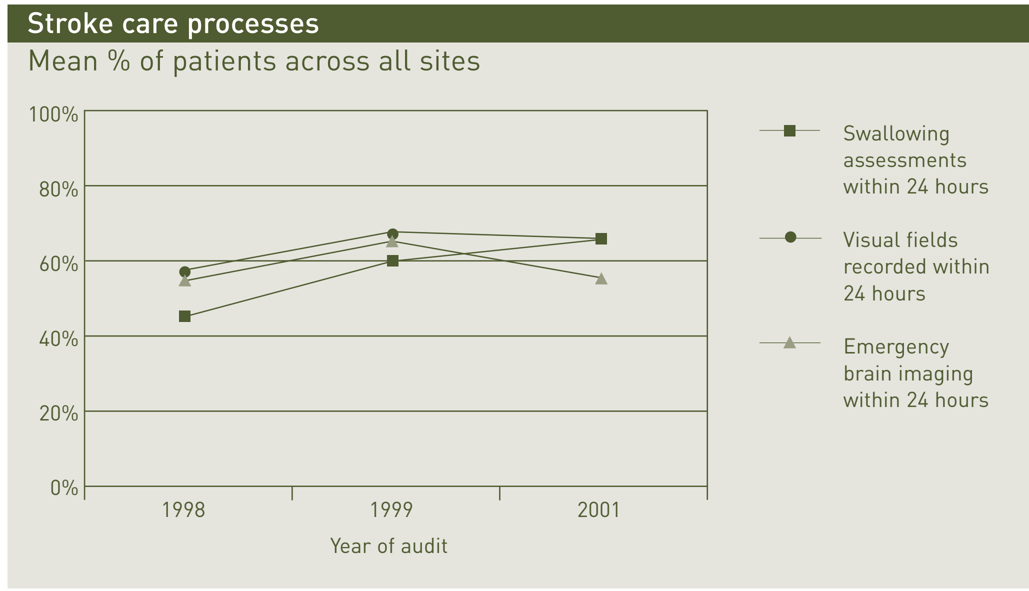


Figure 2. Early improvements in a number of indicators of the care received by stroke patients have levelled off in the third round of the audit.
Source: adapted from Leatherman and Sutherland (2003)[11]

The audit of stroke is not the only one that is producing positive results

Figure 2 plots progress in relation to variables related to three of the standards. It shows that the rate of improvement slowed after the first two years of the audit. The fourth round of the audit will reveal whether this pattern has continued. If it has, there will be a need to understand what obstacles there are to further improvement.

Are outcomes improving?

International research and the views of leading physicians point to the belief that the developments in services tracked by the audit of stroke will lead to better outcomes for patients.[8,12,13] As the improvements are introduced to hospitals across England and Wales, we are beginning to see evidence that suggests that patients are indeed benefiting: while the published reports of the national audit of stroke do not attempt to assess any changes in outcomes achieved by participating hospitals, a recent analysis of data from 172 hospital trusts in England has shown that deaths from stroke are significantly lower in hospitals with a designated stroke unit.[14]

Has the audit led to the changes that have been seen?

Although the Department of Health has judged that the Sentinel Stroke Audit is "very important in promoting better care,"[10] it is hard to say to what extent the changes to services for stroke in recent years can be attributed to the audit. This will become more difficult to determine as other initiatives gather pace. For example, since 2001 the National Service Framework for Older People has focused attention on services for stroke and the Government has made the provision of dedicated stroke services within hospitals a priority for the NHS.[15] From 2004 the proportion of patients who have had a stroke spending time on a specialist stroke unit will be one of the indicators that contributes to a hospital's star rating.[16]

However, it seems likely that an audit that has involved the clinical staff responsible for the services will remain an important part of the process of improvement. Reviewing evidence from the first two years of the audit, the intercollegiate stroke working party concluded that "comparative national audit does appear to have a positive effect by informing and cajoling healthcare providers into modifying entrenched and outdated systems of care."[17]

Room for improvement

The programme of national clinical audits is relatively young but the audit of stroke is not the only one that is producing positive results. For example, the MINAP audit of heart attack is showing encouraging increases in the number of hospitals achieving the standards set out in the National Service Framework for Coronary Heart Disease. The Healthcare Commission's forthcoming national report on the implementation of the Coronary Heart Disease National Service Framework will examine these results in more detail.

However, despite the successes, CHI identified some recurrent problems from its assessment of the activities of hospital trusts in relation to local and national clinical audit activities.[18] These include:

- lack of involvement of patients and service users
- insufficient involvement of staff from across all the various disciplines
- patchy training for staff carrying out clinical audits
- incomplete implementation of action plans to address the findings of audit and to spread good practice

While addressing these problems nationally will take time, new national audits due to start in 2004/2005 will contribute to the development of methods and practice. Two audits in particular will be relevant to involving patients:

- breast reconstruction surgery – this is being developed in collaboration with the Royal College of Surgeons and patients have been consulted on which aspects of care should be examined
- rheumatoid arthritis – this is an extension of an existing audit that will reflect new guidelines developed by patients

What will the Healthcare Commission do?

The Healthcare Commission took over responsibility for commissioning national clinical audits in April 2004. We will continue to support the audits listed in our *Corporate plan*[19] and build on work started by CHI to evaluate audits and proposals for audits by reference to specific criteria. The criteria are likely to include:

- the relevance of topics to clinical priorities and clinical practice
- the methodology used, including the management of databases and the risk adjustment of results
- the involvement of clinicians, managers, patients and the public
- value for money
- project management and delivery

In relation to the audit of stroke, in our first year we will:

- conduct a national survey of a sample of patients who have had a stroke
- publish the 2004 NHS performance ratings which will include an indicator of access to specialist stroke units

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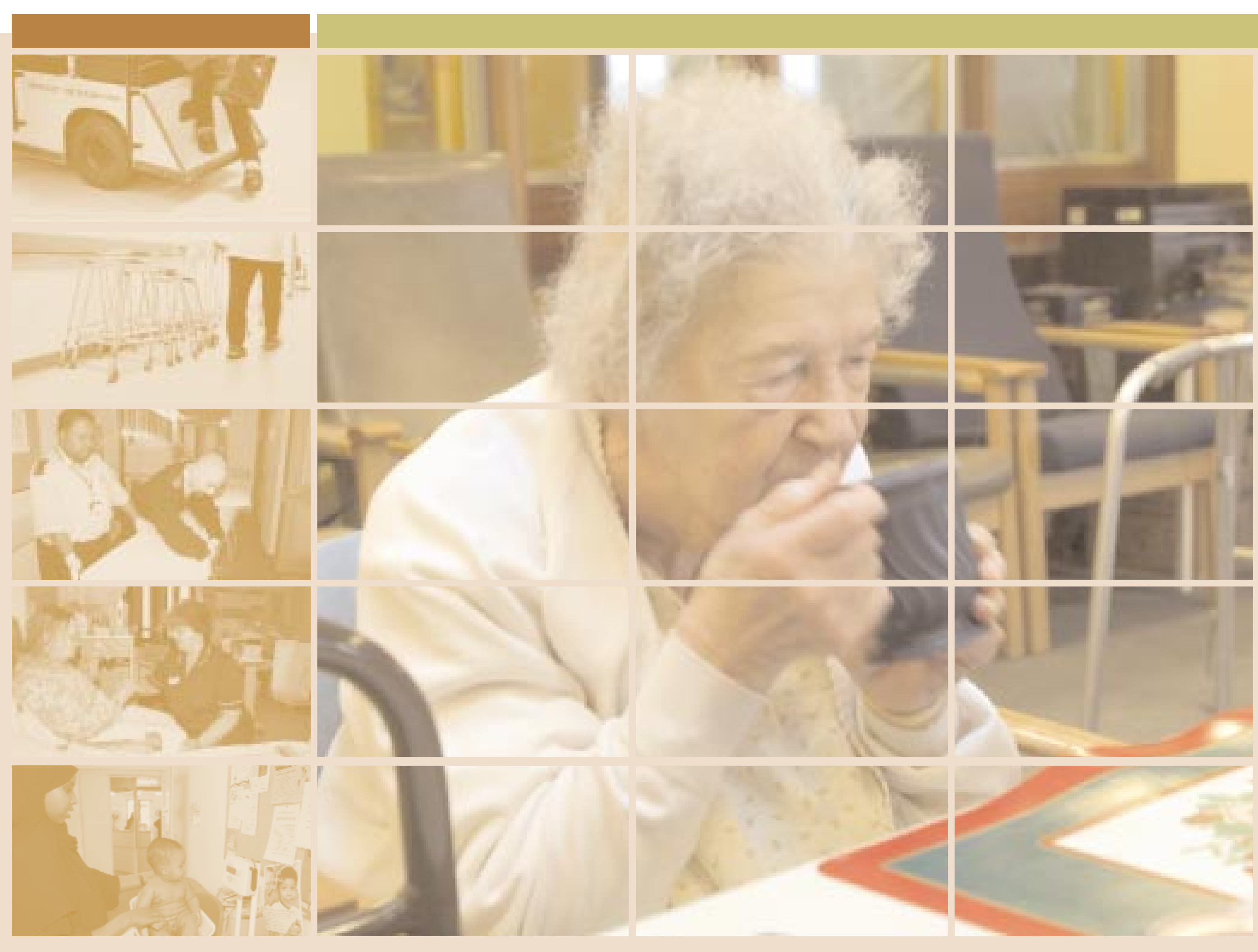
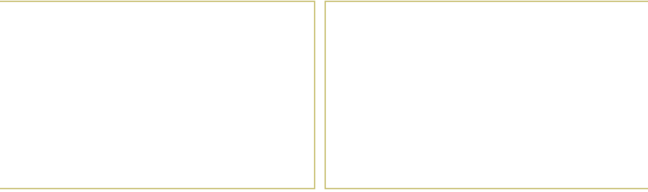
STATE OF HEALTHCARE REPORT
DECISIONS ON SPENDING



EXPENDITURE ON THE NHS IS RISING. THIS SECTION EXAMINES HOW THIS MONEY IS BEING DISTRIBUTED AND HOW THE BENEFITS IT MAY BRING CAN BE ASSESSED.



Why this topic?

The main focus of the Healthcare Commission's work is the quality of healthcare services. In the NHS, however, quality is obviously influenced by how well the health service spends the public money it receives.

Local and national decisions on spending affect the ability of the NHS to achieve value for money. This section examines some of the decisions that determine how funding is distributed within the NHS – to different parts of the country and to different parts of the service.

At a time when the NHS budget is increasing rapidly, such decisions will affect the value that the public gets from the extra spending. This section ends by exploring how to assess the value for money the NHS delivers.

National funding

In the year to April 2003 around 15% of Government's spending was on the NHS – around £65 billion across the UK. This was more than was spent on education and more than twice as much as on defence.[1] It amounted to about £1,100 for every person in the UK.

The Government is increasing spending on health. The Wanless Review[2] reported that compared to many similar countries, the UK spent less of its national wealth on health. The review recommended an increase in funding to allow the NHS to respond to developments such as new treatments, an ageing population and higher expectations from patients.

This will bring spending on the NHS to almost £1,800 a person

In the 2002 Budget, the Chancellor announced the largest ever sustained increase in NHS expenditure.[3] For England, spending is to go up from £56 billion in 2002/03 to more than £90 billion in 2007/08 (figure 1).

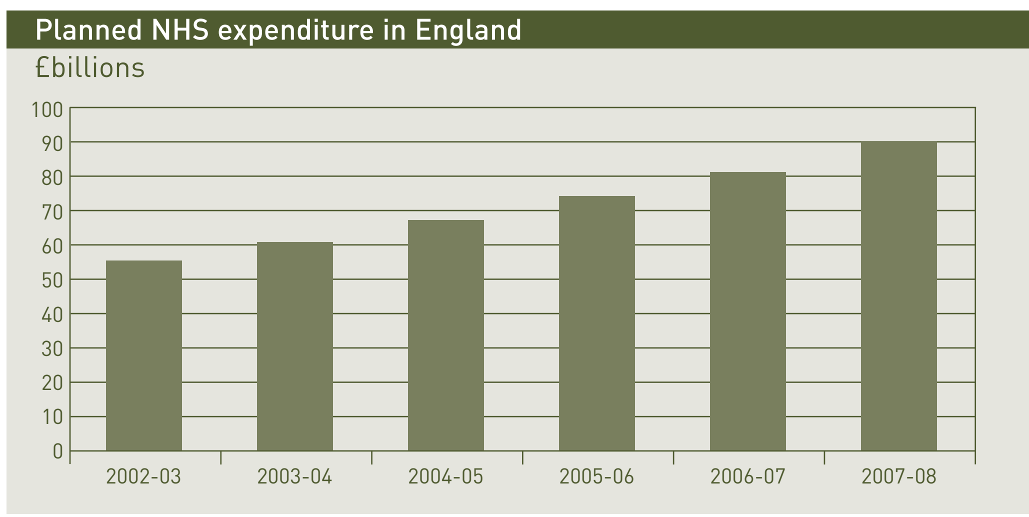
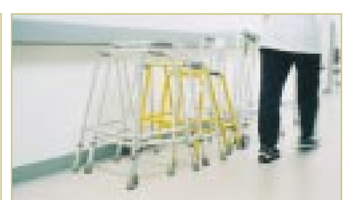


Figure 1. In England NHS spending is due to go up from £56 billion in 2002/2003 to more than £90 billion in 2007/2008.
Source: HM Treasury.[3]

This will bring spending on the NHS to almost £1,800 a person. The longer term plans for spending in Wales have not yet been finalised.[4,5]

Distribution around the country
While some funds pay for national services such as the National Blood Authority, over 98% of funding is spent on local hospital, community and GP services. The Department of Health recognises that decisions about spending on these services should reflect the needs and preferences of local people.



For this reason, most of the NHS budget is shared out among 303 primary care trusts (PCTs)* in England and 22 local health boards in Wales - the organisations that commission local health services. In England, PCTs control around 80% of NHS spending.[6]

Because different factors such as the age of the population or the prosperity of the area affect local needs as regards healthcare, a funding formula is used to calculate the amount of money each PCT should receive. This amount, known as the target allocation, takes into account the size of the population and other factors, including the proportion of older people and the amount of ill health suffered by local residents.

However, PCTs do not necessarily receive their target allocations. Instead, the actual funding received by a PCT is adjusted to reflect additionally the allocations it has received in the past. As a result, the actual funding may be more or less than the target. Past allocations are taken into account to avoid problems that might follow a sudden change in funding. For example, in areas that have been able to rely on relatively high levels of funding, sudden financial cuts might lead to services having to be scaled back dramatically or even closed. The Department of Health's aim is "...to balance the desire to move funding to the most needy areas with the requirement to avoid undue destabilisation."[7] (The distribution of health service funding in Wales is also influenced by a formula reflecting health needs, as well as by the desire to balance fair distribution with stability.[8])

The difference between a PCT's target and its actual allocation is known as the distance from target (DFT). 2003/2004 allocations show a wide range of DFTs: at the extremes, the allocation for Easington PCT (in County Durham), was 20% less than target, while that for Westminster PCT in London, was 31% over. The table below shows the 2003/2004 DFTs in percentages and cash for the ten PCTs most under and over target.

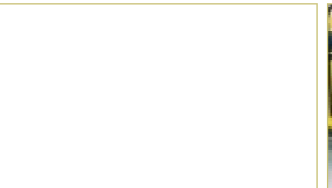
* The term PCTs, here includes care trusts with integrated responsibilities for health and social care

PCTs cannot decide to fund everything that would benefit the health of the local population

10 PCTs with 2003/04 allocations most below target		
Easington	-20.2%	-£26.5m
Tendring	-15.0%	-£23.9m
Knowsley	-14.9%	-£30.0m
Barking and Dagenham	-14.7%	-£28.1m
Ashfield	-12.8%	-£10.6m
North Liverpool	-12.5%	-£17.7m
Central Liverpool	-10.6%	-£35.5m
Heart of Birmingham	-10.6%	-£34.7m
Tower Hamlets	-10.0%	-£28.1m
Basildon	-9.0%	-£9.7m

10 PCTs with 2003/04 allocations most above target		
Westminster	31.1%	£66.3m
Richmond and Twickenham	18.8%	£27.5m
Cambridge City	17.7%	£16.9m
Kensington and Chelsea	16.5%	£30.3m
Wandsworth	14.5%	£37.4m
Oxford City	14.5%	£19.6m
Trafford South	12.8%	£13.2m
Rushcliffe	12.7%	£11.2m
St Albans and Harpenden	12.1%	£12.3m
Sheffield South West	11.8%	£12.4m

Source: Department of Health unified exposition book[9]



PCTs with allocations over target tend to serve relatively well off areas, while those under target are likely to have more deprived populations. Using a standard measure of deprivation[†,10] and taking the 20 PCTs in the table, each can be ranked along a scale of all PCTs from one (the least deprived) to 304[‡] (the most deprived). The ten PCTs most under target have an average deprivation ranking of 272. By contrast the ten most over target have an average rank of 85.

PCTs that are under target may find it harder to offer health services that are as good as those of PCTs with allocations at, or above, target. They tend, for example, to have fewer GPs. The ten PCTs in the upper table have an average of 4.8 GPs[§] for every 10,000 residents, while the ten in the lower table have 5.7.[11] Given that the under-target PCTs serve more deprived populations with more ill health, they might be expected to need more, rather than fewer, GPs when compared to the less deprived areas.

Initial allocations of local funding have been published for 2004/2005 and 2005/2006. These show the gaps between targets and allocations closing, but only slowly. The Government's inequalities action plan envisages a future in which "...by 2010 all PCTs will have reached their target allocation of resources that fully reflect local need."[12] On current trends, this looks to be the earliest by which the funding targets could be achieved.

Distribution among local services

Having received their allocation, PCTs use the money to commission services from hospital trusts, GPs and other primary care providers such as dentists, pharmacists and opticians (in addition they themselves provide some services directly, such as community nursing and chiropody). Given that the money they have to spend is limited by their allocation, PCTs cannot decide to fund everything that would benefit the health of the local population. Every decision to spend a particular sum of money on one aspect of healthcare is, in effect, a decision to refrain from spending it on another. PCTs must therefore set priorities – informed by an understanding of the health needs of their population, and the abilities of different kinds of services to meet those needs.

† Technically, the 'population weighted mean ward Index of Multiple Deprivation'.
‡ The number of PCTs at the time that the allocations were made. The number has since fallen to 303.
§ Specifically, whole time equivalent, unrestricted principals and their equivalents.

Recent reports show that more patients are being treated outside hospital

One way of looking at the results of all these local decisions about spending is to analyse the distribution of expenditure across the different sectors of the health service. Using the latest available figures for England (from 2001/2002), the figure 2 shows that services commissioned from hospitals account for most of the spending.[13] Thirty percent was spent on primary care in England (a proportion similar to the figure for Wales).[**,14]

NHS expenditure in England 2001/02 by sector

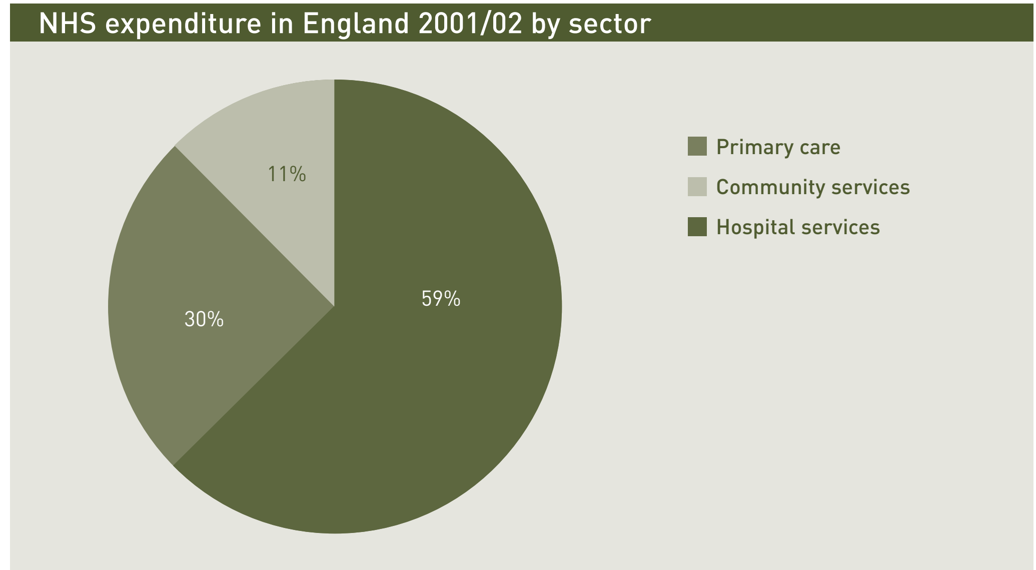
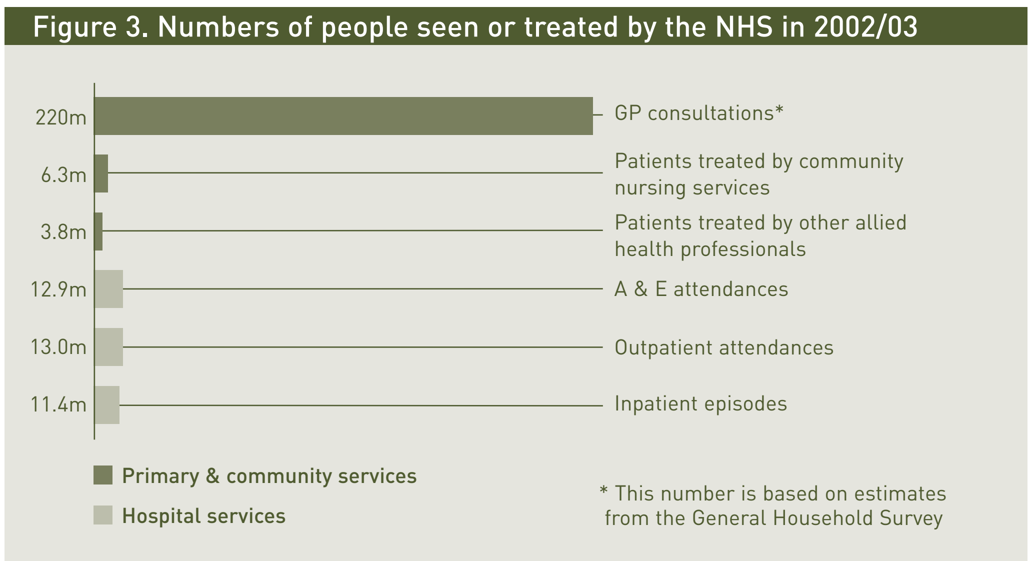


Figure 2. Almost 60% of NHS spending goes on hospital services.
Source: Department of Health[13].

At first sight, these proportions may seem odd, given that so much NHS care takes place outside hospitals. For example, figure 3 shows estimates of the number of patients cared for in different parts of the health service.[13] The vast majority are seen in primary care. Of these, only a small proportion are referred to hospital.[15]

**In Wales acute and community services tend to be provided by the same organisations, and has not been possible to divide the spending between these two sectors.

Figure 3. Numbers of people seen or treated by the NHS in 2002/03



However, a relatively high level of spending on hospital care is to be expected. Hospitals provide complex, highly technical and emergency treatments, and need high levels of staffing, particularly nurses – all factors that make care in hospital relatively costly.

The development of primary and community care is a Government priority[16,17] and recent reports show that more patients are being treated outside hospital.[15,18] A stronger primary and community sector can provide care that is more convenient to patients and play a leading role in health promotion and tackling health inequalities.[6,19] The sector also makes a major contribution when it comes to responding to the poor quality of life that is often a feature of chronic diseases such as asthma, heart failure, or dementia. Patients with long term conditions such as these account for about 80% of GP consultations.[20]

> it is not possible to measure directly the benefit of each extra pound spent on healthcare

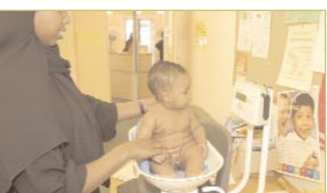
Traditionally, a GP needing guidance on how to manage a patient's care has had to refer the patient to a hospital based consultant. The Audit Commission recently studied how PCTs were developing alternatives for some referrals to hospital.[21] These typically involved new services for diagnosis and treatment by 'practitioners with a special interest' based in primary care. These are GPs, nurses, or therapists who have extended their role to offer a specialist service. Generally, these developments were paid for by the health service's increased funding. However, the PCTs varied greatly in the extent to which they were investing this new money in primary rather than hospital care. Some PCTs were spending as much as a third of their development funds within primary care, while for others it was less than a tenth. Those spending a smaller proportion were working on fewer schemes to develop alternatives to referral to hospital.

The Audit Commission's report also showed that PCTs that had the greatest difficulty in balancing their income and expenditure were investing least in new primary care services. Independent auditors have also expressed concerns about "...inadequate staffing and management capacity in relation to finance..." at around a third of PCTs.[22] Additional investment in these back office areas might result in benefits for the modernisation of clinical services.

National value for money

Unprecedented investment raises new questions: where is all the new money going; is it being spent on the right things; and is health improving as a result? These are difficult questions to answer.

The NHS, like healthcare systems in other countries, does not consistently collate information on the change in patients' health following treatment. As a result, it is not possible to measure directly the benefit of each extra pound spent on healthcare.



In the absence of a measure of achievement based on increases in health, measurement has focused on what the NHS does rather than what it achieves. The NHS counts the number of patients it treats, prescriptions written, operations performed, attendances at outpatient clinics and so on, and uses these as measures of output. Productivity is then taken as the ratio of this output to the input – the funding. If the increase in activity in a year is greater than the increase in funding, then the current methods would judge the NHS to be increasing its efficiency.

Throughout the late 1990s this measure of efficiency was falling,[23] and appears now to be rising only very slowly.[24] This has led to concerns that much of the extra money going into the NHS is being used to pay for increasing costs such as higher salaries, higher national insurance payments, and increased drug and equipment prices, rather than increased outputs. However, before the impact of any such cost increases can be put in context, it is important to make sure that the right outputs are being measured.

Unmeasured outputs

Some NHS spending is being used to:

- increase activities not included in the measure of productivity. Traditional measures of productivity do not include consultations and clinics in GPs' surgeries. Considering the proportion of activity in primary care (see figure 3), this is a significant omission. It also means that many of the efforts of the NHS to promote good health, such as the NHS Stop Smoking Service,25 are not considered productive activities.

- increase the quality rather than the number of certain activities. For example, improving systems within an A&E department to reduce delays in giving victims of heart attacks life saving anti thrombolytic (clot busting) drugs would not contribute to current measures of productivity, which just count the number of people attending the casualty department.

It may sometimes be desirable for the NHS to do less rather than more

There is also a more general problem with measures of productivity based on the activity of the health service. It may sometimes be desirable for the NHS to do less rather than more. As the Secretary of State for Health, John Reid, recently said: "The whole point of an effective health care system must be to reduce the numbers of people who have to go to hospital...."[26] So, even if the measure of productivity were changed to include, say, classes to help people stop smoking, any consequent reduction in admissions to hospital for people with heart disease could still count as a decrease in the output of the health service.

New ways of measuring productivity

Many people now think that better ways of measuring productivity in the public sector (including the NHS) are needed.[27] The intention to move toward measures that include quality and outcomes was signalled by the 2002 Public Service Agreement[28] which sets out the Department of Health's overall aims and objectives. For the first time the target relating to value for money includes increases in quality and service effectiveness. This new kind of target will be applied first to information from hospital and community care for the financial year 2003/2004. The details of the methods have not yet been published, but a key element is likely to be "...the value placed on the lives saved from reducing mortality....".[29]

This may involve a concept such as the 'value of a statistical life' used by the Department of Transport in relation to improvements in road safety. This would, for example, allow the value of the 6,000 to 7,000 lives the Department of Health estimates to be saved each year by cholesterol lowering drugs (statins), to be judged against the £695 million that the drugs cost.[30] The accuracy of this value for money assessment will depend on how accurately the number of lives saved can be estimated and the extent to which all the costs and benefits of diagnosis, prescription and follow up are included in the calculation.

What will the Healthcare Commission do?

The Healthcare Commission will build on the work previously carried out by the Audit Commission to develop an approach to measuring the value for money of healthcare services. This will include, where appropriate, arrangements for monitoring the uses to which new money is put. In developing our approach, we will be keen to make a constructive contribution to the current debates on how best to establish what is being achieved with the public money spent on healthcare.

The Healthcare Commission's wider role in review and inspection will also, over time, allow assessments to be made nationally of the progress the NHS is making in improving the quality of its services and consequently the health of the population. The State of Healthcare Report will remain one of the ways in which the results of those assessments are published.

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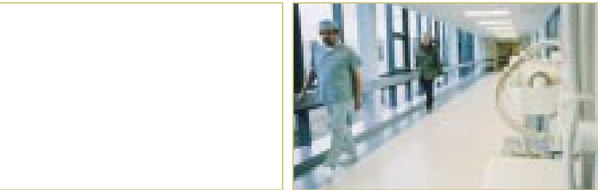
STATE OF HEALTHCARE REPORT

INTERNATIONAL STANDING

THIS SECTION EXAMINES HOW OUR HEALTH AND HEALTHCARE CAN BE COMPARED TO THOSE IN OTHER COUNTRIES.



Why this topic?

Other sections of this report have looked at the state of healthcare in terms of trends over time, whether targets have been achieved, and the range of performance within the country. This section compares some aspects of the performance of our healthcare services with those of other countries. Such comparisons focus on what it has been possible to achieve elsewhere. They can help us learn from others, as well as, perhaps, suggesting where they could learn from us.

Comparing like with like

International comparisons are valuable because countries organise and practice healthcare in different ways. But these differences can also make the comparisons difficult to make and interpret. For example:

- the pattern and causes of ill health in other countries may be different
- important elements of the overall picture, such as diagnoses, may be defined differently
- information may be recorded in different ways

One way of minimising such problems is to make comparisons within a relatively small set of countries that are similar in important ways. Given that the World Health Organisation (WHO) has made comparisons across nearly 200 countries,[1] there is clearly a wide range of countries from which to choose.

In this report we have echoed the Wanless report and selected eight countries with "broadly similar population structures, health care systems and per capita wealth...."[2] These are Australia, Denmark, Canada, Finland, France, Germany, the Netherlands and Sweden. In some cases we have not used comparisons with this core group where there is a lack of up-to-date information or when a particular issue is best addressed by looking at another country. Where published comparisons give figures for England and Wales, we have shown both; some comparisons have only been made for the UK as a whole or for England alone.

Comparisons based on broad indicators of health

Life expectancy at birth is a broad indicator of national health commonly used for comparison (figures 1a and b).

Figure 1a. Female life expectancy at birth in years, 1999

Source: OECD Health Data 2003.[3]

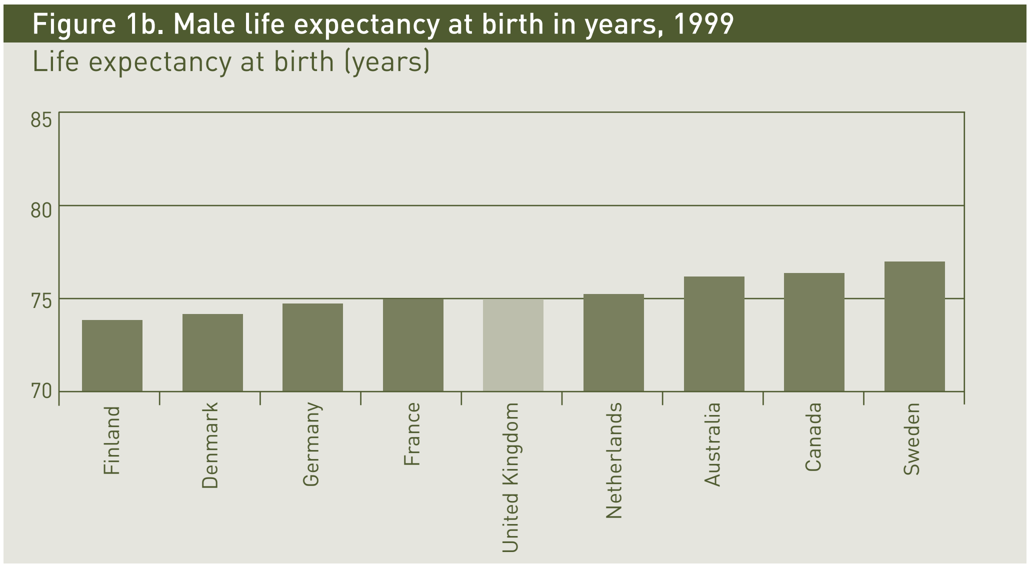
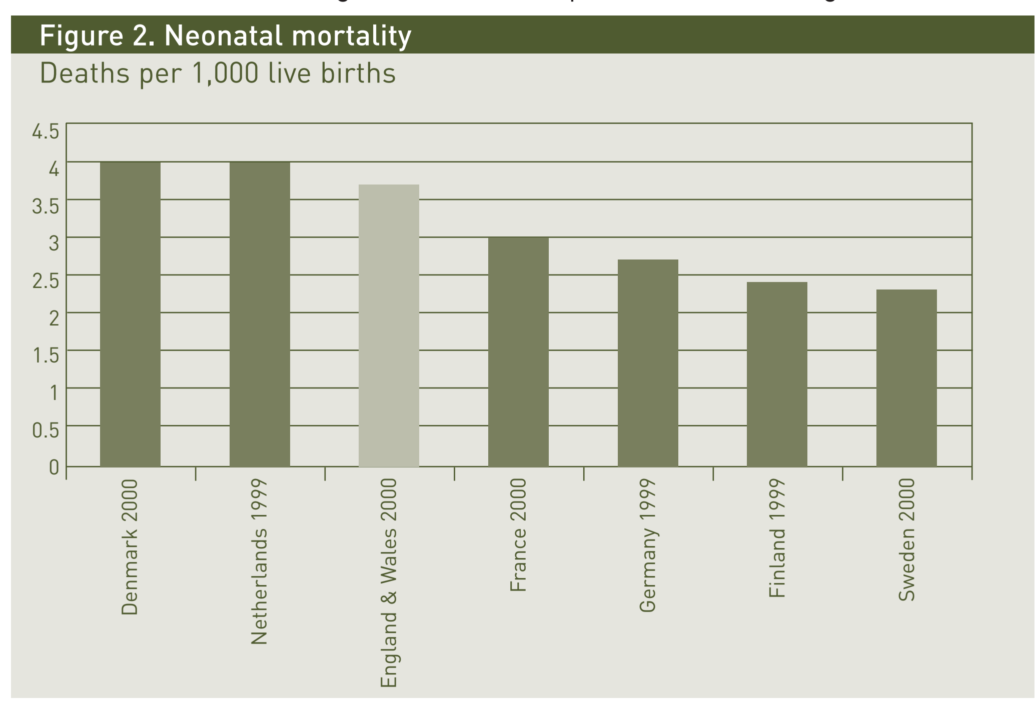


Figure 1b. Male life expectancy at birth in years, 1999

Source: OECD Health Data 2003.[3]

Another widely used measure is the proportion of infants who die within 28 days of birth (figure 2). However, this neonatal mortality statistic is affected by differences in national regulations with respect to the recording of still births.[5]



Source: Buitendijk et al, 2003.[4]

To help overcome this problem, the international PERISTAT project has recommended that comparisons be made within groups defined by the length of pregnancy.[4] Unfortunately some countries, including England and Wales, are currently unable to provide comprehensive neonatal statistics in a form that allows such comparisons to be made.

There is another more fundamental difficulty with using broad measures such as life expectancy and neonatal mortality as indicators of the effectiveness of healthcare services. These measures are affected by the kind of wider determinants of health discussed in the section Setting the scene: the public's health. Thus, smoking, diet, ethnic origin, housing and environment will all influence health. The degree to which healthcare services play a role directly will vary.

Comparisons based on results for particular conditions

Healthcare can, of course, have an impact on conditions such as cancer and heart disease, whatever the factors which play a role in causing these conditions. Below we look at how we compare with other countries in these areas.

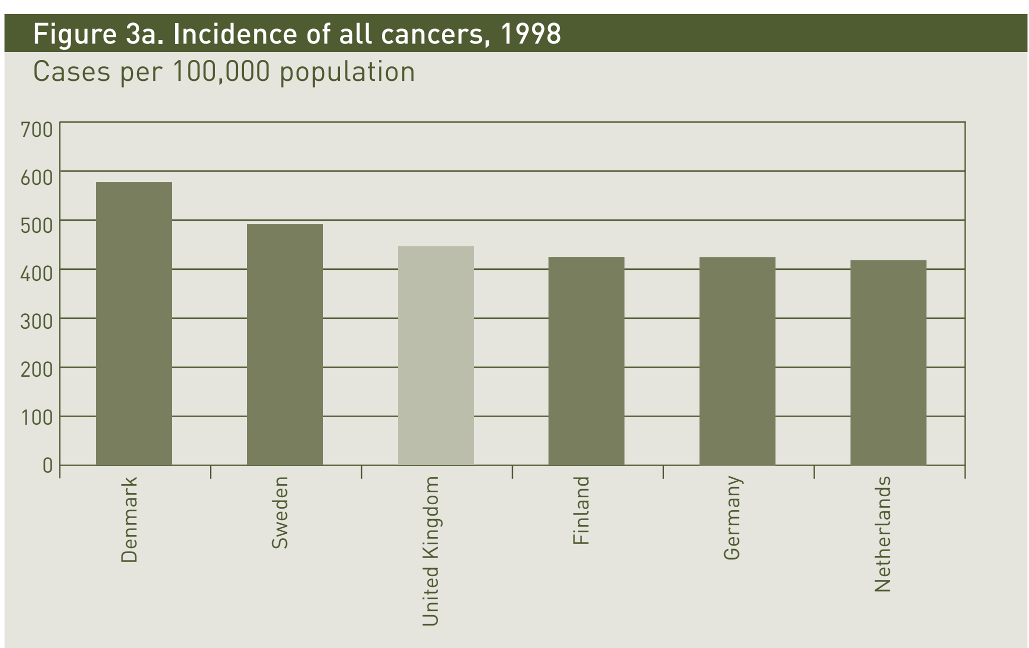
Cancer

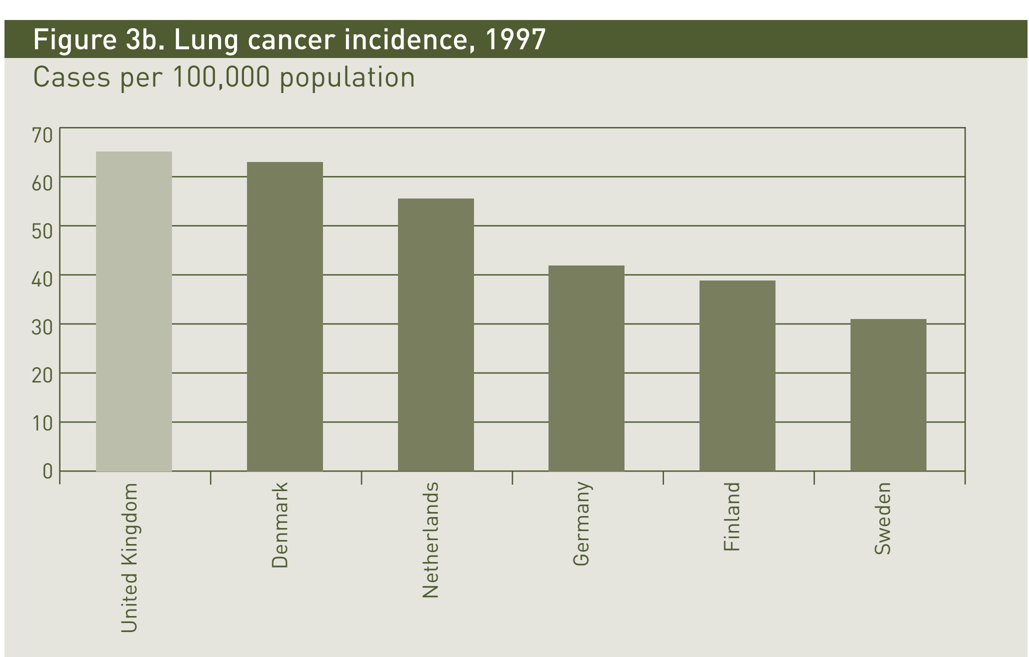
Many countries have registries that collect information on every new case of cancer. Such registries record the nature of the tumour, the treatment and the outcomes. Although not all countries' records have sufficient coverage of their populations to make comparisons straightforward,[6] three linked statistics have become the accepted basis for international comparisons: incidence, survival and mortality.

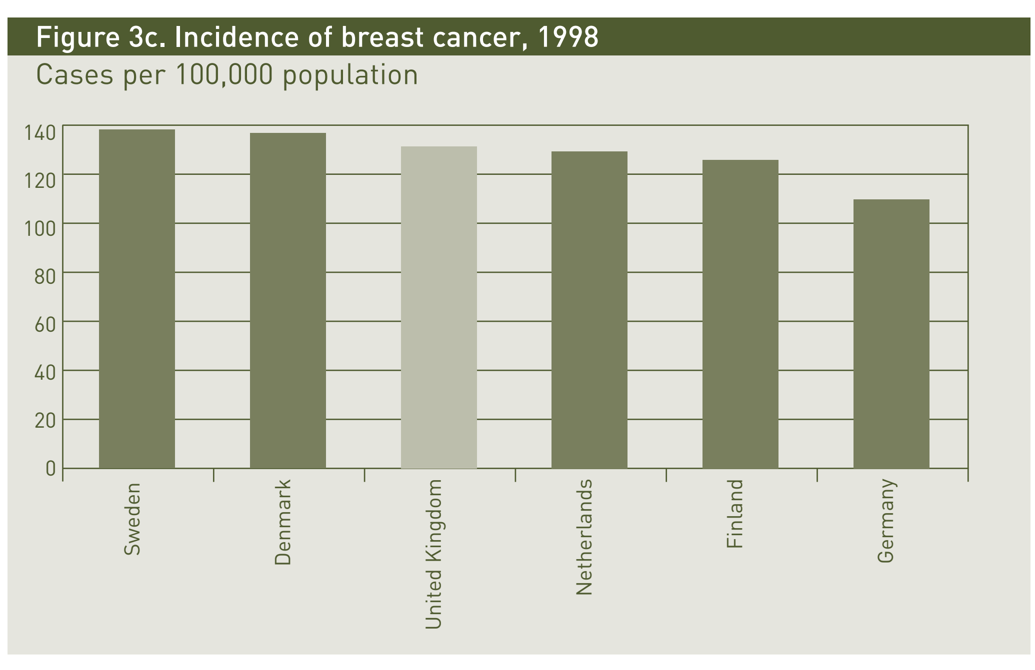
The charts relating to **incidence** (figures 3a, b and c) show the number of newly diagnosed cancers each year for every 100,000 people. The figures describe the size of the problem that a country faces, as well as giving an indication of how successful it has been in tackling those cancers that are preventable.

The charts relating to **survival** (figures 4a, b and c) use the internationally accepted standard measure of the proportion of people still alive five years after a cancer has been diagnosed. A higher percentage shows a better survival. These figures help to demonstrate how successful treatment has been. However, they will also be influenced by factors such as how advanced the cancer was when it was diagnosed.

The charts relating to **mortality** (figures 5a, b and c) show the number of people who die from cancer each year for every 100,000 people.







Source: WHO Europe[7]

Figure 4a. Relative 5 year survival rates for all cancers in men and women diagnosed 1990- 94

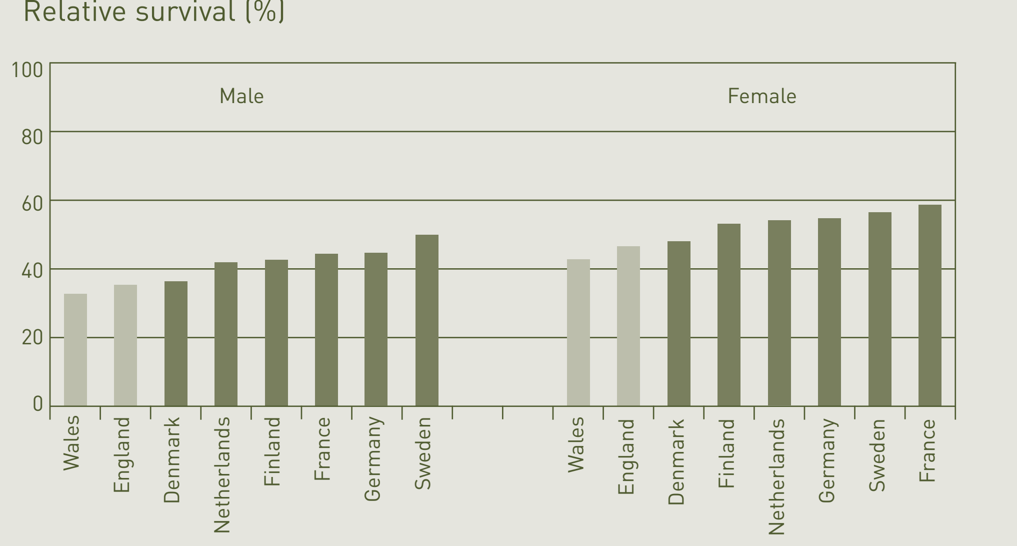


Figure 4b. Relative 5 year survival rates for lung cancers in men and women diagnosed 1990- 94

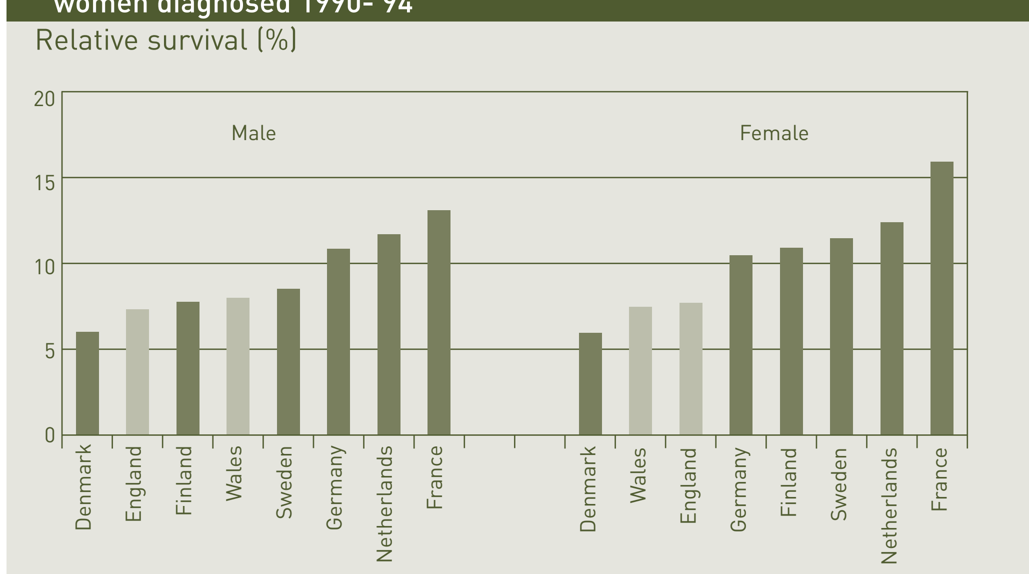
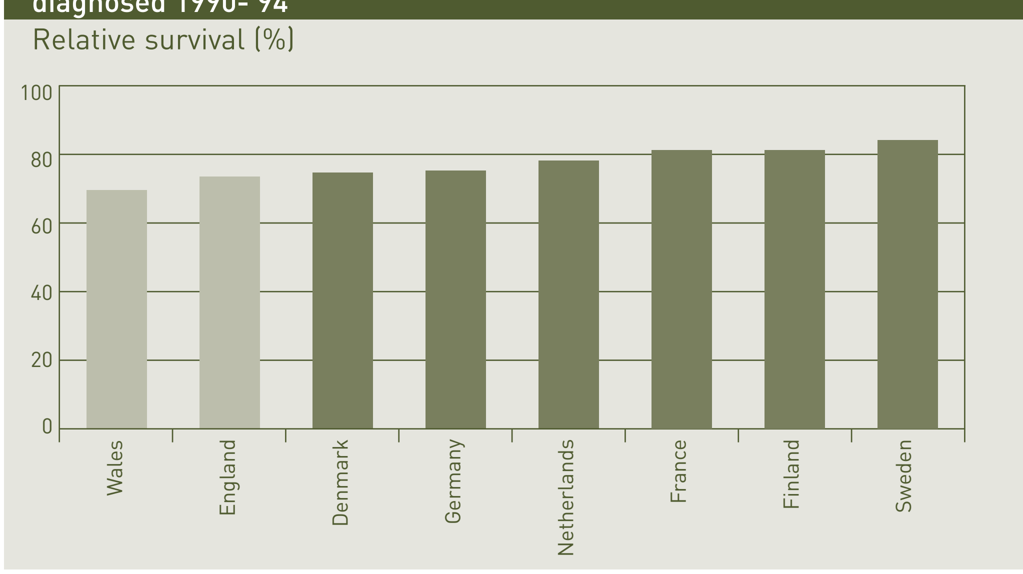
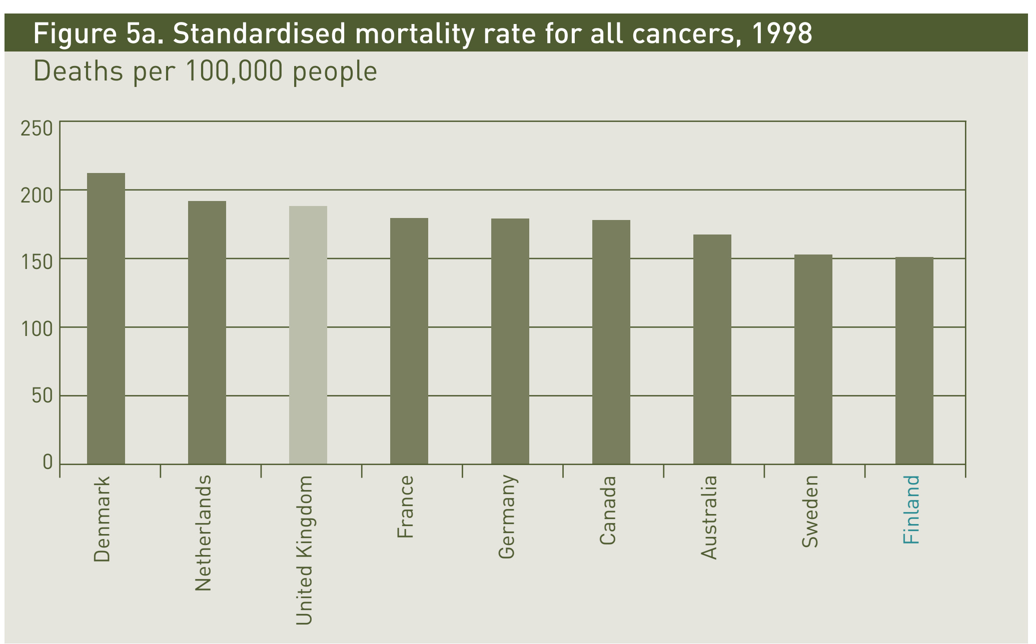
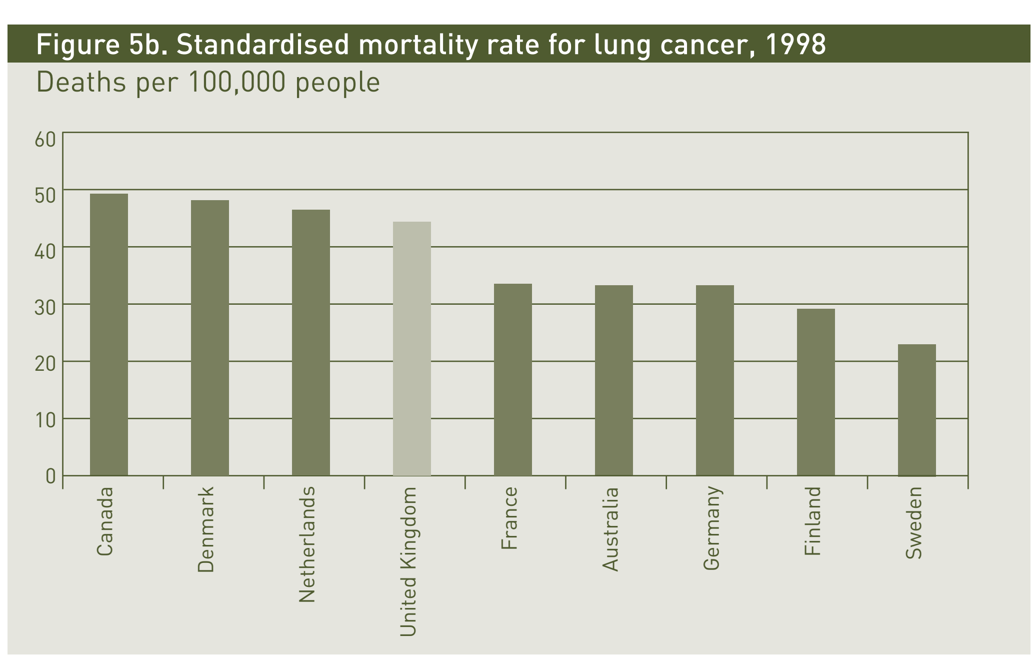


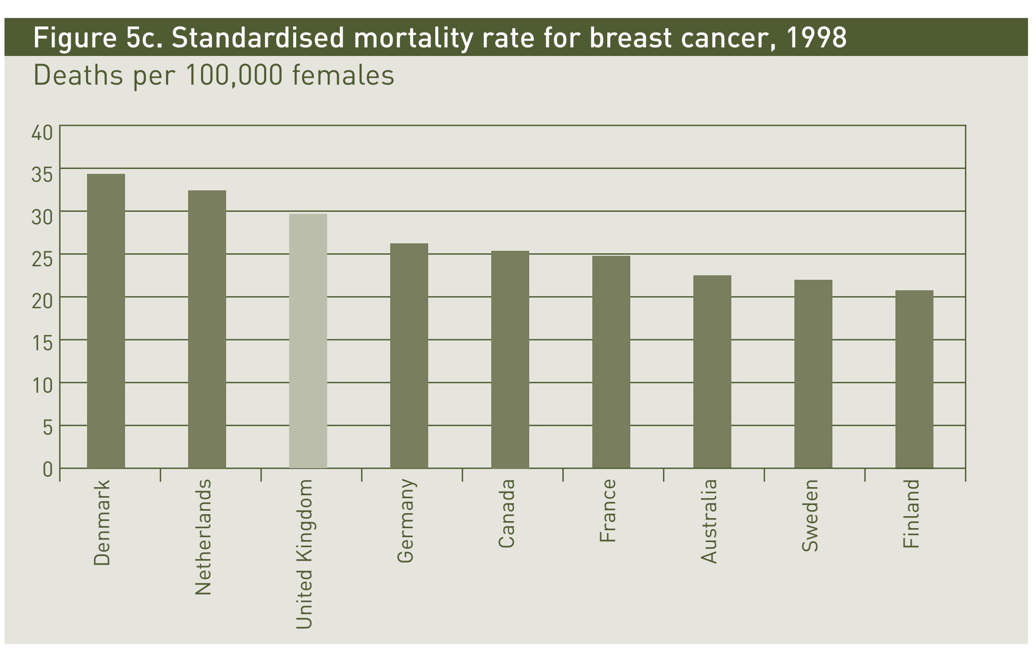
Figure 4c. Relative 5 year survival rates for breast cancer in women diagnosed 1990- 94



Source: Eurocare-3[8]







Source: OECD Health Data 2003[3]

> While the delays associated with international statistics reduce their value, the figures can still have an impact

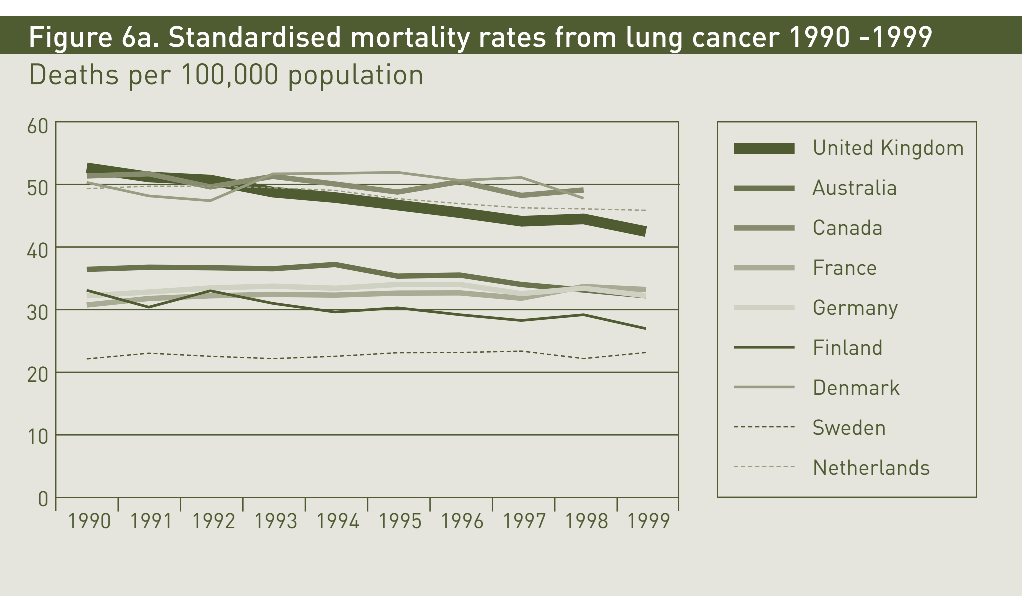
There is little for the UK to celebrate in these comparative statistics relating to cancer. However, these results should be seen in the context of the years to which they refer. There are two issues here. In respect of the graphs referring to survival, the patients were all diagnosed between 1990 and 1994. Logically, reporting has to lag at least five years behind diagnosis, so that the patients' survival can be tracked over the five year period. Treatment has changed since the early 1990s and patients developing cancer today will have the chance to benefit from the improvements.

However, there is another factor underlying this time lag before international statistics become available, one which is also relevant to the figures relating to incidence and mortality. These figures all date from 1997 and 1998, reflecting the difficulty international organisations have had in collecting, collating and publishing statistics from many countries. Information from a single local source is likely to be more up to date. For example, rates of incidence for 2001 for Wales have been available since December 2002.[9]

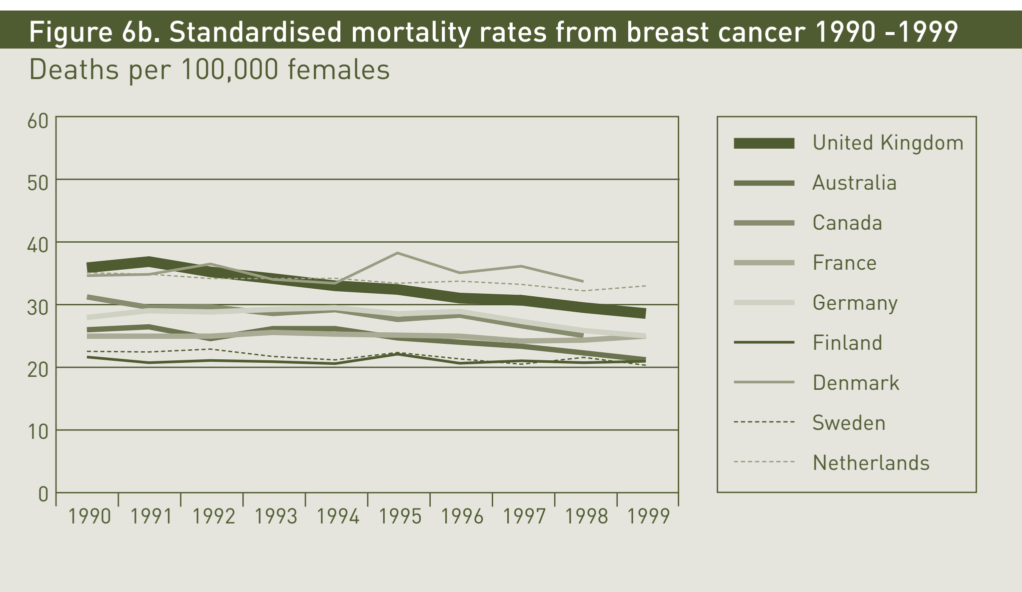
While the delays associated with international statistics reduce their value, the figures can still have an impact. In 2000 the *NHS cancer plan* compared rates of survival in England and Wales with the rest of the European Union and found a situation similar to that shown here.[10] Considering England, the plan identified possible reasons:

- delays in diagnosis
- outdated NHS equipment for detecting and treating cancer
- too few specialists in cancer
- delays in adopting new ways of treating patients

The *NHS cancer plan* outlined how new investment in services in England for cancer would be used to tackle these problems. In 2003 a progress report described improvements in each of these areas.[10] Clearly any improvements flowing from the *NHS cancer plan* are not yet reflected in the latest available international figures – which date from the end of the 1990s. However, even before the *NHS cancer plan*, there were some encouraging trends. For example, figures 6a and b plot the decline in mortality from lung and breast cancer through the 1990s.



Source: OECD Health Data 2000[3]



Source: OECD Health Data 2003[3]

For breast cancer, the fall in mortality has been the steepest in the world

The National Audit Office's recent review of cancer care in England[6] included an analysis of these trends and concluded that:

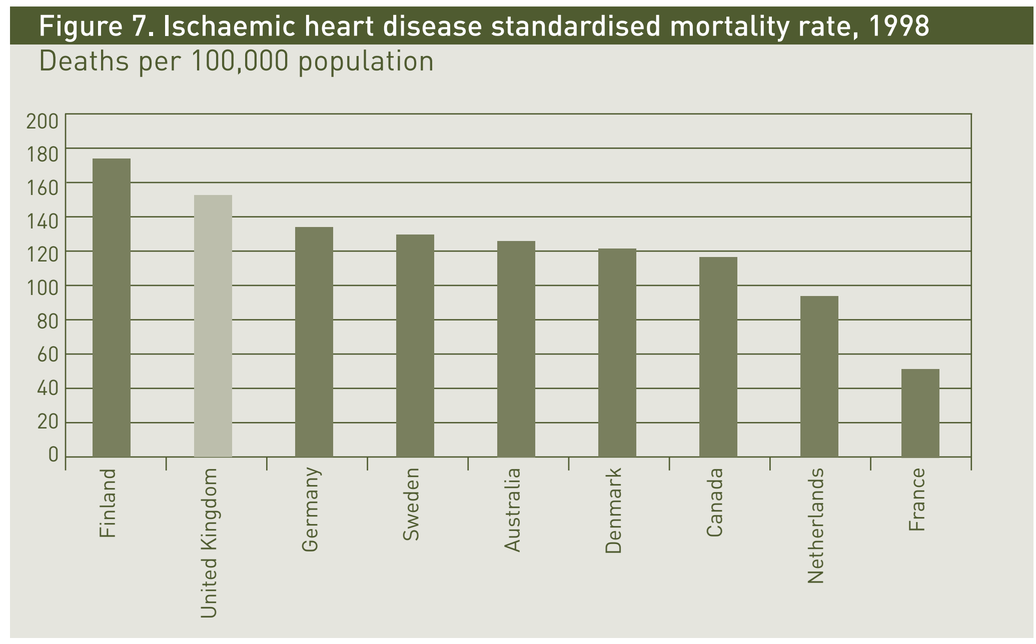
- for breast cancer, the fall in mortality has been the "steepest in the world"
- for lung cancer, rates of mortality could be interpreted in terms of the cycles of tobacco use in different countries – "as lung cancer incidence and mortality trends are now downward for women in England and Wales but incidence trends for women in other countries are now generally on an upward path, mortality rates relative to those in other countries should improve"

Heart disease

Figure 7 shows comparative figures on **mortality** for ischaemic heart disease, which is typically caused by a narrowing of the heart's coronary arteries and can lead to a heart attack.

Figure 7. Ischaemic heart disease standardised mortality rate, 1998

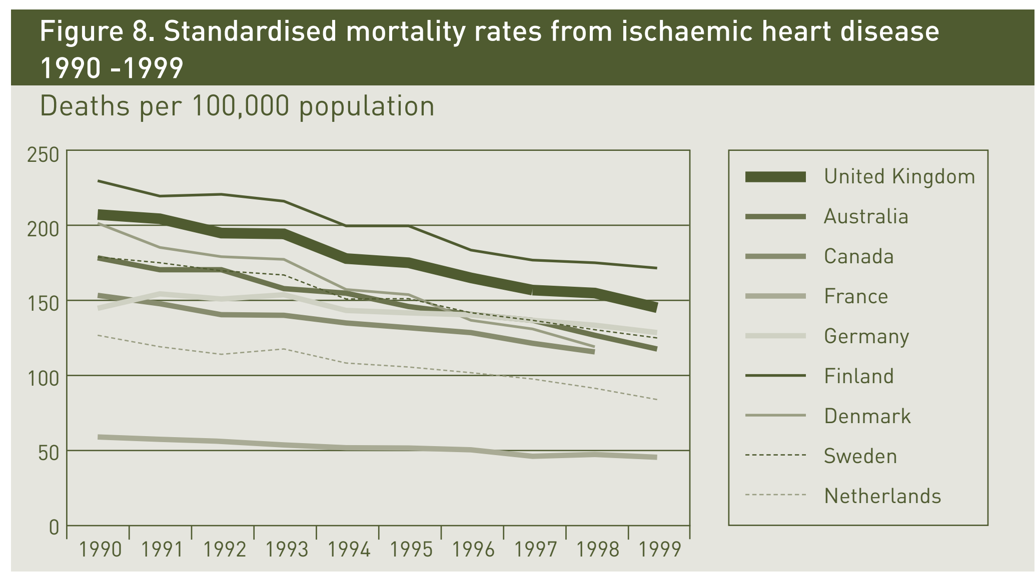
Deaths per 100,000 population



Source: OECD Health Data 2003[3]

The most recent international analysis refers to deaths in 1998. In 2000, the Department of Health launched the National Service Framework for Coronary Heart Disease.*11 Four years later a progress report on the National Service Framework for Coronary Heart Disease noted that in 1997: "We had one of the highest heart disease death rates in the developed world and heart services in this country lagged behind health systems in other countries."[12] The report describes a range of recent improvements and notes that deaths from all cardiovascular disease, including strokes, among people under 75 fell by more than 23% between 1995/1997 and 2000/2002.

Figure 8. Standardised mortality rates from ischaemic heart disease 1990 -1999



Source OECD Health Data 2003[3]

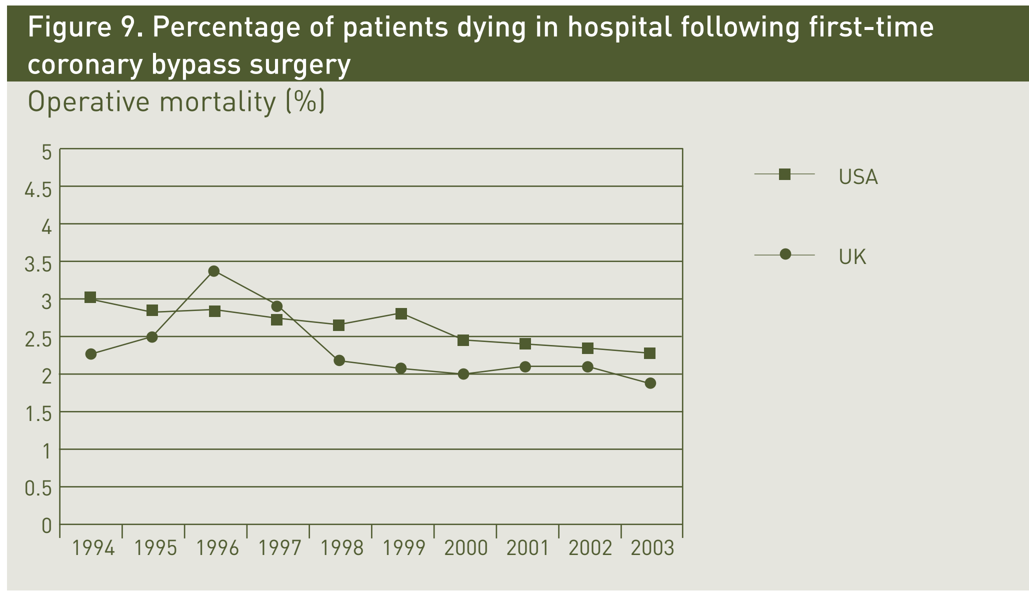
Internationally, we can see trends in ischaemic heart disease up to 1998 (extended to include 1999 for countries for which figures are available). Figure 8 shows that through the 1990s the UK's trend for this cause of death was on a downward gradient similar to that of most comparable countries.

* An equivalent plan for Wales *Tackling coronary heart disease in Wales: implementing through evidence* was published in 2001.

Improvements in cardiac services as a result of the National Service Framework for Coronary Heart Disease may improve our relative position. In time, international results will be available to show if this has happened.

Comparative information on **survival** following treatment for heart disease is not routinely collated and published internationally. However, comparisons between the UK and other countries have been made. For example, a comparison of results recorded by heart surgeons in the UK and US shows the overall results for UK patients having coronary bypass surgery comparing well with those achieved in America (figure 9).

Figure 9. Percentage of patients dying in hospital following first-time coronary bypass surgery



Source: Society of Cardiothoracic Surgeons of Great Britain & Ireland; Society of Thoracic Surgeons (USA)[13,14]

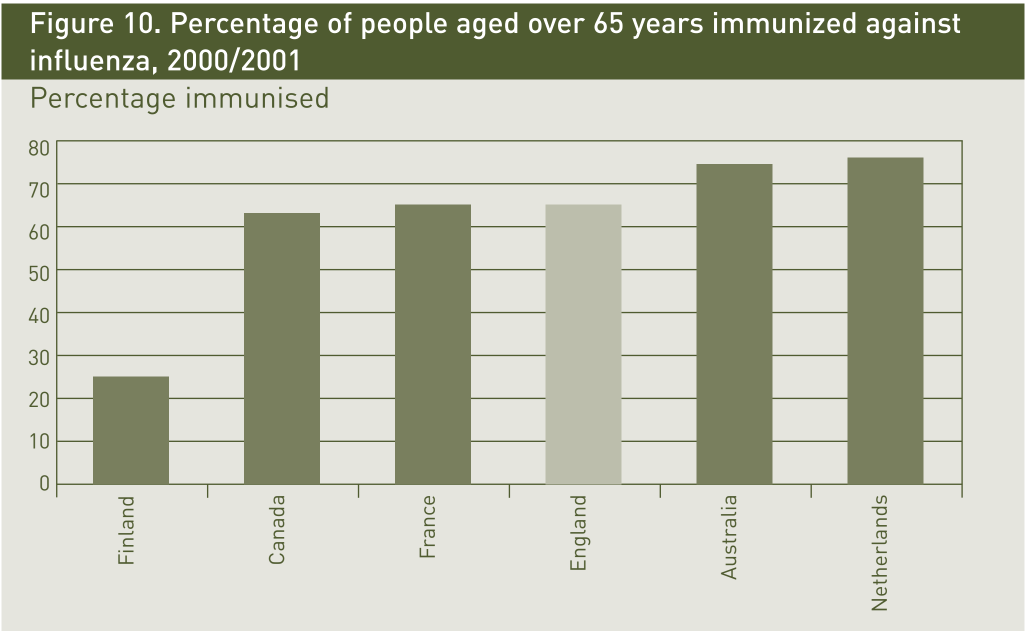
Comparing whole healthcare systems

While international comparisons of specific conditions have helped to direct investment in services, there have also been attempts to compare the results of entire healthcare systems. These aim to find the best ways to organise healthcare nationally.

Variable performance

Drawing general conclusions about individual countries is not straightforward. Healthcare is made up of many different elements, and any country's performance varies across different measures, making it difficult to draw a single overall conclusion. For example, although the UK has a worse record on survival from cancer than Germany, we have a better overall life expectancy for men. And there are other areas in which the UK performs relatively well. For example, we have a higher rate than a number of comparable countries of immunisation against influenza, the importance of which was discussed in the Staying well in old age section (figure 10).

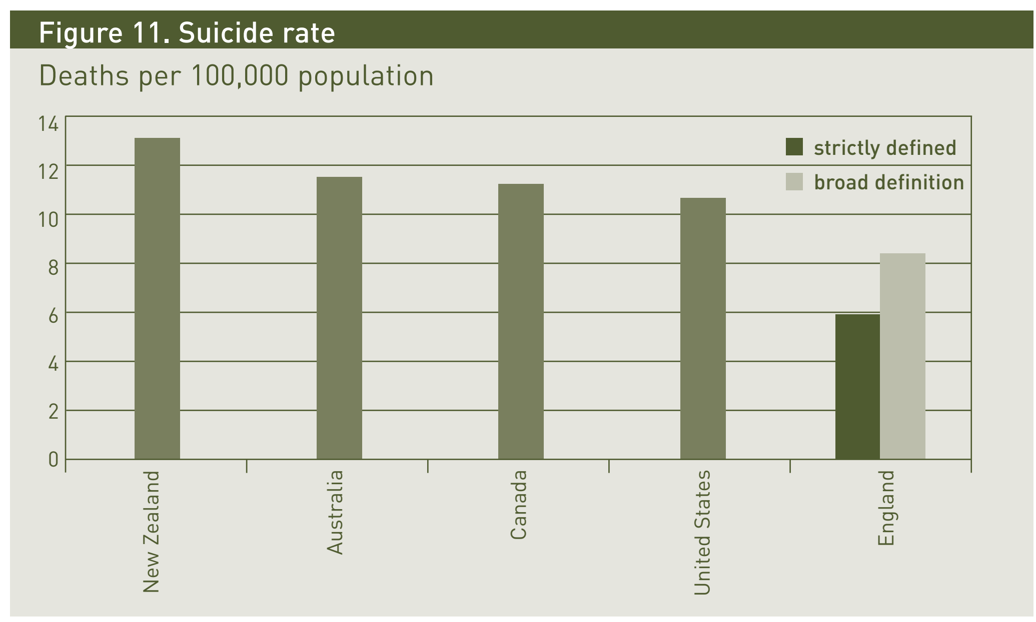
Figure 10. Percentage of people aged over 65 years immunized against influenza, 2000/2001



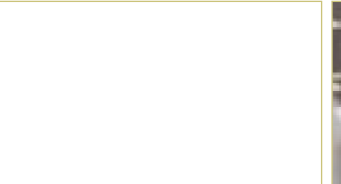
Source: OECD Health Data 2003[3]

Higher spending on health does not automatically produce better performance

The UK also has a low rate of suicide compared to the core group of countries.[3] Figure 11 shows a comparison of rates of suicide published by the Commonwealth Fund. Those compiling the data recognised that England's national statistics tend to use a broader definition of suicide that includes deaths recorded as 'open verdict' by coroners. The chart presents both this definition and the strictly defined measure that includes only those cases in which suicide has been recorded as the cause of death. Regardless of the definition, the rate is lower in England than in the other countries.



Source: Commonwealth Fund[15]



Overall performance

In 2000, the World Health Organisation (WHO) used the notion of 'disability adjusted life expectancy' to compare the efficiency of the healthcare systems of 191 countries. Figures on life expectancy were modified to take account of the levels of disability present in each population. These figures could then be analysed with reference to estimates of each nation's spending on healthcare. The results suggested that higher spending on health does not automatically produce better performance. For example, although France achieved a better 'disability adjusted life expectancy' than the UK, while spending more per head, Germany spent even more than France, but achieved less than the other two countries.

A study in 2003, however, repeated the comparison for a number of countries using a different measure of performance that looked at causes of death that should not generally occur "...in the presence of timely and effective healthcare."[16] The results were very different. Rather than simply claiming that their method (which tended to make the UK look worse relative to many other countries) was better than the WHO's, the researchers emphasised the value of going beyond the overall figures to look "...at specific policies and learn from different experiences."

A similar conclusion is emerging from the debate on another major comparison of healthcare systems. In 2002, a comparison of costs and performance between the NHS and Kaiser Permanente (a health maintenance organisation in California[17]) was published. It concluded that Kaiser had delivered substantially better care to its patients while spending no more per head than the NHS. These findings were debated extensively in the pages of the journal that had published the research and many commentators criticised the methods that the researchers had used to try to make the comparison on a like with like basis.[18]

> The Healthcare Commission will use the results of international comparisons in its assessments of the performance of healthcare services

But there has also been a more positive response. This has stressed that, while problems with the research may have influenced the conclusions, there are probably things to learn from a system such as Kaiser's, particularly as regards providing help for people with long term conditions, and the integration of community and hospital care. Further research has been carried out[19,20] and the Department of Health has commissioned pilot projects in which eight English primary care trusts will adapt and test aspects of Kaiser's system.[21]

What will the Healthcare Commission do?

As this section has shown, international comparisons of healthcare systems are complex and often not definitive. However, they can help to set the standards for, and direct investment in, our healthcare system. They can also help to identify where we can learn from others. The Healthcare Commission will:

- contribute to the development of methods for making international comparisons (in particular, through the involvement of our researchers in relevant collaborations)
- use the results of international comparisons in its assessments of the performance of healthcare services in England and Wales. Comparisons considered for use in this manner will go beyond the set discussed here, to include, for example, healthcare resources and the experience of patients
- work to promote the collection and use of relevant and accurate information on healthcare in England and Wales, so that their contributions to international comparisons accurately reflect reality

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