

# State of Healthcare 2007

Improvements and challenges in  
services in England and Wales

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ISBN 978 0 10 295155 4

# Healthcare Commission

## State of Healthcare 2007

Improvements and challenges in services in England and Wales

Ordered by the House of Commons to be printed on 4 December 2007.

Presented to Parliament by the Secretary of State and by the Comptroller and Auditor General in pursuance of Section 128(2) and paragraph 10(4) of Schedule 6 of the Health and Social Care (Community Health and Standards) Act 2003.

A copy of the report has also been provided to the Secretary of State for Wales and the Minister for Health and Social Services, National Assembly for Wales, pursuant to section 128(3) of the Health and Social Care (Community Health and Standards) Act 2003.

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# Foreword



During 2007, the Healthcare Commission highlighted some instances of seriously poor practice and failures in service in healthcare. Are these a sign of more widespread problems in healthcare in England and Wales?

The reality is complex. For example, in a 2007 report by the Commonwealth Fund, the UK was ranked first among six developed countries for its provision of healthcare, in relation to quality of care, access, effectiveness and efficiency. In 2007, we rated significantly more NHS organisations “excellent” for the quality of their services and their use of resources than in 2006. Basic standards in the NHS and the independent healthcare sector are also getting better.

The overall health of the population also continues to improve. People are living longer and infant mortality is falling. Access to hospital services, including treatment for cancer, continues to improve as waiting times fall. The numbers of doctors and nurses working in the NHS increased during 2007.

However, there are areas that need to improve. We found that although patients rated their overall quality of care highly, some aspects of their experience of healthcare fell short. For example, providers of services need to improve their planning of patients’ care to ensure that their services meet individuals’ needs.

Primary care services and GPs are the bedrock of healthcare in England and Wales and the main point of contact for most people. Primary care trusts have a crucial role in promoting health at a local level and improving public health. In addition to providing services themselves, they plan and purchase services on behalf of the populations they serve. We identified significant room for improvement in both areas.

High-quality information about patients’ care is crucial for measuring how well healthcare providers are performing and highlighting where they need to improve. Where data was not available, for example on sexual health, we could not be confident about the performance of services. Information needs to be available on a comparative basis across the public and private healthcare sectors, and published in a way that patients can access and understand.

In this report, we make six high-level recommendations to Government and those providing and purchasing healthcare. These focus on the need to: improve the planning and commissioning of services; improve access outside the waiting time targets; promote a culture of safety more effectively; improve healthcare for children and young people; demonstrate more sensitivity to the individual needs of patients and users of services; and use information better.

We urge Government and commissioners and providers of healthcare, working with patients and the public, to act on our recommendations and take account of them in their future plans, so that improvements can continue to be made.



*Ian Kennedy*

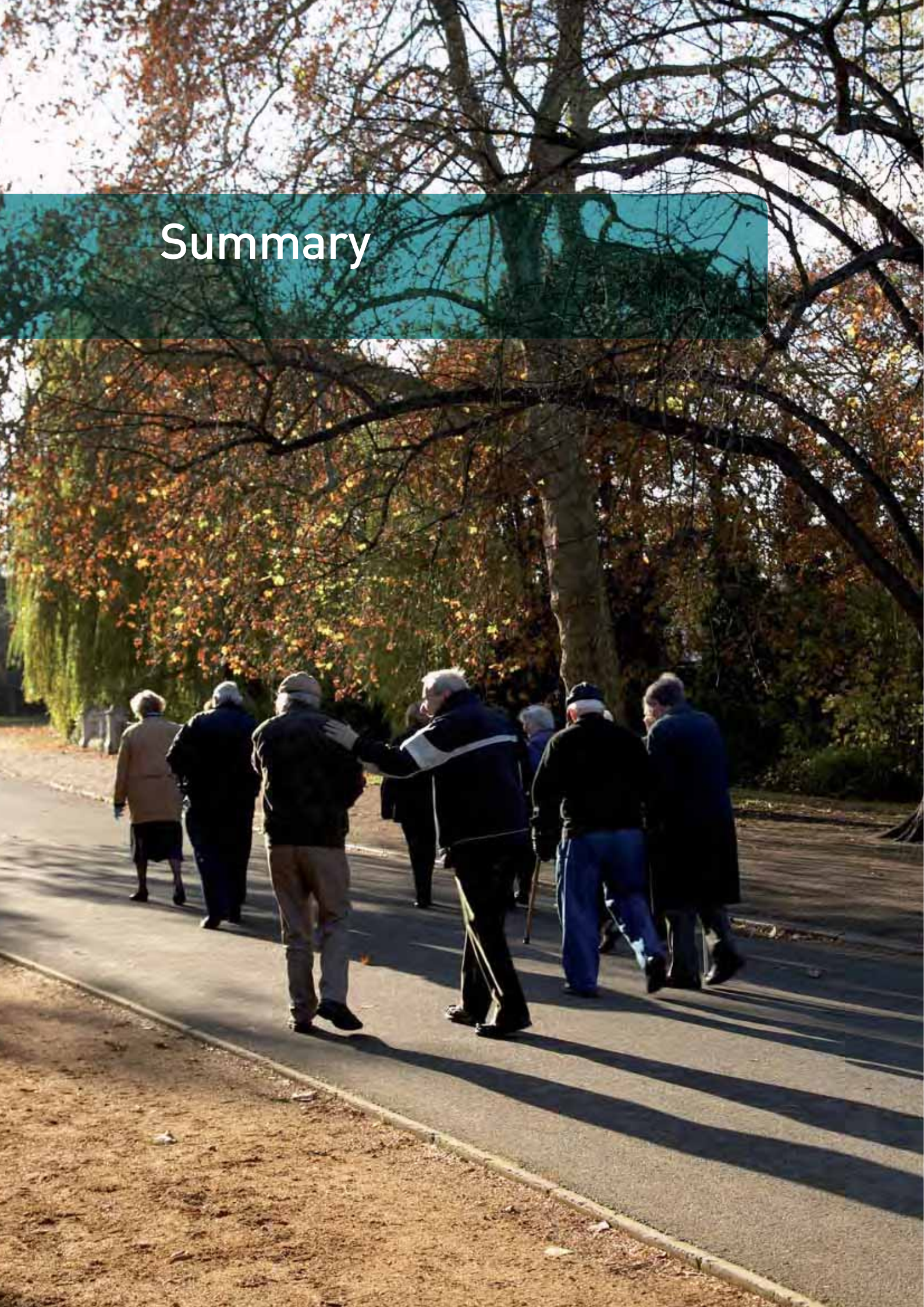
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Anna Walker CB  
Chief Executive

# Summary



## Our fourth *State of Healthcare* report sets out the main improvements in healthcare in England and Wales during 2006/2007 and six key challenges for service providers.

The Healthcare Commission is the independent healthcare watchdog for England. We assess and report on the quality and safety of services provided by the NHS and the independent sector, to promote ongoing improvement in healthcare in England and Wales. This is our fourth annual *State of Healthcare report*. In it, we set out the findings of our recent assessment work, focusing on the 2006/2007 financial year. Although the formal purpose of *State of Healthcare 2007* is to report to Parliament and the Welsh Assembly Government, we hope that other audiences will find it informative and useful as well.

Our work as a regulator asks two fundamental questions. Are the healthcare organisations we inspect and regulate getting the basics right in terms of quality and safety, and are they building on the basics to deliver real improvements? With this in mind, in the pages that follow we focus on how organisations in England and Wales are performing in five broad areas:

- Providing a positive experience for patients.
- Working to improve health and wellbeing.
- Meeting the needs of children and young people.
- Developing a culture of safety in healthcare.
- Improving quality and effectiveness.

Our chapter on the health needs of children and young people is the only one that focuses on a particular group. The

Healthcare Commission has a statutory duty to pay particular attention to children's needs. In view of our increasing work in this area, and that of other organisations, we felt the time was right to report in detail on the particular issues facing young patients and users of services.

Throughout this report, we have drawn mainly from our own findings. We have included relevant information produced by other organisations where it is helpful to our analysis. Although our main focus is on 2006/2007, in some instances we have used information from earlier or later periods where it has added to our understanding.

The Commission has a more limited role in Wales than in England. As in previous years, when preparing this year's report we have worked closely with Healthcare Inspectorate Wales, which reviews NHS and independent healthcare providers in Wales, the Wales Audit Office and other partners.

### Context

Funding for the NHS rose from over £55 billion in 2002/2003 to nearly £90 billion in 2007/2008, an increase of 7.2% a year in real terms. Levels of activity have risen substantially over the past 10 years, with the number of consultations in GP practices growing by around 70 million to almost 290 million in 2006. The number of first outpatient appointments has risen by more than one million since 2000/2001. The NHS workforce in England has grown by 27% in the 10 years since 1996.



During 2006/2007, the NHS in England saw major reconfigurations of its ambulance services and primary care trusts (PCTs), with the number of PCTs halved. These changes are expected to benefit patients and the public in the long term, but during the year they presented challenges for the NHS in terms of maintaining a high quality of service for patients

Our annual assessment of NHS trusts in England for 2006/2007 showed improvements in both the quality of services offered by trusts, and in trusts' use of their resources. Compared with results for 2005/2006, a larger proportion of trusts scored "excellent" for quality of services and a smaller proportion scored "weak".

Our assessments of the independent sector in 2006/2007 also found improvements in compliance with core national minimum standards.

## Providing a positive experience for patients

The vast majority of NHS trusts provide care that patients and users of services regard as "good" or better than good. For example, more than 90% of those who responded to our survey of acute hospital inpatients rated their care overall as "excellent", "very good" or "good". Most people said that they had trust and confidence in the healthcare professionals treating them. We only rated a minority of trusts "below average" or "poor", but were concerned to see that some of them are consistently poor performers.

Patients tell us that cleanliness, timely access to treatment and care, good communication and personalised care are all also important to those who use healthcare services.

Through our inpatient survey, patients reported high levels of cleanliness in acute

hospitals. This view was supported by the annual assessment of hospital cleanliness carried out by patient environment action teams, which awarded a higher percentage of inpatient facilities "excellent" or "good" in 2007. Most of the patients who took part in the survey (around 70%) reported that doctors and nurses always washed or cleaned their hands between touching patients, though there is still some room for improvement.

Improving people's access to treatment and reducing the length of time they have to wait for it has been a major focus of Government policy in England. We have seen long-term and yearly improvements in waiting times for diagnostic tests, for outpatient appointments and for planned admissions to hospital. The vast majority of acute trusts continued to meet the standard requiring them to see 98% of patients in A&E within four hours.

Although this is positive news, many trusts still need to pay more attention to 'hidden' waiting times. These are waiting times for areas that historically haven't been monitored or had clear targets set, or are partially or wholly excluded from the current 18-week waiting times target. Examples include physiotherapy, psychological therapies or audiology services. We welcome that the Government is starting to turn attention to this issue and we look forward to seeing improvements.

Our report highlights problems that particular groups have in accessing services. Deprivation and geographic location are major influences. The most deprived areas in England have considerably fewer GPs per 100,000 members of the population than the least deprived areas. People with mental health problems or learning disabilities have poorer access to primary care – they receive standard tests and treatments for conditions such as diabetes or heart disease less often than required.

While most patients consider that they receive a good standard of care, the NHS has some way to go before every patient's right to dignity and privacy during care are fully addressed. In our inpatient survey, 78% of respondents said that they were always treated with dignity and respect while in hospital. However, 20% of people who wanted it did not get help with eating. We also found that food and nutrition were common themes in patients' complaints about the NHS.

As regards privacy, 70% of respondents in the inpatient survey told us that they always had enough privacy when discussing their treatment or condition. In acute trusts, a minority of patients spend time in mixed-sex accommodation. However, in mental health and learning disability wards, more than half of people were in mixed-sex accommodation. We welcome the Government's announcement in 2007 of additional investment to resolve this issue.

Good communication is important to help patients understand their treatment and care, and what will need to happen for their health to improve. Our surveys showed that overall, patients and users of services were positive about the way that clinicians communicated with them. However, we had concerns about the level of information provided to them about their condition or treatment. For example, in our survey of community mental health service users, a third of those who had been prescribed new medication said that they were not told about the possible side effects.

Our report highlights the differences in experience of healthcare in particular groups, including carers, people with learning disabilities, older people, users of mental health services and women from 'seldom heard' groups accessing maternity services. While their experiences varied, lack of planning for their individual needs by providers was a common theme.

Because of these issues, we recommend that healthcare providers and commissioners assess where there are gaps in access, both in relation to particular services and for particular patient groups, and work with partners on solutions to closing these gaps and increasing sensitivity to individuals' needs.

### Working to improve health and wellbeing

Healthcare services have contributed to some dramatic improvements in the health of people in England and Wales over the last 20 years.

Since 1986, average life expectancy for men has increased by nearly five years and for women by more than three years. The number of infant deaths has fallen substantially, from around nine per 1,000 live births in 1986<sup>1</sup> to around five per 1,000 live births in 2003-2005.<sup>2</sup> However, the gap in life expectancy between those living in the most deprived areas and the population as a whole continues to widen. There is a difference of 10 years between the life expectancy of men living in the least and most deprived local authority areas in England.

The leading causes of premature death are cancer, circulatory diseases such as coronary heart disease and stroke, and respiratory diseases such as chronic obstructive pulmonary disease and emphysema. Healthcare services have contributed to the fall in the rates of death from these three 'big killers' over the last 10 to 20 years. Premature deaths from circulatory disease have fallen by over 40% since 1995. Early deaths from cancer have been cut by nearly 20%.<sup>3</sup> Quicker diagnosis and treatment, as well as lifestyle changes, are among the factors that have led to these improvements.

However, rates of death are still much higher among more deprived groups. Cancer survival rates are lower for people living in the most deprived areas and the rate for England and Wales overall compares unfavourably with those of most European countries.

We are starting to see improved performance by PCTs in the most deprived areas. These PCTs outperformed other PCTs in some areas of healthcare, such as helping people to continue not to smoke four weeks after they have quit. The Government has stated that by 2007/2008 it will fund all PCTs at, or near to, target levels, as a result of improvements to its system for allocating funds in accordance with need.<sup>4</sup> In 2004, we raised concerns that some PCTs were seriously underfunded.

The NHS faces major challenges in tackling the increased prevalence of obesity and alcohol-related illness. In England in 2005, 22% of men and 24% of women were obese. Alcohol-related deaths in the UK almost doubled between 1991 and 2005 (from 6.9 to 12.9 per 100,000) and over the last 10 years the number of people admitted to hospital for alcohol-related reasons has increased by 80%.

Our assessments of the progress being made by PCTs in preventing illness and improving public health revealed a mixed picture nationwide. The role of the PCT is a very important and difficult one. Primary care is the setting in which most patients have contact with NHS healthcare services. At the same time, PCTs must plan and purchase all the services that their local populations need, including hospital and mental health services. Our work over the last year, including the annual health check, showed us that many PCTs need to improve their commissioning and delivery of services.

We have concerns that PCTs do not fully understand the health needs of their local populations. For example, an in-

depth study conducted this year into heart failure found that 140,000 fewer people were reported as having heart failure than expected. This could indicate a failure to diagnose accurately or problems with how information about patients is recorded. Twenty per cent of PCTs do not have an up-to-date local assessment of older people's mental health needs and services.

We also found that PCTs do not always plan and purchase the right mix of services. For example, 41% of PCTs failed to commission sufficient crisis services for people who were seriously mentally ill and 33% failed to commission sufficient early intervention services for young people at risk of psychosis. Where good commissioning arrangements are in place, people are more likely to receive the support they need, such as access to education programmes for managing diabetes. However, our review of diabetes services showed that 85% of PCTs did not have arrangements for education programmes in place.

The provision of community-based services is also a cause for concern. Forty-one per cent of PCTs did not have their planned levels of community matrons and case managers in place to support people with complex health conditions.

Over half of PCTs did not meet the indicator for having GP practice registers for people at risk of long-term conditions such as diabetes or heart disease. These registers are an important tool for making sure that people with long-term conditions receive the right information and support. GPs also fell short on measuring obesity in their patients. This is a concern to us, in view of increasing obesity and its links to long-term illnesses such as diabetes and coronary heart disease.

The Department of Health is putting in place a programme of work to improve how PCTs plan and purchase services. We welcome this initiative, which complements our work as the independent assessor of PCTs' performance.

Nonetheless, we recommend that PCTs, working with their partners, improve commissioning for public health and community services.

## Meeting the needs of children and young people

The health and wellbeing of children and young people is a matter of national importance. The Government has, through its framework *Every Child Matters* and other national initiatives, brought the issue to the heart of its programme. Our role as an inspectorate is to report on the key challenges facing healthcare organisations and the progress they are making in tackling them.

While the overall rate of deaths in infancy has fallen to five per 100,000, things are not improving as quickly for children in the least well-off families as they are for other children. Mothers from more deprived areas are more likely to smoke during pregnancy and less likely to breastfeed, both of which can affect the health of a child. Deprivation is likely to increase a child's chances of being obese, suffering an accidental injury, experiencing mental illness and for girls, having a teenage pregnancy.

Obesity in childhood is increasing and is forecast to get worse. This presents a serious challenge for healthcare services. As an increasingly obese young population grows into adulthood, the result is likely to be an increased prevalence of circulatory diseases, cancer and diabetes. The Government is taking action to improve monitoring of childhood obesity and has introduced a public service agreement (PSA) ambition to halt and reverse the increase in obesity.

Trends for smoking and drug-use by children are moving in the right direction. The figures for 2006/2007 suggest that the Government has achieved its long-term target for England of reducing smoking

among 11 to 15 year olds to 9%. Drinking, however, is becoming more of a problem for a minority of children. Among those children who drink, average weekly consumption now stands at 11.4 units (equivalent to around five and a half pints of beer at 4% abv). Over the last 10 years, there has been a 29% increase in the number of under-16s admitted to hospital with conditions related to alcohol.

All types of diabetes are increasing among children and young people. Diabetes in the under-16s is not managed as well as it could be, with just 17% achieving the blood sugar control targets set by National Institute for Health and Clinical Excellence (NICE) guidelines.

We found that a substantial minority of children, and young people with diabetes did not get access to the support services they need, and in a third of PCTs children and their families did not have access to a structured education programme. Systems for transferring young people with diabetes to adult care were not always adequate.

In our review of acute hospital services for children, we found that the quality of inpatient paediatric services was mostly "good" or "excellent", but across the full range of services offered by hospitals quality was mostly "fair". Where children were treated by specialist paediatric services, their needs were better met than where they were treated by more general services. This difference between paediatric and general services shows room for substantial improvement. Trusts had generally made poor progress in meeting children's broader needs. In a small minority of units, our review highlighted serious concerns about the quality and safety of care for children.

Trusts have, however, made progress on mental health services for children and young people, although local services are not always fully established and inspections often highlight weaknesses regarding

access. Our 'value for money' work in this area suggests that the NHS is not currently commissioning child and adolescent mental health services in an informed way.

In our work with other regulators, we found examples of poor monitoring and assessment of the needs of vulnerable children, especially as they make the transition to adulthood. This particularly applied to children with disabilities, looked after children and young offenders. Young people in contact with youth offending services with physical or mental health needs, or with drug and alcohol misuse, were not always referred to the appropriate services.

In general, young people making the transition from children's services to adult services are poorly served. Not only is this evident for the services mentioned above, it is also an issue in services for children and young people with diabetes, and in palliative care.

Child protection and safeguarding is still unacceptably weak in a minority of NHS trusts in England and Wales. In 2006/2007 one in 20 NHS trusts in England was not compliant with statutory child protection standards. Our review of children's hospital services in England found that levels of training in child protection were not adequate, and similar problems have been identified in Wales.

In order to improve the quality of care available to children and young people and the outcomes achieved, we are calling for the development of a well thought out set of performance indicators focusing on current areas of concern. We will be discussing the scope of such key indicators with the Department of Health. This would enable NHS organisations and their partners to assess more precisely the local need for services to improve children's health and how to deliver them effectively. The indicators would help us, as the

independent regulator of health services, to identify key areas of risk and to intervene where necessary to protect the interests of children and young people.

In light of these findings we are calling on healthcare providers to improve their care for children and young people

### Developing a culture of safety

Our surveys of NHS staff and information collated by the National Patient Safety Agency suggest that while the NHS has made some progress in improving safety, there is still room for improvement. It is encouraging that levels of incident reporting to the National Reporting and Learning System continue to increase. However, our surveys showed that awareness among staff of incidents affecting patient or staff safety, and how to report them, may be decreasing. It also highlighted real or perceived barriers for staff about reporting incidents, and that their confidence in how their employers handled reports was not as high as it could be.

In 2006/2007, most NHS trusts in England were compliant with all applicable core standards relating to safety. However further improvement is needed. Sixty-four per cent of acute trusts and 46% of PCTs were compliant with all nine of the safety standards. Seventy-seven per cent of mental health trusts and 58% of ambulance trusts were compliant with each of the eight safety standards applicable to them. However, some problems remain and need further attention from trusts. The standards with which trusts had the greatest difficulty were those on infection control and hygiene, medical devices and medicines management.

In 2006/2007, the majority of independent healthcare providers met most of the national minimum safety standards. We have seen an improvement in the

proportion of independent providers reporting that they met both the generic core minimum standards on safety and the safety standards that apply to their specific sector of healthcare. However, relatively low compliance with standards on decontamination remains an issue across both the NHS and independent sector.

Our inspections of NHS hospital trusts against some of the key duties under the statutory hygiene code found good levels of compliance. By the end of October 2007, we had undertaken 87 of the 120 planned visits, and had issued just one trust with an improvement notice. Overall, we are encouraged that trusts seem to be putting basic steps in place to tackle infections. However, we identified some areas where more attention is needed, including governance, compliance with policies and procedures, uptake of staff training and the provision of adequate isolation facilities. These findings are echoed in our earlier study of healthcare associated infections<sup>5</sup> and to a more serious extent in our investigations into outbreaks of *Clostridium difficile* in NHS hospitals.<sup>6</sup>

There was positive news on MRSA in England, as both the number and rate of infections fell nationally between 2005/2006 and 2006/2007. At a local level progress was varied – in 2006/2007 just 44% of NHS hospital trusts were on track to meet their targets for reduction by 2008, although figures for early 2007/2008 show improvement. In Wales, the rate of infection was around half that in England and decreasing faster.

Rates of infection for *Clostridium difficile* have risen each year since the start of mandatory surveillance in 2004. However, between 2005 and 2006 the rate of increase slowed, and the first published data for 2007/2008 gave some ground for cautious optimism that rates of infection may have peaked. We hope that this is the beginning

of a sustained decrease, but to get the problem under control permanently the NHS needs to maintain constant vigilance and compliance with the hygiene code, and follow best practice.

Levels of violence and aggression in healthcare settings remain unacceptably high, with too many staff and patients experiencing incidents on a routine basis. There have been improvements in arrangements for dealing with violence and aggression in adult mental health wards, but there is some way still to go in older people's mental health wards. In general, incidents of violence and assault are under-reported across the NHS.

In the light of our findings, we are asking healthcare providers to improve the safety culture within their organisations so that they can better learn from information available to them, including clinical outcomes, complaints, errors and near misses.

We will continue to develop our procedures for assessing the safety of healthcare services, building on our assessments of organisations' corporate approach to safety and our in-depth work on healthcare associated infection. We will also look closely at other areas of risk, including the management of medicines, patient accidents (particularly falls by older people in inpatient settings), the safety of medical devices, the implementation of safety alerts and the reporting of serious incidents.

## Improving quality and effectiveness

There have been some notable areas of good practice and improvement in relation to the quality and effectiveness of care and services provided in England and Wales during 2006/2007.

It is difficult to measure the results or 'outcomes' of many procedures and

treatments, because a clear measure of success cannot always be agreed or determined. In common with other regulators and healthcare experts, the Healthcare Commission also uses measures that focus on effective management or processes – such as waiting times or compliance with national standards and guidelines – to provide insight into the effectiveness and quality of particular services.

Examples of two of these measures are the extent to which NHS organisations are following national clinical guidance and the extent to which they ensure that staff are appropriately trained.

During 2006/2007, most NHS trusts in England said they met the Government's standard for ensuring that they were taking into account guidance from the National Institute for Health and Clinical Excellence and other national guidance. Our in-depth review of heart failure services showed that progress had been made by services in implementing the relevant frameworks.

Eighty-four per cent of NHS trusts in England stated that staff were receiving all mandatory training – this is not as high as it should be. However, the picture was far more positive for compliance with the standard for ensuring clinical staff update their skills – almost all NHS trusts met it.

Our assessments showed that, although standards in the independent sector as a whole improved considerably during 2006/2007, more improvement is needed by providers of independent mental health services. Our review of independent sector treatment centres showed that information needs to be collected and published on a comparative basis across the public and private sectors in order to monitor quality of care effectively.

We saw some very positive developments in services for people with particular conditions during the year. More people with a suspected heart attack had access to clot-dissolving drugs and primary angioplasty, and the prescribing of medication to prevent heart failure, such as aspirin, continued to exceed targets. The proportion of patients being managed under the care of a cardiologist improved. Survival rates for bypass operations were higher than expected, and rates for aortic valve operations was within the expected range.

Despite improvements in access to cancer services, the clinical audits that we sponsored still showed a wide variation in the care offered to patients. For example, some patients were not being treated by multidisciplinary teams, which could affect the outcomes of their treatments.

In Wales, Healthcare Inspectorate Wales found that maternity services were generally delivered in a safe and effective way, but that more women would benefit from being cared for within the recommended clinical pathway for normal labour. It also found that some trusts had shortfalls in cover by consultant obstetricians and that trusts needed to strengthen the implementation of their policies for dealing with increases in activity or reductions in numbers of staff.

In response to these findings, we recommend that healthcare providers in both the independent sector and the NHS do more to assess the quality of their services through benchmarking and audit.

We are working closely with the royal colleges to create an assessment framework that integrates measures of process with measures of clinical outcomes. Our aim is to provide a more rounded view of quality and effectiveness in the future.

## Looking ahead

We are calling on policy makers and healthcare organisations to focus on six key areas for improvement in the year ahead. These issues need to be championed at a strategic level and implemented locally.

- **Better commissioning to improve public health and community services:** Primary care trusts working with their partners need to gain a better understanding of the health needs of the populations they serve, in order to target preventative measures more effectively and purchase the healthcare services their populations need. The Healthcare Commission and the Department of Health need to work together to create a more effective way of evaluating how well PCTs commission services.
- **Improve access:** Healthcare providers and commissioners need to identify where there are gaps in access – both to particular services and for particular groups of patients – and work with partners to find ways of closing these gaps.
- **Improve safety and effectiveness:** Healthcare providers and commissioners need to focus more on learning from information already available to them, in particular from data on clinical outcomes and complaints, errors and near misses. Senior staff must take the lead in establishing a culture of learning from mistakes and putting patients at the centre of the decision-making process.
- **Improve care for children and young people:** NHS trusts need to do more to ensure that they have effective systems for protecting children, and ensure that staff who work with children have comprehensive, up-to-date training. Particular attention should be given to the needs of adolescents.
- **Increase sensitivity to individual needs:** Healthcare organisations need to place more emphasis on listening to patients, providing them with accessible information, and understanding and addressing their individual needs. People with a particular need for personalised care plans, such as users of mental health services and people with learning disabilities, must be involved in drawing them up, and be offered the best possible support to live independently.
- **Assess quality through better information:** Healthcare providers in the independent sector and NHS need to do more to assess the outcomes of their services through benchmarking and audit. At a national level, there needs to be agreement on which information is important, and information should be published on a national comparative basis.



# Introduction



## Healthcare services are improving and treating more people than ever before. However, where you live can affect the quality of service available to you.

In this introduction, we provide a brief overview of some of the recent developments in healthcare policy, alongside facts and figures showing the current size and configuration of healthcare services in England and Wales. We also give a short summary of our main findings on the performance of healthcare organisations. More detailed information is provided later in the main body of the report.

### Policy issues in healthcare

Government funding for the NHS has risen from over £55 billion in 2002/2003 to nearly £90 billion in 2007/2008,<sup>7</sup> an increase of 7.2% a year in real terms.<sup>8</sup> This rate of growth is now due to slow to 4% a year, resulting in total funding of £110 billion by 2010/2011.<sup>9</sup> The forecast for total UK public sector health spending has risen from 6.9% of gross domestic product (GDP) in 2004/2005 to 7.8% of GDP by 2007/2008.<sup>10</sup> A smaller proportion (around 1% of GDP) is spent on private health.

Against this backdrop of budgetary increases, the Government has introduced a programme of healthcare reform in England. It involves changes to the way services are commissioned and provided, with a movement towards a more market-based system.

The Government has sought to strengthen the ability of PCTs to commission local healthcare services, through its *Commissioning framework for health and well-being*. It has also looked to involve frontline clinicians in the development of local health services through practice-based commissioning.<sup>11</sup>

At the same time, patients have been given more control over the services they use, by being able to choose at which hospitals they receive elective surgery.

The Government has encouraged the development of a broader range of providers, including wider use of the independent sector and more NHS foundation trusts.

In recent years, the way that professional staff are rewarded has changed to increase flexibility, through the Agenda for Change initiative and new contracts for consultants and GPs. Agenda for Change is the single pay system introduced in the NHS in 2004. It applies to all directly employed NHS staff (with the exception of doctors, dentists and some very senior managers) and aims to encourage new ways of working and stretching of staff roles.\*

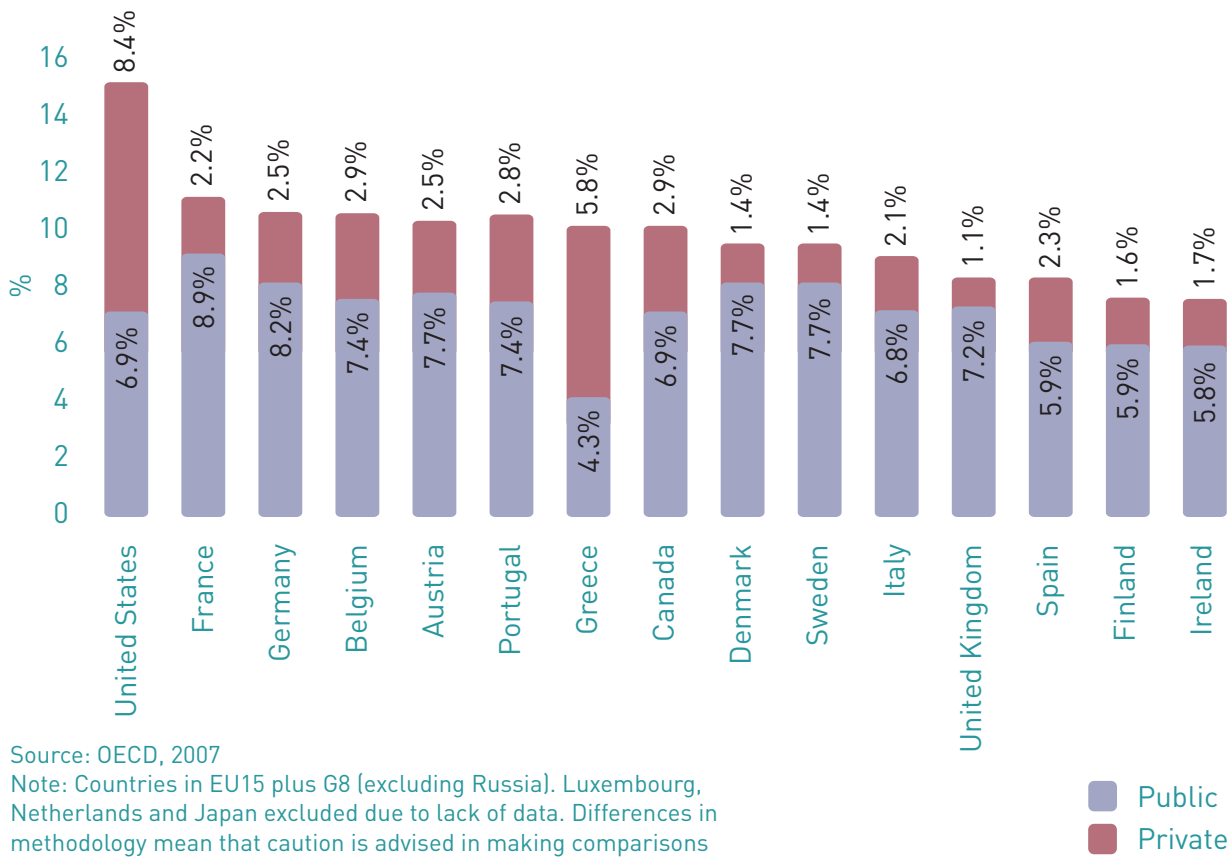
In April 2004, the Government introduced the Payments by Results system to help drive efficiency in the NHS. Within this national system, many procedures have a fixed, average price that PCTs pay to the trusts delivering them.

Recently, the Government has put renewed emphasis on improving the safety and cleanliness of services.

In the independent healthcare sector, analysis undertaken for the Healthcare Commission in 2007 has shown that NHS outsourcing is the principal driver of growth, next to cosmetic surgery and IVF treatment.

\* Department of Health, Agenda for Change Final Agreement, December 2004

**Figure 1: Total health expenditure as proportion of GDP, 2005**



In Wales, the *Healthcare Quality Improvement Plan* has set out practical steps for reform of the NHS over the next decade, with a greater focus on the quality of services to improve outcomes for patients and reduce premature deaths.<sup>12</sup> It is underpinned by the *Healthcare Standards for Wales* and has a number of key actions, including assessing at a national level the effect of introducing potentially life-saving interventions, the identification of high level indicators to assess the quality of care, and the development of programmes to share best practice.

**Healthcare activity during the year**

Healthcare services in England provide care for 50.7 million people. During 2006/2007, people in England visited their GPs almost 300

million times, made around 19 million visits to accident and emergency (A&E) departments and called NHS Direct more than five million times.<sup>13</sup> They attended nearly 1.2 million appointments with independent inpatient, day case and surgical outpatient services, and made over three million visits to independent outpatient services.<sup>14</sup>

In England, healthcare is increasingly provided in a range of different settings, including treatment centres that specialise in procedures for which there has been a long history of waiting times. More healthcare is also being provided by the independent sector and in the community, as policies such as the national service framework for mental health and *Our Health, Our Care, Our Say* move the emphasis away from inpatient care.

Levels of activity are increasing. The number

**Table 1: NHS activity in England in 2006/2007**

<b>Primary care</b>	<ul style="list-style-type: none"> <li>• There were just over 289 million visits to GPs.<sup>15</sup></li> <li>• Around 700,000 minor operations were performed compared to 525,000 in 2003/2004.</li> </ul>
<b>Acute hospitals</b>	<ul style="list-style-type: none"> <li>• There were 4.7 million emergency admissions to hospital.<sup>16</sup></li> <li>• There were 5.8 million planned admissions to hospital.<sup>17</sup></li> <li>• There were 13.6 million first outpatient appointments.<sup>18</sup></li> </ul>
<b>Emergency care</b>	<ul style="list-style-type: none"> <li>• There were 19 million attendances at emergency departments.<sup>19</sup></li> <li>• There were 6.3 million calls to ambulance services.<sup>20</sup></li> <li>• NHS Direct answered over five million calls.<sup>21</sup></li> </ul>
<b>Mental health</b>	<ul style="list-style-type: none"> <li>• There were over 26,000 people on NHS mental health wards.<sup>22</sup></li> <li>• There were over 95,000 people receiving crisis resolution services, compared to 83,800 people in 2005/2006.<sup>23</sup></li> </ul>

of consultations in GP practices in England has grown by nearly 70 million (more than 30%) in 10 years (see figure 2), while the number of first outpatient appointments has risen by over a million since 2000/2001.<sup>24</sup>

Staffing levels in the NHS have also risen significantly. Over the last decade, 2006 was the only year in which there was a fall in staff numbers rather than an increase. The workforce is now 29% larger than it was in 1996 (see table 2).

Healthcare services in Wales provide care for around three million people, who contact NHS services around 22 million times each year. In 2006/2007, these included more than 800,000 first outpatient appointments and 600,000 inpatient and day cases. Eighty per cent of all contacts took place outside hospital.<sup>25</sup>

NHS Wales employs some 89,000 staff, making it the biggest employer in the country. In addition, there are independent contractors, including dentists, opticians, pharmacists and nearly 1,900 GPs, who work predominantly in primary care.

## Healthcare services in England

### NHS services

During 2006/2007, a series of mergers and reconfigurations significantly reduced the number of ambulance trusts and PCTs in England. The total number of NHS trusts fell from 570 to 394 during the year.

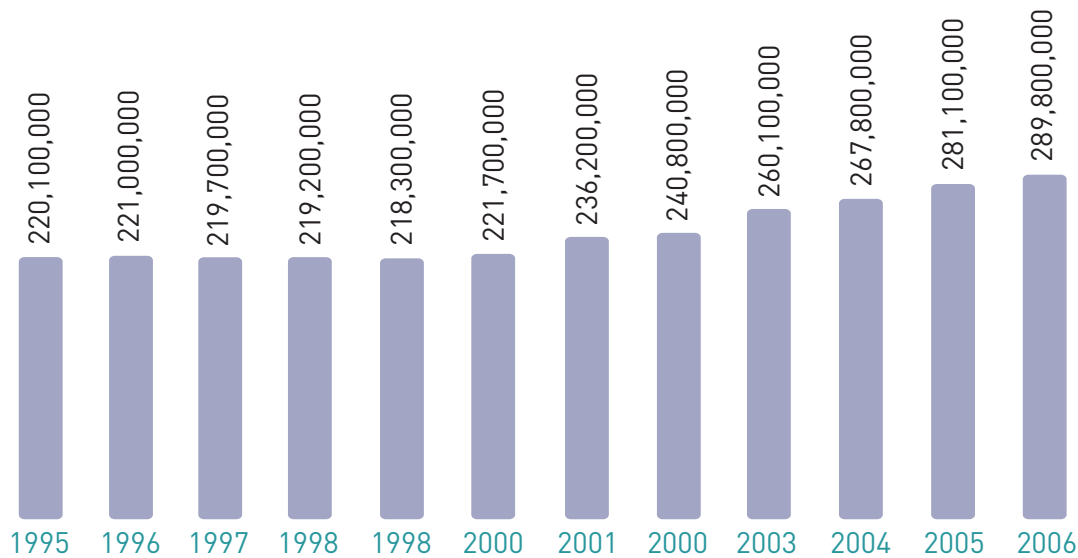
At 31 March 2007 there were:

- 171 acute and specialist hospital trusts, of which 55 were foundation trusts\*
- 152 PCTs, working with around 8,400 GP practices that range from single practitioners to practices with 10 partners or more<sup>26</sup>
- 56 mental health trusts, of which four were foundation trusts
- 12 ambulance trusts
- three learning disability and other trusts.

There are 10 strategic health authorities in England, whose role it is to help plan services

\* Foundation trusts have more financial and managerial freedom than other trusts, including freedom from central government control and from strategic health authority performance management. Only trusts that achieve a high level of performance may become foundation trusts.

Figure 2: GP consultations in England, 1995-2006



Source: The Information Centre, QResearch<sup>27</sup>

and manage the performance of NHS trusts (except foundation trusts) within their areas.

### Independent sector services

In the independent sector, the Healthcare Commission regulates around 2,000 providers. These include 279 private hospitals, 192 mental health establishments, 178 hospices and 350 private doctors.

In 2006, there were 27 independent sector treatment centres. They are commissioned by Government and provide NHS patients with a range of elective procedures, including cataract operations and hip replacements.

An estimated 1.2 million inpatient, day case and surgical outpatient procedures were carried out in independent hospitals in 2006, with a further three million outpatient visits estimated to have taken place. In 2006, NHS-funded patients accounted for around a fifth of all activity in the acute independent sector.

There are around 6,800 overnight beds in the independent mental health sector, 85% of which are estimated to be funded by the NHS.<sup>28</sup>

There are over 90 NHS walk-in centres in operation in England.<sup>29</sup> Independent providers run 21 such centres, 10 of which are contracted directly to provide NHS services.<sup>30</sup>

The British Ambulance Association estimates that there are around 300 independent ambulance providers, who provide approximately 10% of Britain's ambulance services.<sup>31</sup> Most of their work is provided under contract to the NHS. Where they are subcontracted by ambulance trusts, their activity levels are recorded by the Department of Health through NHS data collections. However, activity levels are not recorded centrally if the providers contract directly with acute trusts.<sup>32</sup>

The Healthcare Commission does not regulate private ambulance providers, and these providers are not regulated at all, other than under the Road Traffic Act. The Department of Health is developing options for the regulation or independent accreditation of private ambulance providers.<sup>33</sup>

**Table 2: NHS staff levels (full-time equivalent), 1996 and 2006**

	1996	2006	% change
All doctors	81,783	119,096	+45.6
All qualified nurses (including practice nurses)	257,891	322,062	+24.9
Scientific, therapeutic & technical staff	80,273	114,492	+42.6
Qualified ambulance staff	13,942	15,723	+12.8
<b>Total professionally qualified clinical staff</b>	<b>433,889</b>	<b>571,374</b>	<b>+31.7</b>
Support to clinical staff	215,122	283,198	+31.6
NHS infrastructure support	144,450	177,871	+23.1
Practice staff other than nurses	49,497	62,361	+26.0
Other and those with unknown classification	5,147	359	-93.0
<b>Total full-time equivalent staff</b>	<b>848,104</b>	<b>1,095,164</b>	<b>+29.1</b>

Source: The Information Centre<sup>34</sup>

Note: Excludes GP retainers for comparison purposes

## Healthcare services in Wales

In Wales, 22 local health boards commission services for their catchment areas, which reflect local authority areas. NHS Wales is divided into 15 trusts, which provide both hospital and community services. Foundation trusts have not been established.<sup>35</sup> The Welsh Ambulance Services NHS Trust is the sole provider of NHS ambulance services in Wales.

There are around 70 private healthcare providers in Wales, which include independent hospitals, hospices and mental health hospitals.<sup>36</sup> Wales does not have any independent sector treatment centres.<sup>37</sup>

## The performance of healthcare services

This year, healthcare in the UK was ranked first by the Commonwealth Fund (a New York based health policy research charity and a widely respected commentator on health affairs), in an international study that compared the healthcare

provided by six developed countries across variables including quality of care, access, effectiveness and efficiency.<sup>38</sup>

The UK was ranked best of all six nations for overall quality (and within this dimension was ranked best for “coordinated care” and second for “right care” and “safe care”), efficiency and equity. Its poorer results were for patient-focused care, access and long healthy and productive lives – in each case the UK was ranked fourth.

**Table 3: Healthcare comparison among developed countries**

1	UK
2	Germany
3 =	Australia New Zealand
5	Canada
6	US

Source: The Commonwealth Fund, 2007<sup>39</sup>

**Table 4: Quality of services ratings in the NHS, England 2006/2007**

Type of trust	Excellent	Good	Fair	Weak
Acute and specialist	33 (19%) ↑	62 (36%) ↓	64 (37%) ↓	12 (7%) ↑
Ambulance	0 (0%) ↔	5 (42%) ↑	5 (42%) ↑	2 (17%) ↓
Learning disability and other	1 (33%) ↔	1 (33%) ↑	1 (33%) ↓	0 (0%) ↔
Mental health	29 (52%) ↑	14 (25%) ↓	12 (21%) ↓	1 (2%) ↓
Primary care	2 (1%) ↓	38 (25%) ↓	94 (62%) ↑	18 (12%) ↑
All trusts	65 (16%) ↑	120 (30%) ↓	178 (45%) ↓	31 (8%) ↓

Source: Healthcare Commission annual health check 2006/2007

While this is good news, our assessments show that the quality of healthcare can vary considerably depending on where a person lives and the types of services they need (see “the best and worst performers” below).

### Performance in England

Each year, the Healthcare Commission carries out the annual health check, a comprehensive assessment of the performance of all NHS trusts in England. We give each trust a rating that consists of two parts – a score for the quality of its services and a score for how effectively it has used its resources. These scores are awarded on a four-point scale of “excellent”, “good”, “fair” or “weak”.

In 2006/2007, our assessment of all 394 trusts showed that there had been an improvement

in the quality of their services since 2005/2006. A higher proportion of trusts scored “excellent” and a lower proportion scored “weak”. Around half of trusts received a score of “fair” for quality of services, with roughly a third scoring “good”.

This year also saw improvements in the way in which NHS trusts manage and use their resources. Around a third of trusts received a score of “fair”, with roughly a quarter scoring “good” and a further quarter scoring “weak”. In 2006/2007, there was a higher proportion of trusts scoring “excellent” and a lower proportion scoring “weak”.

### The best and worst performers

Mental health trusts performed the best and were the most improved type of trust, for both quality of services and use of

**Table 5: Use of resources ratings in the NHS, England 2006/2007**

Type of trust	Excellent	Good	Fair	Weak
Acute and specialist	48 (28%) ↑	36 (21%) ↑	32 (19%) ↓	55 (32%) ↓
Ambulance	0 (0%) ↔	1 (8%) ↓	8 (67%) ↓	3 (25%) ↑
Learning disability and other	0 (0%) ↔	2 (67%) ↔	1 (33%) ↔	0 (0%) ↔
Mental health	4 (7%) ↑	27 (48%) ↑	23 (41%) ↓	2 (4%) ↓
Primary care	5 (3%) ↑	25 (16%) ↑	78 (51%) ↑	44 (29%) ↓
All trusts	57 (14%) ↑	91 (23%) ↑	142 (36%) ↓	104 (26%) ↓

Source: Healthcare Commission annual health check 2006/2007

resources. More than half scored “excellent” for quality of services, and 55% achieved a score of “excellent” or “good” for use of resources. We recognise that mental health trusts are assessed against fewer measures than other types of trust. However, this is still a very positive outcome.

Foundation trusts performed better than non-foundation trusts for both parts of the overall rating.

PCTs were the poorest performers for the second year running, with those that were reconfigured in October 2006 struggling in comparison with other PCTs. Around three-quarters (74%) received a score of “fair” or “weak” for quality of services, with a similar level of performance (80%) for use of resources. In comparison, of the 72 PCTs that were reconfigured during the year, 88% scored “fair” or “weak” for quality of services, and 96% for use of resources.

Looking at this year’s results from a regional perspective, the Central region performed best on quality of services, with 21% of trusts rated as “excellent” and a further 29% rated as “good”.

For its use of resources, the best performing as well as the most improved region was the North, where 19% of trusts scored “excellent” and only 16% scored “weak”. This is an increase of 16 percentage points for the proportion of “excellent” trusts, as well as a fall of eight percentage points for the number of “weak” trusts. The South West region also improved, showing the greatest decrease in the proportion of “weak” trusts, from 41% in 2005/2006 to 22% in 2006/2007.

The worst performing regions for use of resources were London and the South East, with just 10% of trusts scoring “excellent” and 34% scoring “weak”, and Central, with 70% of trusts scoring “fair” or “weak”. Despite this disappointing performance, London and the South East showed a higher proportion of “excellent” trusts and a lower proportion of “weak” trusts compared to last year.

In the independent sector, compliance with core national minimum standards improved during 2006/2007 (see chapter 5 for more details).



# 1 Providing a positive experience for patients



## Most patients are positive about their experience of healthcare. However, for those who need more individual care, the experience is often not as good as it should be.

What matters to patients, other users of healthcare services and carers matters to the Healthcare Commission. These groups provide vital insights into where healthcare is working well or failing. It is for them that we assess the quality of healthcare services in England and promote continuous improvement.

In 2000, the Government set out its vision for a service designed around the patient – one of reduced waiting times, easy access and modern methods of care. That vision has been reaffirmed by the recent policy document, *Our NHS, Our Future*,<sup>40</sup> which emphasises the need for an NHS tailored to individual needs, especially those of the most vulnerable.

Integral to this reform are effective partnerships between patients and frontline staff, so that services are geared to the needs of local communities. From April 2008, 150 newly created Local Involvement Networks (LINks) will be responsible for the formal involvement of patients in the NHS, across all health and social care services. We will be working with LINks to ensure that their local knowledge feeds into our annual assessments of NHS trusts.

In 2006, a survey of hospital inpatients highlighted the issues that are most important to people:

- **Clinical competence:** Patients want reassurance that the doctors, nurses and other healthcare professionals treating them know enough about their medical history and treatment.
- **Communication and information:** Patients want doctors to explain and answer questions about their condition and treatment in a way they can understand. They want clear explanations of the benefits and risks of any procedure, and for doctors and nurses to be open and honest with them.
- **Cleanliness:** Patients want doctors and nurses to wash their hands between touching patients, and for rooms and wards to be kept clean.

In addition, we know that patients want quick and equal access to services, and that they expect and deserve to be treated with dignity and respect. The views and needs of family members and carers are also important.

The information we have from our assessments and from patients, their families and the public, show that patients have a good experience overall and continue to have a very high level of confidence in the professionals treating them.

However, we remain concerned about access to some services and the care of people least able to care for themselves.

Our key findings are:

- Overall, people report a largely positive experience of healthcare services.
- There is a small number of NHS hospitals that consistently score poorly on measures of patient satisfaction.
- Excessive waiting times for hospital services have largely been addressed, but some services are not yet on track to

deliver the 18-week waiting time target. In addition, the NHS needs to pay more attention to 'hidden' waiting times.

- We have real concerns about the treatment of older people, although hospital services are beginning to focus more on dignity, nutrition and privacy.
- Poor communication by healthcare professionals continues to let patients down.

### An assessment of patient experience

Of those trusts that participated in patient surveys, the vast majority received results that we have judged satisfactory. As part of the annual health check, we publish an assessment of how trusts performed on patient experience. The results are summarised in figure 3 below.

However, a small proportion of NHS hospital trusts consistently lag behind when it comes to providing a good experience for patients. Of the 18 hospital trusts that were "poor" or "below average" on this measure in the 2006/2007 annual health check, 11 were in one of these categories in 2005/2006.

The Healthcare Commission is working closely with the Department of Health and the relevant strategic health authorities to ensure that under-performing trusts take action to improve their services.

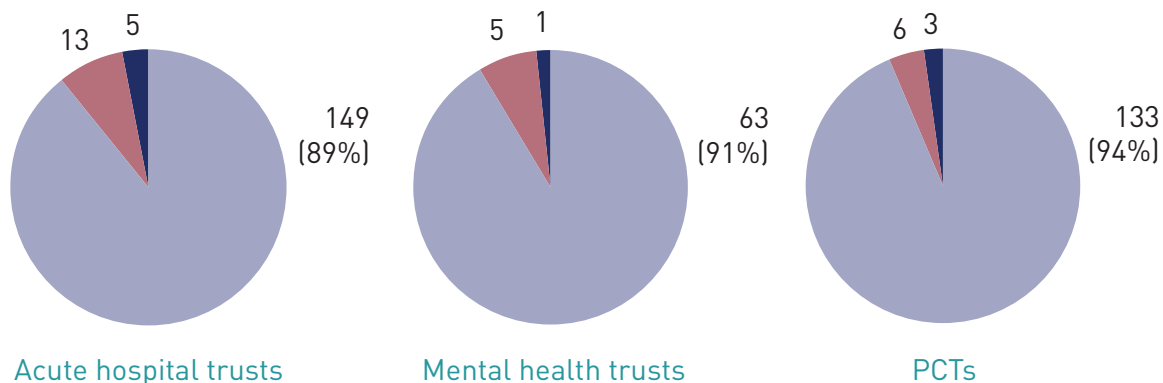
### Effective treatment

Most people make a simple judgement on whether their care and treatment was effective: does it make them better, or at least improve their condition?

In a survey of patients, 96% said the main reason for visiting their GP or health centre had been dealt with to their satisfaction – either "completely" (74%) or "to some extent" (22%). The same percentage said they had confidence and trust in their doctor, either "definitely" or to some "extent".<sup>41</sup>

In our survey of hospital inpatients, more than 90% of people rated their overall care as "excellent", "very good" or "good". While not everyone will have the expert knowledge needed to determine whether or not they received the best possible treatment, overall they believed the care they received was of a good quality.

**Figure 3: The experience of patients by type of trust**



Source: Healthcare Commission, annual health check 2006/2007  
 Note: The 2006 national survey of people with diabetes was used to calculate the PCT score. The 2006 survey of adult inpatients was used to calculate the acute hospital score and the 2007 survey of community mental health service users was used to calculate the scores for mental health trusts.

■ Satisfactory  
■ Below average  
■ Poor

Most people (81%) said that they “always” had confidence in the hospital doctors treating them and the figure for nurses was similar (73%). In primary care, 84% said they “definitely” had confidence in the last healthcare professional they saw.<sup>42</sup> Within community mental healthcare, 61% reported that they “definitely” had trust and confidence in their psychiatrist and 30% did “to some extent”.

Ninety-six per cent of patients surveyed at independent sector treatment centres reported that they “always” had confidence in the doctors treating them; for nurses the figure was 90% of patients.

The Healthcare Commission reviews 7,500 cases a year where patients who have made a complaint are unhappy with the way their local NHS service has handled it. Concern about the effectiveness and safety of clinical treatment was the number one issue raised by patients in the complaints we reviewed this year. This was consistent across all sectors of care.

For example, almost a quarter of complaints we reviewed this year were about a GP’s delay or failure to diagnose a condition. Most of these related to cancer treatment, with many complainants saying that their GPs missed signs that could have led to an earlier diagnosis. When this happens, we often recommend that GP practices review their referral procedures and that their local PCT monitors these procedures. Many PCTs have their own referral pathways and the performance of individual doctors can be measured against them, often using the GP appraisal system.

### Clean, good quality environments

One of the most important priorities for patients and their families was the cleanliness and overall quality of the environment in which they were treated. Most people were satisfied in this respect.

In our 2006 inpatient survey, a large majority of respondents said their room or ward was “very clean” (53%) or “fairly clean” (40%). There has been a slight improvement in the number of people rating hospital toilets and bathrooms as “very clean” or “fairly clean”, from 87% in 2005 to 88% last year.

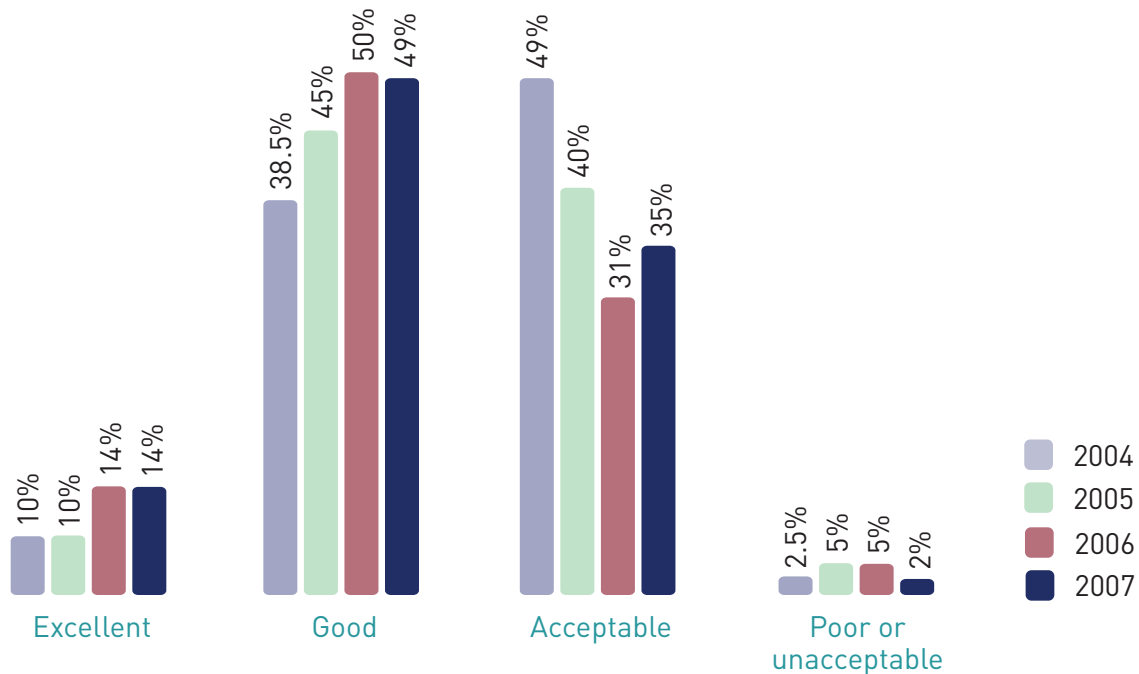
Patient environment action teams, which consist of NHS staff, patients and the public, annually assess every hospital in England with more than 10 inpatient beds, including acute, mental health and community hospitals. The scores they have given hospitals for cleanliness have improved over the last four years. In 2007, 63% of inpatient facilities were awarded a score of “excellent” (14%) or “good” (49%) – in 2004, only 49% of facilities were awarded a score of “excellent” (10%) or “good” (39%). However, the proportion of facilities rated as “poor” or “unacceptable” has remained fairly constant (see figure 4).

Patients also have a role to play in monitoring infection control procedures in hospitals. In 2006, 69% of inpatients who took part in the survey reported that doctors always washed their hands, a 2% increase on the previous year. However, we were concerned to learn that 12% said that doctors didn’t wash their hands between touching patients. Seventy-one per cent reported that nurses always washed or cleaned their hands – only 6% said they did not.

By contrast, in our survey of people who used independent sector treatment centres, only 2% reported that, as far they knew, doctors did not wash or clean their hands between touching patients.

In a national survey of 10,000 GP patients conducted by the Picker Institute for the Department of Health, nearly all (99%) said their GP practice or health centre was “very” or “fairly” clean, a figure that has been steady since 2003.<sup>43</sup>

Figure 4: Hospital cleanliness scores, 2004 to 2007



Source: Patient Environment Action Teams data, National Patient Safety Agency

## Impressive improvements in access to services

Improving people's access to treatment and reducing the length of time they have to wait for it has been a major focus of government policy in England. In 1997, 30,000 people were waiting longer than 12 months for inpatient treatment.<sup>44</sup> Nearly 6,000 were waiting more than 15 months. The introduction of waiting time targets in 2000 has seen a yearly improvement in a number of key areas, including waiting times for diagnosis, outpatient appointments, planned admissions to hospital, and accident and emergency (A&E) services.

### Access to GPs

A government target states that all patients should be able to see a primary healthcare professional, such as a practice nurse, within 24 hours and a GP within 48 hours. In 2006/2007, 70% of PCTs met this target, compared to 94% the year before. This fall

may be the result of a new, more rigorous way of collecting information from GP practices.

In 2006, 86% reported being able to get an appointment on the same day, or on one of the next two days the surgery was open.<sup>45</sup>

People report different experiences depending on their ethnicity and where they live. For example, people in deprived areas reported worse access to a GP on the same day or within the next two days the surgery was open – 83% as compared to the national average of 86% and against 88% in the least deprived areas.

Bangladeshi and Pakistani people found it hardest to see a GP quickly. Only 70% of Bangladeshi people and 74% of Pakistani people said they could get an appointment on the same day or within one of the next two days the surgery was open.

These differences in experience may in part be due to other factors, for example

levels of deprivation, rather than straightforward differences in treatment for different ethnic groups.

A quarter of patients who wanted to book an appointment in advance said they were not able to do so.<sup>46</sup> In another survey, one in four said they had been put off from going to their GP practice because the opening hours were inconvenient.<sup>47</sup>

### Waiting times for diagnostic tests

Doctors arrange for diagnostic tests when they need further specialist information to diagnose and treat their patient. This covers a wide range of procedures, including scans, x-rays, colonoscopies and echocardiography. An increasing number of these tests are performed in the independent sector.

The Department of Health has stipulated that, from the end of March 2007, such tests should be done within 13 weeks of referral. At the end of March 2007, there were nearly 700,000 people waiting for a diagnostic test in England. Of these, 105,000 had been waiting more than 13 weeks and more than 40,000 for over a year. Chapter 5 has more detail on how NHS trusts are performing on their targets for diagnostic waiting times.

### Outpatient appointments

A government target states that by 2008, no one should have to wait longer than 13 weeks from GP referral to an outpatient appointment.<sup>48</sup> We assess this as part of our annual health check and, in 2006/2007, 98% of PCTs met the target. Although there have been changes in the way this data is recorded, we can see a clear improvement. At the end of 2006/2007, only 59 people had been waiting 17 weeks or more for an outpatient appointment, compared to more than 38,000 people who had been waiting 17 weeks or more at the end of 2002/2003.<sup>49</sup>

### Planned admissions to hospital

The NHS Plan states that the maximum waiting time for inpatient treatment should be 26 weeks. This year, 83% of hospital trusts met this target. This means that by the end of March 2007, 352 patients had been waiting longer than 26 weeks, compared to 264,000 patients at the end of 2000.<sup>50</sup>

Looking at what patients told us, 84% said that they waited 26 weeks or less for their planned admission, compared to 78% in 2005. Sixteen per cent, however, said they waited longer than 26 weeks.

### Accident and emergency

Patients should not have to spend more than four hours in A&E before being admitted to the hospital, transferred or discharged.

There has been considerable improvement in this area over the last five years. In 2001/2002, only 20% of trusts were seeing 90% of patients within four hours. By 2004/2005, all trusts were meeting this operational standard. From January 2005, the Government stated that trusts should meet this standard for 98% of patients. Ninety-three per cent of trusts saw 98% of patients within four hours in 2005/2006 – against a backdrop of 18.8 million patients attending A&E in England during that year. In 2006/2007, the percentage of trusts that achieved this dipped slightly, to 89%, but this is a very high level of performance nonetheless.<sup>51</sup>

When we checked this information against patients' perceptions, we found that in 2006, 28% of them reported waiting longer than four hours for a hospital bed, up from 25% in 2005. It is important to note, however, that the survey of hospital inpatients cannot be used to assess performance in meeting the target. This is because children and patients who are not admitted to hospital are not included in the survey.

## Equality of access

Concerns persist about whether everyone is able to access the services and treatments they need. Deprivation and geographic location are major influences on access. In 2005, there were about 54 GPs per 100,000 population in the most deprived areas in England, compared to 66 GPs for the same number of people in the least deprived areas.<sup>52</sup> It is a major worry that, in poorer areas where people tend to experience worse health, access to GPs is at its worst.

Last year, a report by the Disability Rights Commission, *Closing the Gap*, highlighted the fact that people with learning disabilities and mental health problems have poorer access to primary care. Those with mental health problems received some standard treatments and tests less often than required – for example, cholesterol checks and statins drugs for people with heart disease. People with learning disabilities who suffered from diabetes had fewer measurements of body mass index while those who had had a stroke had fewer blood pressure checks than required. Such inequalities are unacceptable.

The report also highlighted that both groups experienced ‘diagnostic overshadowing’, whereby their reports of physiological ill health were viewed as part of their mental health problem or learning disability, and so were not investigated or treated.

An independent inquiry into access to healthcare for people with learning disabilities is currently underway, led by Sir Jonathan Michael on behalf of the Department of Health. The inquiry is in response to Mencap’s report *Death by Indifference*,<sup>53</sup> which reported on the deaths of six people with learning disabilities.

Refugees and asylum seekers are fully entitled to register with a GP and to access all NHS services.<sup>54</sup> Failed asylum seekers do not have the same level of entitlement. They may, at the discretion of a GP, be refused

primary care and be charged for secondary care unless in an emergency.

In 2005, the National Audit Office estimated that there were over 280,000 failed asylum seekers living in England.<sup>55</sup> According to the Refugee Council, failed asylum seekers are rarely able to pay for essential healthcare, including maternity care, treatment for cancer and operations to assist with trauma recovery. As a result, they usually go without treatment.<sup>56</sup>

In addition, the Refugee Council suggests that refugees and asylum seekers are sometimes not accessing healthcare to which they are legitimately entitled. This may be due in part to these groups being wary of approaching services as a result of earlier bad experiences or misunderstanding over what their entitlements are.

Our survey of community mental health patients also raised concerns about unequal access. For example, 50% of those service users who said they would have liked information about local support groups said they did not receive it. A similar proportion did not get the help they wanted in finding work and nearly a third did not get the help with benefits that they needed. We have consistently highlighted these issues as ones that need to be addressed urgently.

In our audit of how NHS trusts manage patients’ complaints, only 22% of the trusts we visited had adequate systems in place to ensure complainants were not discriminated against. We found that trusts need to work harder at communicating their anti-discrimination policies to staff and patients. There was also a serious absence of systems to monitor whether care had been altered as a result of a patient or carer making a complaint.

## The patient’s journey

The patient’s journey through the healthcare system – for example, from GP appointment

## 'Hidden' waiting times

The government's target of 18 weeks from GP referral to treatment was designed to improve people's access to hospital treatment. It does not apply to mental health services and treatment, except where the services are consultant led. As a result, the length of time that people wait for mental health services is not consistently monitored at a national level.

Mental health charities report that, for those people referred for psychological therapies by their GP, waiting times are an average of six to nine months but up to two years is not uncommon.<sup>57</sup> Surveys conducted for the Healthcare Commission show a persistent gap between the proportion of people in contact with community mental health services who want counselling (such as talking therapies) and those that actually receive it. In 2007, our survey found that 55% of people wanted counselling in the previous 12 months, but just 39% received it. In 2004, the figures were 59% and 42% respectively.<sup>58</sup>

In 2006, the Department of Health and the Care Services Improvement Partnership launched a programme to improve people's access to psychological therapies. It involves employing additional therapists

in 12 pilot areas as a means of increasing access, especially to cognitive behavioural therapy. If the programme is successful in improving wellbeing, reducing waiting lists and helping people remain in or return to employment, the plan is to roll it out nationally over the next 10 years.

Similarly, not all audiology services are included in the government's 18-week target. Although there is no national data on waiting times to obtain hearing aids, the charity RNID has evidence that – despite improvements in some parts of the country – in other areas people are still waiting between one and two years between GP referral and having their first hearing aids fitted.

The Department of Health report *Improving Access to Audiology Services in England* states that local health services should tackle long waiting times, including those that are technically outside the target. The Department of Health pledged to improve access to audiology services, partly through procuring additional capacity from the independent sector. In order to measure the initiative's success, it will be essential to collect and publish data on how long people are waiting for assessments and to obtain hearing aids.

to outpatient referral to treatment – can take time. It can be frustrating for patients and users of services if they feel they are not being moved through the system quickly and efficiently.

Seven per cent of the complaints that the Healthcare Commission is asked to review relate to delays and coordination of care.<sup>59</sup> One point of frustration for patients is when staff do not have access to their notes, so they have to repeat their story over and over again

to different clinicians. Eight per cent of people surveyed said that when they were referred to a specialist, the specialist did not seem to have all the information they needed.<sup>60</sup>

When people leave hospital, delays can occur if there is insufficient community and social care to enable them to be cared for in the community or at home. The NHS is required to reduce such delays to a minimum. This year, 86% of primary care trusts met the target.



Cancelled operations are another source of frustration for patients. In 2006/2007, over 51,000 operations were cancelled by hospital trusts in England, less than 1% of the total. Of those people who had an operation cancelled, around 6% did not have a new date scheduled within the following 28 days.

A significant proportion of people (38%) who took part in the inpatient survey said their discharge from hospital was delayed on the day they were due to leave hospital. In the majority of cases (61%), this was due to delays in their medication being available. In our survey of independent sector treatment centres, most people (86%) did not experience any delay on leaving. However it should be noted that these centres tend to deal with patients requiring less complex elective treatment.

The Wales Audit Office is currently undertaking a review of delayed transfers of care in the Gwent and Cardiff and Vale of Glamorgan health and social care communities, in order to identify the key issues causing these delays. They hope to develop long-term solutions that will benefit patients moving across the health and social care pathway.

## Personal care and comfort

Whether they are being cared for in a general hospital, a hospice, or in their own home, people deserve a certain level of care and comfort. They expect a minimum of pain, to be given nutritious and appetising food, and to be treated with dignity and respect.

We have little evidence about the experience of people cared for in the community, hospices or in their own homes, a shortcoming that needs to be addressed. We do have information about the experience of people cared for in NHS hospitals and independent treatment centres.

## Dignity

A significant proportion (30%) of the complaints about hospitals that we reviewed related to dignity and respect, nutrition and other aspects of basic personal care.<sup>61</sup> Many complainants reported that their own dignity, or that of a relative, had not been maintained. Examples included:

- Patients left in soiled bedding and clothing.
- Personal hygiene needs not met – in particular no regular baths or showers, hair care, nail care or oral hygiene.
- Inappropriate or inadequate clothing – for example, gowns or nightdresses not maintaining patients' modesty.
- Bedside curtains or room doors being opened when a patient is receiving intimate care, or staff entering without knocking or waiting for permission to enter.

In response to these and other concerns raised in the media and elsewhere, we conducted a review of dignity in care for older people in 2007. (See the “spotlight on the experience of older people” on page 37 for more details.)

Looking more broadly, around 78% of respondents to the inpatient survey reported that they were always treated with respect and dignity while in hospital. As regards GP services, 92% said their doctor treated them with dignity and respect at all times<sup>62</sup> and for independent sector treatment centres the figure was 96%.<sup>63</sup>

Concerns about food and nutrition were another common theme in patients' complaints – for example, poor choice or variety in meals, lack of assistance with eating, and food and drinks placed out of reach, particularly for elderly people. We have consistently recommended that trusts review their practice against the *Essence of Care* toolkit.<sup>64</sup>

It is deeply worrying that 20% of inpatients in our survey did not get the help they needed with eating, compared with 18% in 2005.

The management of pain is another important aspect of patients' comfort. In our survey of inpatients, only 5% thought that NHS hospital staff did not do everything possible to control their pain. In the independent sector, the figure was 2.5%.

### Privacy

Privacy is fundamental both to maintaining a patient's sense of dignity and to preserving their right to confidentiality. It is worrying that in our assessment of NHS trusts in England, more than one in 10 did not meet the standard requiring them to maintain patient privacy and confidentiality. Clearly there is more to be done.

Of hospital patients surveyed, 70% said they "always" had enough privacy when discussing their condition or treatment, compared with 71% in 2005. A further 22% said they "sometimes" had enough privacy, while 9% said they did not. Most patients (88%) said they had enough privacy when being treated or examined, the same as in 2005.

Sharing accommodation and bathrooms with members of the opposite sex can be embarrassing for patients and compromises their need for privacy and sense of dignity. This may be the case particularly for older patients from some ethnic minority groups, due to their different cultural backgrounds,<sup>65</sup> and for mental health patients who find it distressing to be with members of the opposite sex. The Department of Health states that men and women should not normally have to share sleeping accommodation or toilet facilities.<sup>66</sup> Irrespective of where patients are, staff should always take the utmost care to respect their privacy and dignity.

In mental health hospitals in England and Wales, we found that 55% of people were

# 78%

of people in our inpatient survey said they were always treated with dignity and respect

not in single-sex accommodation, and this figure rose to 57% for people with learning disabilities.<sup>67</sup> However, it is worth noting that for 2007/2008, the Government has made available £30 million for schemes to address safety on inpatient wards in England, particularly those for women.<sup>68</sup>

In acute trusts, just under a third of patients who entered hospital in an emergency said they shared a sleeping area with a member of the opposite sex when first admitted. For those who moved to another ward, this proportion fell to 16%. Eleven per cent of inpatients said they had to share a room or bay with a patient of the opposite sex during a planned admission.

Thirty per cent of hospital inpatients said they shared a bathroom or shower area with patients of the opposite sex, while a further 2% said they shared facilities at least once because that area contained special bathing equipment that they needed. Trusts need to ensure that single-sex accommodation is provided wherever possible and that single-sex toilets and bathrooms are clearly signposted.

In independent sector treatment centres, 98% said they were always given enough privacy when being examined or treated.

### Good communication

Communication with patients about their condition and care can often make the difference between them feeling able to cope with their health problem, and them feeling powerless, anxious or even angry.

Good information on the availability of services, the possible side effects of medication, the risk of complications, and prognosis not only enhances a patient's experience but can also have a positive impact on the clinical effectiveness of their treatment.

Too often we hear from people who say they are not receiving the right information to help them manage their condition, and are not properly involved in decisions about their care.

Primary care, such as GP surgeries, dental practices and community nursing, is where the majority of people come into contact with healthcare services.

There is not enough data on whether professionals such as nurses and health visitors give patients information that is clear and helpful. However, two surveys of GP patients carried out in 2006 give some insight. The proportion of people who said that the doctor listened carefully to what they had to say (82%) has remained constant over three years; a further 16% said that the doctor listened carefully "to some extent".

However, one in five said they got no information about the side effects of medication, up from 18% in 2004. Although it is a small proportion overall, 4% said they did not get enough time to discuss their health or medical problem with their doctor and, while 97% said they understood the answers their GP gave them, 2% did not and 1% said they did not have an opportunity to ask questions.

The majority (63%) said they did not get copies of letters between their hospital doctor and family doctor, although this is an improvement on 2005 when it was 65%.

For patients in hospital care, the inpatient survey found that 89% said they were "definitely" (52%) or "to some extent" (37%) involved as much as they wanted in



decisions about their treatment. Ninety-five per cent said that they could "always" (68%) or "sometimes" (27%) understand the way a doctor answered their question, while 81% said they were appropriately informed about the risks and benefits of their procedure.

However, 21% said not enough information about their condition or treatment was given to them and 28% said that doctors sometimes or often talked in front of them as if they weren't there. Sixteen per cent reported that they or family members did not have enough opportunity to talk to a doctor when they wanted to.

Our 2007 survey of community mental health patients showed that 95% felt that their psychiatrist "definitely" listened (71%) or listened to them "to some extent" (24%). A third of those prescribed new medication said they were not told about possible side effects.

### Responding to concerns

The NHS in England and Wales provides more than 380 million treatments each year.<sup>69</sup> A very small proportion of these treatments – around 140,000 – lead to

concerns that patients formally complain about. The Healthcare Commission receives 7,500 requests for independent reviews of complaints from people in England unhappy with the way in which the trust involved has handled their complaint.

We conducted an audit in early 2007 that found little evidence that trusts learn from complaints. This is not acceptable in an NHS that is striving to be patient-focused. Of the complaints that patients send to us for independent review, we send nearly a third back to the trusts because they need to carry out more work at a local level to resolve the complaint.

We also found that trusts are not doing enough to make their complaints systems open and accessible, especially for groups such as people with learning disabilities and people from minority ethnic groups.

These results are even more concerning when viewed alongside the results of a survey conducted this year by the consumer watchdog, Which?<sup>70</sup> It found that half of patients who had concerns about an aspect of their care said nothing to staff or the hospital because:

- 35% didn't think it would make a difference
- 27% "did not want to make a fuss"
- 23% "just expected it to be like that"
- 23% thought staff were too busy already
- 12% believed that raising issues could compromise other aspects of their care.

NHS trusts clearly need to do more to create a culture where people feel able to voice complaints, and have confidence that their concerns will be dealt with appropriately.

The Healthcare Commission has no formal role in resolving complaints about independent healthcare providers,

although we follow up on information from members of the public who believe that an independent provider is not meeting its legal requirements.

Complaints about independent healthcare establishments are dealt with by the provider of the service. The Independent Healthcare Advisory Services provides an adjudication process for complaints that cannot be resolved in this way. The Healthcare Commission has recently agreed a protocol with them for sharing information about complaints where a patient asks us to do so.

### Spotlight on the carer's experience

There are around 5.2 million carers throughout England and Wales,<sup>71</sup> roughly 10% of the total population.<sup>72</sup> They provide unpaid care for family and friends and are a vital part of healthcare services. The people they care for may be physically or mentally ill, frail or have a disability.

Research conducted for the charity Carers UK estimated that the value of unpaid support that carers provide is £87 billion a year.<sup>73</sup>

Most carers (58%) are female and more than one in five people aged 50 to 59 provide some unpaid care. The number of carers providing support for 20 hours or more a week is increasing, as is the number providing over 50 hours of care a week.

Caring can be stressful and difficult work, and can have a negative impact on the carer's health. Longer-term carers often reach crisis point, due in part to lack of support from health and social care providers.<sup>74</sup>

Those caring for others for 50 hours a week are twice as likely as others to be in poor health (21% against 11%).<sup>75</sup> Carers are more than twice as likely to have mental health problems if they provide substantial care – 27% of those providing over 20 hours a week care had mental health problems, compared with 13% of those providing less than 20

hours of care.<sup>76</sup> Carers are also more likely than non-carers to be permanently sick or disabled.

Low incomes, a lack of breaks from their challenging work, ignoring their own health needs because there is no one else available to provide care and lack of emergency planning – these are all factors contributing to poor health among carers.<sup>77</sup>

Given the increasing number of carers and the likely impact on their health, it is vital that we gain better information about their needs and their contribution to the population's health. The Government's recent consultation on the New Deal for Carers, and the revision of the national strategy for this area, provides a valuable opportunity to look at the issues anew.

### Spotlight on the experience of people with learning disabilities

There are around one million people with learning disabilities in England and Wales.<sup>78</sup> On average, they experience worse health than the general population.

People with learning disabilities face barriers in accessing the NHS.<sup>79</sup> This in part has contributed to them experiencing more ill health and having a greater chance of premature death than the general population.<sup>80</sup>

People with learning disabilities have higher rates of respiratory disease than the remaining population and are more likely to be obese. They have very low rates of breast and cervical screening. People with learning disabilities have told us that their appointments with GPs were sometimes too short, leaving them little time to explain their concerns or understand what their GP had told them.

During 2006/2007, we raised serious concerns about the care and treatment of people with learning disabilities following investigations that we carried out at



Cornwall Partnership NHS Trust and Sutton and Merton Primary Care Trust. We found that there were cultures of institutionalised care within both trusts, which sacrificed the individual needs of people with learning disabilities in favour of the needs of the service. In some cases this led to a culture of abuse.

We conducted an audit of 638 individual learning difficulty services earlier this year, which provide care to around 4,000 people.<sup>81</sup> This did not cover the care for the 3,600 people who live in units registered with the Commission for Social Care Inspection.

The audit<sup>82</sup> found that wide-scale change was needed in services for people with learning disabilities, and that most only provide basic standards of care. It found that that many services were poor at planning the care of people with learning disabilities and that there was insufficient evidence that care plans were accessible to people with learning disabilities or that they were current and reviewed frequently enough.

The audit found that nearly all people with learning disabilities had spent periods of time away from their residential units in the

preceding month – most of these involved going shopping or eating out. However, there were 17 units where at least one person with learning disabilities had not left the site in the preceding month. Around half of the units were not engaging people in activities on the unit or off the site.

Some of the people living in the units had very little contact with family and friends. In 24 of the units in the audit, no one other than healthcare professionals, advocates, social workers and people offering spiritual support had visited them during the preceding month. The audit also found access to advocacy services were patchy and as such we are not confident that the needs and rights of people with learning disabilities are protected.

The majority of units stated that they had had no recorded complaints either from people using the services or from carers or advocates in the last six months. Our inspections found that some units had no accessible information about making a complaint. The audit also found there was insufficient attention paid to services for people with learning disabilities by those responsible for commissioning them.

It appeared that most (81%) of the people using learning difficulty services are offered a routine health check.

At the time this report went to print, Healthcare Inspectorate Wales was scheduled to publish a report on learning disability services in Wales.<sup>83</sup>

### Spotlight on the experience of older people

Older people are the highest users of acute hospital services. It is estimated that the NHS spends 45% of its total budget on them.<sup>84</sup>

Numerous concerns have been raised in the media, by voluntary organisations and through our complaints system about the

care of older people in hospital. *Living Well in Later Life*, a review conducted by the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission, highlighted the frequent lack of dignity and respect shown towards such patients.

Following up on the concerns raised by our first review, in 2006 we looked at the extent to which older people are treated with dignity in hospital. Our report, *Caring for Dignity* found that, while problems do exist, dignity, nutrition and privacy are being given a higher priority within hospitals.<sup>85</sup>

Vulnerable older people – such as patients from minority ethnic groups, people with a disability, those at the end of their lives, and those with dementia and confusion – are likely to be less involved in decisions about their care than other older people. Furthermore, their needs present more challenges for staff, who are often inadequately trained to deal with them. As a result, vulnerable older patients are more likely to have a negative experience of healthcare.

The review also found that older people did not always feel adequately involved in their care. Only 55% of older people surveyed said that they felt involved in their care as much as they wanted, while 94% were never asked for their views while they were in hospital.

Maintaining privacy for older patients was the issue with which acute hospital trusts had the most difficulty.

Over 10,000 people over the age of 65 are being cared for in mental health hospitals in England and Wales.<sup>86</sup> These people are suffering from a range of conditions including mental illness, dementia and Alzheimer's disease. An audit conducted by the Royal College of Psychiatrists for the Healthcare Commission found that standards relating to respect and dignity were generally good on older people's wards. In a survey conducted as part of the

audit, 99% of carers and next of kin reported that their relative was treated with respect and 92% of patients said they were treated in a dignified manner.

However, the survey also found that 16% of patients reported that they sometimes had to share space with members of the opposite sex; 14% of patients had been threatened or made to feel unsafe while staying on the ward; and 5% had been physically assaulted. While we have confidence that mental health providers are taking positive measures to ensure older service users are treated with dignity, there is still more that they can do to improve the safety of people (see chapter 4 for further details).

### Spotlight on the experience of people who use mental health services

There are currently over 30,000 people in mental health hospitals in England and Wales.<sup>87</sup> Nearly one in 10 people within the general population suffer from some form of depression or anxiety.<sup>88</sup>

People with mental health problems use healthcare services in a wide variety of ways. For someone suffering anxiety or depression, their contact may be limited to consultations with their GP and monitoring the effect of any drugs prescribed. For those who suffer more serious mental illness, such as psychosis, bi-polar disorder or schizophrenia, treatment may involve regular contact with a member of the community mental health team.

Community teams and outreach services, designed to prevent the more seriously ill from having to receive care in hospital, have been the focus of mental health service development over the last 10 years. Sadly, over 150,000 people attend A&E departments each year for treatment of self-injury or self-poisoning (including overdoses).<sup>89</sup>

We have little evidence about the experience of people with mental health problems who are only seeing their GP, or using no formal healthcare services at all. A joint review of community mental health services published earlier this year found “considerable under-performance” in each of the three areas assessed. Of particular concern was the fact that people who use the services were not being routinely involved in decisions about their care and treatment. Only half of those interviewed for the review had been offered a copy of their care plan, and just 29% of care plans contained an agreed course of action in the event of the individual being unable to take decisions for themselves.

Access to effective care and treatment is vital to people’s recovery and to their social inclusion. As part of the review, our audit of the National Institute for Health and Clinical Excellence (NICE) guidelines for schizophrenia, identified that a significant number of eligible people were not being treated in accordance with these guidelines.<sup>90</sup> Our 2007 survey of users of community mental health services shows that 93% reported being on medication and 39% reported having had counselling, such as talking therapies, in the last year. Fifty-one per cent reported that they did not have the number of someone from the mental health service that they could phone out of hours if they were in crisis.

Only 20% of those who took part in our community mental health survey are in paid employment. Forty-nine per cent of respondents had received help in trying to find work, while 51% had not had help but would have liked it.

For those in hospital, we know from the *Count Me In* census that around 30% have been in hospital for over a year and that 40% are detained under the Mental Health Act.

Around 30% of informally admitted inpatients were deemed incapable of

consenting to treatment. For detained patients, the figure was 20%.

People from the Black Caribbean, Black African and Other Black groups are more likely to be referred to hospital care from the criminal justice system and less likely to have been referred to inpatient care from GPs or community mental health teams. The reasons for this are complex.

Six per cent of inpatients had harmed themselves on one or more occasions and around 8% had experienced one or more episodes of restraint.

White British inpatients are more likely to self-harm than those from the Black Caribbean, Black African and Other Black groups and those from the Indian, Pakistani and Bangladeshi groups.

In chapter 3 we present a case study on the experience of adolescent mental health users of services in the South West of England.

### Spotlight on the experience of users of maternity services

Earlier this year, the Healthcare Commission conducted a series of discussions with parents from different minority groups to help inform the development of our review of maternity services, which is due to be published in 2008.

As part of the exercise, we gathered the views of African women, Bangladeshi women, women with physical disabilities and parents with learning disabilities.

Positive and negative experiences were discussed. Many of the issues raised relate to services in general but some reflected experiences that are likely to be particular to minority groups. Here we report on a few of the key messages from these events.

# 51%

of users of community mental health services did not have an emergency number to phone out of hours

### Information during pregnancy

Most of the women in the discussion groups had received written information during their pregnancy. Interpreter services were available when required, but not all midwives knew how to access these services.

Meeting the information needs of disabled parents was more problematic. One woman with learning disabilities said: "They gave me a book... I was scared stiff, none of it was accessible, they gave me no help and assistance in how to do things."

A number of women said that there had not been enough time to talk through their worries or the information they had been given at antenatal appointments.

Very few of the women in the groups had birth plans, and not all of them seemed aware of their different options for where to have their baby or about birthing aids that may have helped them manage pain.

### Choosing where to give birth

Women said that when they had been given a choice of where to have their baby, their choice had been influenced by previous experience, feedback from friends and their view on cleanliness of the maternity units.

Some women reported feeling under pressure to consider home births. Those living with an extended family did not always see this as an attractive option, and there were worries about the safety of giving birth without immediate access to doctors.



## Key results from the 2006/2007 surveys of patients in England

### Hospital inpatients

#### What's good:

- More than 90% rated their care as "excellent", "very good" or "good".
- 93% said their room or ward was "very clean" or "fairly clean".
- 88% rated cleanliness of hospital toilets and bathrooms as "very clean" or "fairly clean", compared with 87% in 2005.

#### What needs to improve:

- 15% reported that it took over five minutes for a member of staff to answer the call button, compared with 13% in 2005.
- 45% of patients said they were not told about what side effects of medication to look for when they went home.
- 20% of the patients who indicated that they needed help eating said they did not get enough help, up from 18% in 2005.

### Community mental health patients

#### What's good:

- 71% said their psychiatrist had "definitely" listened carefully to them (up from 68% in 2004) and 82% said their psychiatrist "definitely" treated them with respect and dignity.
- 82% said their psychiatrist "definitely" treated them with respect and dignity.

#### What needs to improve:

- 63% reported not having any counselling sessions in the last 12 months.
- 33% of those prescribed new medication said they were not told about possible side effects.
- 50% of those who said they would have liked information about local support groups said they did not receive it.

### GPs' patients

#### What's good:

- 77% say they were seen by a GP as soon as they thought necessary.
- 82% said their GP had "definitely" listened carefully and 16% said they had listened carefully "to some extent".

#### What needs to improve:

- 22% said their medications had not been reviewed in the past 12 months.
- One in five said they were not given information about any side-effects from medication and 12% said they were not involved as much as they wanted to be in decisions about their medication.

### Staying in control

Access to pain relief and insensitivity about this issue was raised by a number of women. African women reported being told that they become hysterical with pain, or that they should be used to pain and so did not need pain relief.

A couple of women talked about a sense of losing control when complications arose during labour: “It was embarrassing and uncomfortable. I had a problematic birth and every time they gave me an internal examination they brought the student in, it wasn’t nice.” Another woman described how her birth plan “went out the window” when there were complications during labour.

The partner of one participant was told he could not attend the birth because his wheelchair presented a safety hazard.

### Postnatal care

Generally women reported good support for breastfeeding, which is known to have positive benefits for babies. Some women with learning disabilities said that they tried breastfeeding but the baby did not take to it, so they had bottle fed instead. This suggests that not enough individualised care was provided to these women.

Some of the women with disabilities reported a lack of accessible equipment and facilities. For example, one visually-impaired woman expressed her frustration at not being able to identify her milk in the fridge: “I was so upset that I gave up breast feeding.” Some disabled women reported that they had to rely on their partners to provide them with basic care – for example, help with eating and showering.

The consensus within a number of the groups was that women felt pressured to leave hospital too soon after having their baby.

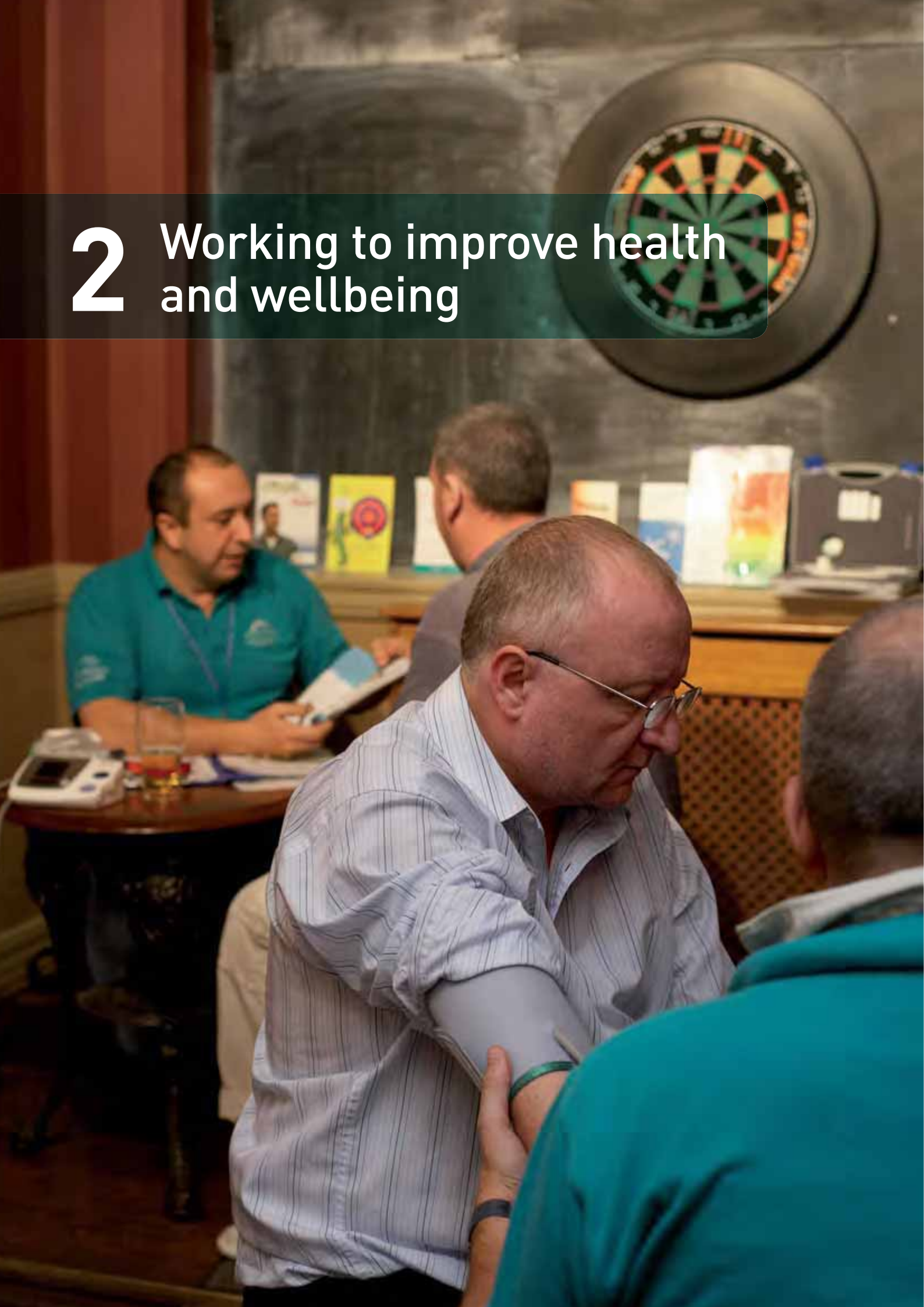
Overall, the clear message was that what mattered most was the friendliness of staff caring for them during their maternity experience.

### Looking ahead: recommendations and key challenges

The vast majority of NHS trusts provide care that patients and users of services regard as “good” or better. Only a minority of trusts provide an experience that we rate “below average” or “poor”. Some aspects of the patient experience are not as good as they should be. In the light of this, we make the following recommendations:

- It is important that NHS trusts remain focused on ensuring they provide good quality nursing care, especially to vulnerable people.
- There needs to be more attention on the part of policy makers, commissioners and healthcare providers on improving access to services that currently do not fall within the 18-week target.
- Those organisations that provide healthcare or commission it on behalf of local communities need to work with patients and users of services to ensure that they have equal access to the services that they require, and that individualised care is provided where necessary.
- Healthcare providers need to do more to ensure that patients and users of services have information tailored to their needs, including information about their medications.
- The NHS needs to improve its ability to act on and learn from complaints by patients. Complaints systems need to be made more open and accessible, and changes made in response to patient feedback need to be communicated.

# 2 Working to improve health and wellbeing



## People's health in England and Wales is getting better in some important ways, such as increased life expectancy. Yet more must be done to prevent poor health and improve services for people with long-term conditions.

The health of people in England and Wales has improved, and in some ways dramatically, over the last 20 years. Premature deaths from circulatory disease, including heart failure, have fallen by over 40% since 1995. Premature deaths from cancer have been cut by nearly 20%.<sup>91</sup> Life expectancy for men has increased by almost five years since 1986, and for women by more than three years.<sup>92</sup>

However, in some respects the nation's health is getting worse. Obesity is increasing rapidly<sup>93</sup>, as is the rate of sexually transmitted infection. More people are being admitted to hospital with alcohol-related conditions. People from the most deprived areas\* live at least five years less than those from the most well-off areas, and spend a greater proportion of their life in poor health.<sup>94</sup>

All of these issues are of concern to the Healthcare Commission and form the backdrop to how we assess healthcare organisations.

The NHS has responsibility for managing and preventing poor health, in partnership with local people, schools, authorities and the voluntary sector. In England, primary care trusts (PCTs), working with local authorities, play a leading role in meeting the health needs of their communities and in planning and purchasing (or 'commissioning') the services needed. In Wales, the responsibility lies with local health boards, again working with their local authorities.

Our assessments during the year showed that most NHS trusts in England have made substantial improvements in meeting the more urgent needs of their populations – for example, in improving access to cancer services. However, they show a particularly mixed picture for both the commissioning and delivery of services by PCTs, especially in relation to preventing illness and enabling those with long-term conditions to best manage their condition. More also needs to be done to reduce the health differences between the most well-off groups and the most deprived.

This chapter is organised in two parts. In the first, we outline some of the main causes of death and health problems within the adult population. Our focus is on trends over the last 10 years and how the health of people living in more deprived areas is generally worse than those elsewhere. In the second part, we look at what progress healthcare services have made in addressing these problems, particularly at a local level. The health of children and young people is discussed separately in chapter 3.

The key messages we wish to convey are:

- The health of the people in England and Wales is getting better overall, with life expectancy and infant mortality improving.
- Impressive results have been achieved in addressing the 'big killers'.

\* We use the term "most deprived areas" to describe the fifth of PCTs that fall within the local authority areas that are in the bottom fifth nationally for three or more of the following factors: male and female life expectancy; cancer and cardiovascular disease mortality; and the average score for the index of multiple deprivation 2004. These PCTs are otherwise known as the 'spearhead' PCTs.

- On the other hand, progress has been slow in addressing the more complex, long-term health problems: alcohol-related illnesses, obesity and conditions such as diabetes. These issues are a potential time-bomb for healthcare services.
- Differences in circumstances still play a major role in determining the health of the nation.

### The policy and funding environment

The British and Welsh Governments have recognised the need to take positive action to improve people's health. In 2005/2006, the Department of Health reported spending £1.3 billion on public health initiatives through their 'healthy individuals' budget, compared to £1.1 billion in 2004/2005.<sup>95</sup>

In England, the Department of Health set out a preventative approach to improving the health of the public in its reports *Tackling Health Inequalities: A Programme for Action* and *Delivering Choosing Health: Making healthier choices easier. Delivering Choosing Health* prioritised six areas:

- addressing health inequalities
- reducing the numbers of people who smoke
- tackling obesity
- improving sexual health
- improving mental wellbeing
- reducing harm and encouraging sensible drinking.

In 2008, the Healthcare Commission will be reporting on a joint study with the Audit Commission on the impact that policy over the past 10 years has had on the delivery of programmes designed to address these problems.

# 9.2%

the average increase in funding for PCTs over the last year

A new way of assessing local services in England is to be introduced in 2009. The Comprehensive Area Assessment (CAA) will examine those outcomes for health for which councils are responsible, either alone or in partnership. This means that, in addition to local authority services, the CAA will consider health and wellbeing, community safety, sustainable communities, economic development, housing strategy and children's services. This will enable a holistic assessment of how well communities are functioning, rather than relying on assessments of individual service providers.

The Department of Health has established a programme to improve commissioning in the NHS with the aim of delivering best value and improved health outcomes, underpinned by the consultation paper *Commissioning framework for health and wellbeing*.<sup>96</sup>

In Wales, the Government set out a 10-year action plan to improve health and reduce inequalities by 2015, in *Designed for Life: Creating world class health and social care*. A national initiative, Health Challenge Wales, provides a focus for both individuals and organisations in the fight to improve public health.

The treasury allocated £64 billion to PCTs in 2006/2007, an average increase of 9.2% on 2005/2006. Funding is allocated to individual PCTs on the basis of a formula which takes into account, among other things, population size and need, the level of

primary medical services the PCT provides, and its projected payments to healthcare providers such as hospitals under the payment by results scheme.<sup>97</sup>

We raised concern in our *State of Healthcare 2004* report that under the formula some PCTs received less than they were due and others received more. The Department of Health has been addressing the issue and states that, by 2007/2008, no PCT will receive funding that is more than 3.5% under target.<sup>98</sup>

### Life and health expectancy

When measured by life expectancy and infant mortality, the health of people in England and Wales has improved significantly over the last 20 years. In 1986, life expectancy for men was 72 years and for women it was 78 (see figure 5). Today, men in both countries can expect to live on average to around 76-77 years and women to about 81, with people in England living slightly longer. In 1986, more than

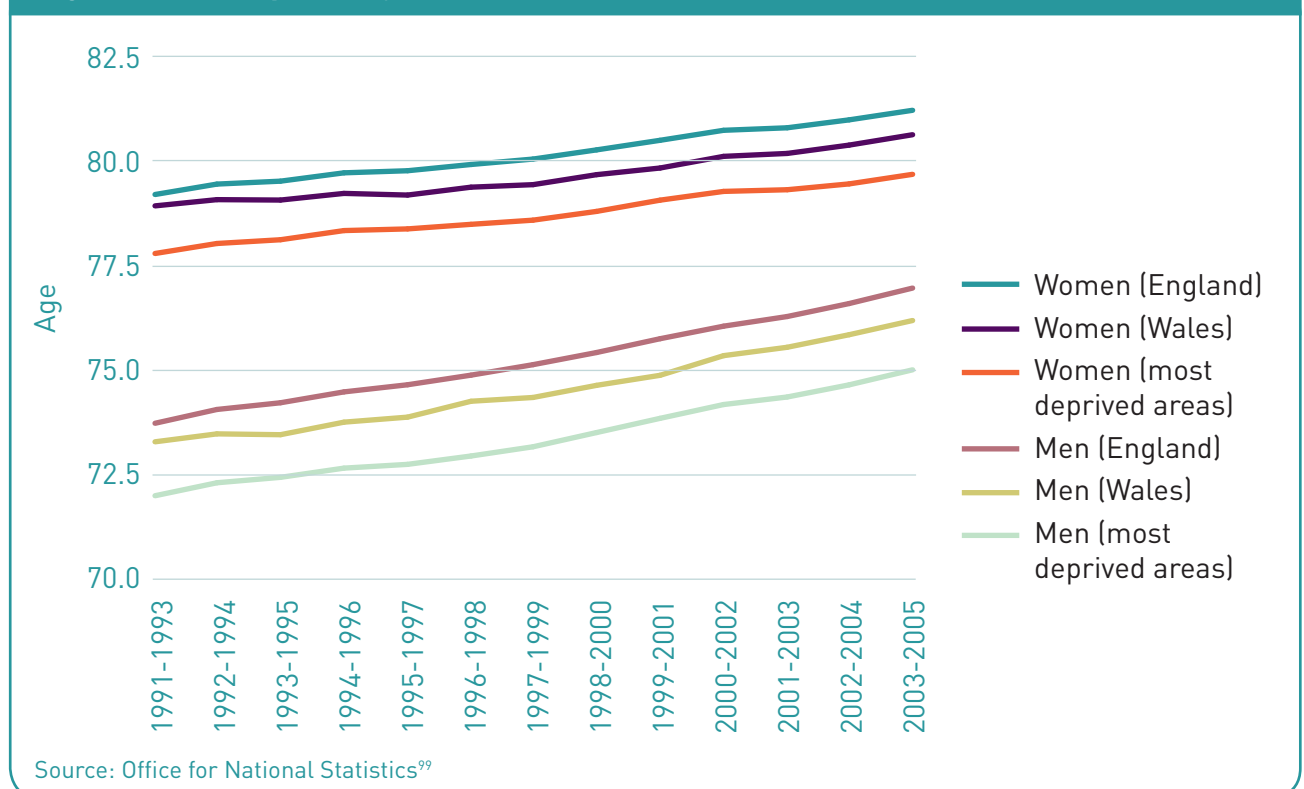
nine children in 1,000 died before their first birthday. Today the proportion is five in 1,000.

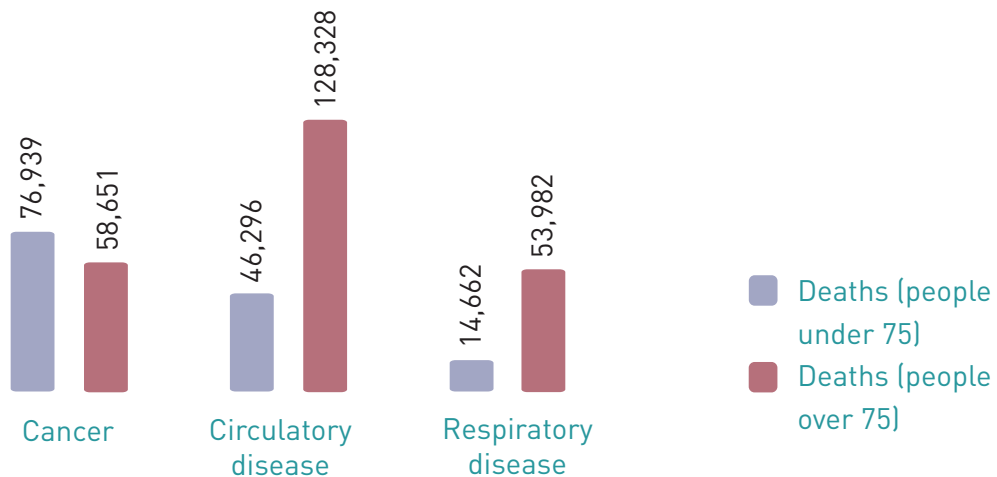
The reasons for these improvements are complex. Increased wealth, more people staying at school for longer, improved diet, better housing, improvement in immunisation programmes, development in healthcare technology and clinical understanding have all played their part.

However, the gap in life expectancy at birth between those living in the most deprived areas and the population as a whole continues to widen slightly, as figure 5 shows. In addition, there is a difference of nearly 10 years between the life expectancy of men living in the least and most deprived areas in England.<sup>100</sup>

Moreover, the number of years that people are living in poor health is increasing.<sup>101</sup> This is because people are living longer and the likelihood of developing a disease increases with age.

Figure 5: Life expectancy at birth, 1993-2005



**Figure 6 : Deaths from the three 'big killers', England and Wales 2006**

Source: Office for National Statistics, Health Statistics Quarterly 34

This burden of poor health is felt more acutely in deprived areas. People living in the most well-off areas can expect to live 93-94% of their life in good health, whereas in the most deprived areas, people can expect to live only 84-86% of their life in good health.<sup>102</sup>

In England and Wales, people die younger than in most other countries in Western Europe and, while the numbers are small, there are higher rates of infant mortality. Clearly there is still work to be done.

### Premature death – the leading causes

In England and Wales, the three biggest causes of death before the age of 75 are cancer, circulatory diseases, including coronary heart disease and stroke, and respiratory diseases, such as chronic obstructive pulmonary disease and emphysema. Cancer is by far the biggest cause of premature death.

As figure 7 shows, premature mortality rates for cancer and circulatory diseases fell significantly between 1993 and 2005. While this is good news, it does not tell the whole story.

### Cancer

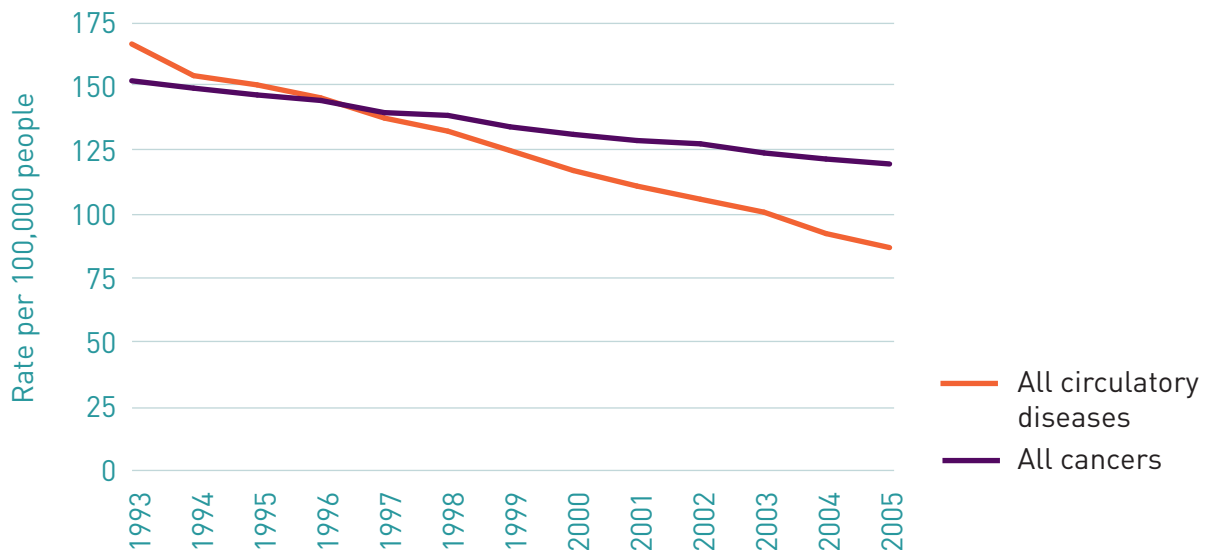
Cancer is the most common cause of early death in England and Wales. Of the 135,500 people who died of cancer in 2006, half were under the age of 75.<sup>103</sup> One in three of us will develop cancer in our lifetime, and one in four will die from it.

The number of new cancer cases is rising by 1.4% a year, partly because we are living longer. Lung cancer, breast cancer, bowel cancer and prostate cancer are the most common forms of the disease in England and Wales.

However, survival rates for most cancers are improving. The mortality rate for people under 75 who are diagnosed with cancer fell by almost 17% between 1996 and 2005, which means that 60,000 fewer people have died prematurely over the last 10 years.<sup>104</sup>

Breast cancer survival at five years among the 170,664 women diagnosed in England between 1999 and 2003 was 81%. Compared with the 139,221 women diagnosed from 1996 to 1999, the survival figure has increased by 3.5 percentage points. There have been big improvements for adults with colon cancer. Men diagnosed between

**Figure 7: Premature mortality rates for cancer and circulatory diseases, England and Wales 1993-2005**



Source: ONS/Compendium of Clinical and Health Indicators, July 2007

1999 and 2003 have a 2.7% higher chance of survival after five years, than those diagnosed from 1996 to 1999, while the equivalent difference for women is 2.9%. Prostate cancer survival in men increased by almost 10 percentage points, from 64.8% to 74.4% in the same period.<sup>105,106</sup>

Nevertheless, the UK lags behind most of Europe in its survival rates. When comparing similar data for patients diagnosed between 2000 and 2002, it was found that the five-year survival estimates for lung cancer were 8.4% for England and 10.4% for Wales. Iceland and Belgium were at the top of the table with 16.8% and 16.3% respectively, with all participating European countries, apart from Scotland and Malta, performing better than England.<sup>107</sup> For breast cancer, survival rates for this period were 77.8% for England and 78.4% for Wales, lower than for most other countries included in the study.

A recently published study, covering five-year survival rates for European adults diagnosed from 1995 to 1999, found that

countries with higher national expenditure on health (between 1994 and 2002) generally had better all-cancer survival, apart from the UK and Denmark, which had lower survival than countries with similar expenditure.<sup>108</sup> The same study showed that, generally, survival for the four most common cancers was lowest in eastern Europe, followed by the UK and Ireland. It was intermediate in southern Europe and best in Nordic countries (except Denmark) and central Europe.

Cancer incidence is higher and survival rates are lower in areas of social deprivation.<sup>109</sup> For example, survival rates for people living in the most deprived areas are 2.4% lower than in the rest of England for breast cancer, and 3.8% lower for prostate cancer.<sup>110</sup> This may in part be due to later diagnosis, because of lower take-up of screening and patients with symptoms waiting longer before consulting their GP. Higher smoking levels and poorer diet may also be contributing factors.



## Circulatory disease

Circulatory disease is the second highest cause of preventable death in England, and the leading cause of death overall. Of the 174,600 people who died from circulatory diseases in 2006, 26.5% were under 75. The most common form stems from hardening of the arteries (atherosclerosis), which can lead to coronary heart disease, stroke, vascular disease and heart attack (acute myocardial infarction).

However, the number of premature deaths from circulatory disease is falling in England. As figure 8 shows, whereas in 1995 to 1997 the death rate was 141 per 100,000 people under 75 years, in 2002 to 2004 that figure had dropped to 97 per 100,000.

In the most deprived areas, the rate fell from 173 per 100,000 to 122 per 100,000 over the same period. Although absolute inequalities have narrowed, the relative gap has widened – from a 22% difference in 1995 to 1997 to 26% in 2002 to 2004.<sup>111</sup>

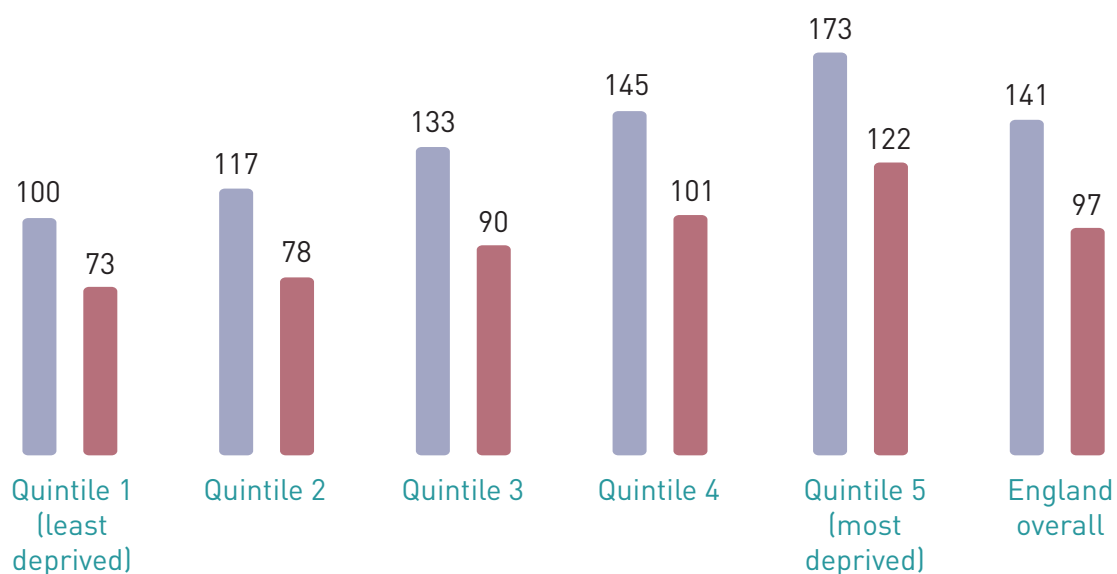
## Respiratory disease

Respiratory disease includes asthma and chronic obstructive pulmonary disease (COPD). The third leading cause of premature death in England and Wales, it has traditionally attracted far less attention than cancer and circulatory disease. Of the 68,600 people who died from respiratory disease in 2006, 21% were under 75.

In 2005/2006, the latest year for which data is available, there were nearly one million episodes of hospital care related to respiratory disease (922,925), around 80% of which followed an emergency admission.<sup>113</sup>

Although deaths from respiratory diseases are falling (in 2004 they accounted for 74.1 deaths per 100,000 in the UK compared to 92.4 in 1985), we still lag behind many of our European neighbours.<sup>114</sup> In many cases, the rates of death in European countries are half what they are in the UK – in Germany the rate is 36.1 per 100,000 deaths, in Austria it is 33, in Poland 37.8 and

**Figure 8: Premature mortality rates for circulatory disease, England 1995-1997 and 2002-2004**



Source: The Health Foundation<sup>112</sup>

■ Deaths per 100,000 population, 1995-1997  
■ Deaths per 100,000 population, 2002-2004

in Switzerland 28.8. Only Ireland, with 85.2 deaths per 100,000, is higher than the UK.<sup>115</sup>

### Health and lifestyle

To fully understand the challenges healthcare providers face, we must also consider the impact that environmental and lifestyle factors have on people’s health.

#### Smoking

Smoking is the most common avoidable cause of death under the age of 75 in the UK. It is also a major contributing factor in the three main causes of early death described above. Around 24% of people over 16 smoke in England, while in Wales the figure is 25%.

In England, the Government aims to reduce the percentage of people who smoke to 21% by 2010. For people employed in routine and manual jobs, its goal is to reduce the figure from 31% to 26%.<sup>116</sup>

The ban on smoking in public places that came into effect in England and Wales in

2007 may help to improve health and reduce smoking rates. Scotland introduced a ban in March 2006, and early research findings suggest that it is already helping to reduce the number of heart attacks.<sup>117</sup>

#### Obesity

Obesity is linked to many illnesses and is directly related to a lower life expectancy. In England, the proportion of men classified as obese increased from 13.2% in 1993 to 22.1% in 2005; for women it rose from 16.4% to 24.3% (2005 figures are weighted for non-response).<sup>118</sup> In Wales, 19% of adults are classified as obese (though it should be noted that figures for Wales are self-reported, and therefore are not directly comparable to England).

As figure 9 shows, obesity generally increases with deprivation, although this is not the case for the most deprived men.<sup>119</sup>

The National Audit Office estimates that if there were one million fewer obese people in England, this would lead to around 15,000 fewer people with coronary heart disease,

Figure 9: Percentages of people classified as obese, England 2003



34,000 fewer people with type 2 diabetes, and 99,000 fewer people with high blood pressure. Reducing rates of obesity could therefore have a significant impact on quality of life and life expectancy in England, and reduce NHS costs.<sup>120</sup>

### Poor mental health and wellbeing

Stress, depression and anxiety are the leading causes of people taking time off work, and result in millions of lost working days in the UK every year. About one in three of the 1.3 million people claiming long-term incapacity benefit in the UK has a mental health problem, mostly mild to moderate depression.<sup>121</sup> One in three visits to a GP relates to a mental health issue, and one in six people will suffer from a mental health problem at some stage in their life. In total, mental health problems cost the UK around £77 billion a year.

In 2003, the General Health Questionnaire found that 11% of men and 15% of women showed evidence of possible psychiatric ill health. This percentage increased as household income decreased, particularly in men. Research has also shown that African/Caribbean British people are more likely to be diagnosed with a psychotic illness than white British people.<sup>122</sup>

Death rates for conditions including coronary heart disease and stroke are higher than average for people with severe mental illness, who die on average of five to 10 years younger than other people. People with a diagnosis of schizophrenia or bi-polar disorder are also more than twice as likely to have diabetes and more likely to experience coronary heart disease, stroke and hypertension.<sup>123</sup>

Suicide mortality rates have fallen in recent years. In 1997, around 12 people per 100,000 died from suicide, whereas in 2004 the number was less than 11.<sup>124</sup> This has resulted in 350 lives saved every year.<sup>125</sup>

### Alcohol misuse

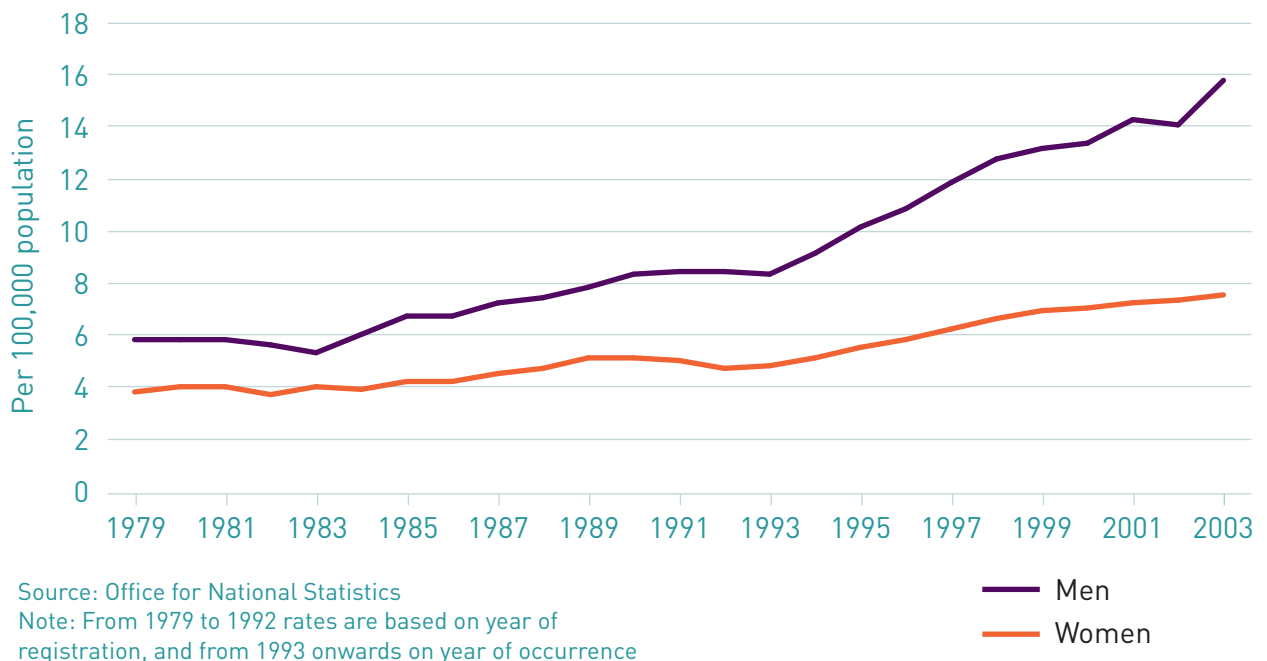
Alcohol-related deaths in the UK almost doubled between 1991 and 2005, from 6.9 to 12.9 per 100,000.<sup>126</sup> In 2005, there were over 6,500 alcohol-related deaths in England and Wales. This figure has remained relatively stable since 2003.<sup>127</sup>

The number of people admitted to hospital for alcohol-related reasons has risen by more than 80% in the last 10 years, to 180,000 in 2005/2006.<sup>128</sup> The risks of developing liver disease, stroke and a range of other conditions are significantly higher for men who drink more than eight units of alcohol a day and women who drink more than six units (One unit of alcohol is equivalent to one small glass of wine, one pub measure of spirits or half a pint of normal strength beer.)

The amount of alcohol consumed by people in the UK was fairly constant in the 1980s and 1990s, but it has been rising since.<sup>129</sup> In 2005, people in the UK consumed an average 11.3 litres of alcohol, compared to 9.4 litres in 1995 and 9.3 litres in 1985.<sup>130</sup> Latest data suggests that the UK average is slightly higher than the EU, which in 2003 was 11 litres.<sup>131</sup>

Young people aged 16 to 24 are significantly more likely than other age groups to consume more than twice the recommended amount of alcohol. This excessive drinking is more common in highly deprived areas and analysis by the Department of Health has shown that the rate of alcohol-related deaths is about 45% higher than in other areas.

There have been no targets for the NHS relating to alcohol misuse, although this has recently been addressed with the introduction of a public service delivery agreement. This focuses on reducing the harm caused by the misuse of alcohol and drugs, including an indicator on reducing the rate of hospital admissions due to alcohol.<sup>132</sup>

**Figure 10: Alcohol-related mortality rates, England and Wales 1979-2003**

### Poor sexual health

There has been a significant increase in cases of sexually transmitted infections (STIs) in both England and Wales over the last 10 years.

Between 1997 and 2005, the number of diagnosed cases of HIV increased from 2,700 to almost 7,500 in the UK<sup>133</sup>, although some of this increase could be due to increased numbers coming forward for testing. In the same period the number of cases of AIDS and deaths from HIV/AIDS decreased to a third of the former rate. Particular communities are at greater risk of HIV, including gay men and other men who have sex with men (but who do not identify themselves as gay) and people who have acquired HIV abroad, including African community members. In 2005 there were 2356 new HIV diagnoses among men who have sex with men, representing an increase of 59% since 1995.<sup>134</sup>

Cases of chlamydia, which can cause infertility in both women and men, rose

by more than 300%, from 35,840 to 109,958, although this could in part be the result of better screening and detection programmes. Young men and women aged between 16 and 24 are most at risk of chlamydia<sup>135</sup>. Although far less prevalent, the incidence of gonorrhoea increased substantially to around 30,000 new cases in 2002, but the incidence has since reduced by about 25%.<sup>136</sup>

In the UK between 1998 and 2004, rates of diagnoses of infectious syphilis in males increased by 1,520%.<sup>137</sup> This is largely as a result of a number of localised outbreaks that occurred during this period.

The number of new sexually transmitted infections diagnosed in genito-urinary medicine clinics in the UK rose by 2% from 368,341 in 2005 to 376,508 in 2006.

### Long-term conditions

Around 27% of people in England and Wales report having a limiting long-term illness.<sup>138</sup> These are conditions that cannot

yet be cured, but can be controlled by medication and other therapies. They can lead to premature death and have a considerable impact on a person's quality of life if managed poorly. Examples include diabetes, arthritis, asthma, heart disease and neurological conditions such as epilepsy and Parkinson's disease.<sup>139</sup> Tackling lifestyle factors such as obesity and smoking would help to reduce the prevalence of some long-term conditions.

The Government aims to improve care for people with long-term conditions by moving away from hospital care when major problems emerge, towards a more preventative, patient-centred approach. The target is to reduce by 5% the number of days that people with long-term conditions go into hospital as emergency patients in 2008.

During 2006/2007, we reviewed NHS services for people with heart failure and diabetes. Our key findings and recommendations are outlined below.

### Addressing poor health

In England, PCTs are responsible for the healthcare services in their local communities, and to do this they must have a robust understanding of the population they serve. They plan and purchase the services they need from a variety of providers, including NHS hospital trusts, private and voluntary providers, and independent contractors such as GPs. As part of the annual health check, the Healthcare Commission assesses how well PCTs are meeting the standards set by the Department of Health in *Standards for Better Health*.

In Wales, local health boards are responsible for planning how healthcare is delivered and for assessing their own performance against the *Healthcare Standards for Wales*.

### Urgent care for the big killers

From our assessments, we know that PCTs are making significant improvements in tackling the more urgent health problems.

For example, there has been a considerable improvement in the speed with which people with suspected cancer receive help. Very few patients now wait more than two weeks between an urgent referral from their GP and their first outpatient appointment with a clinician. Also, very few wait longer than a month between diagnosis and starting treatment. The two-month urgent referral to treatment target has traditionally proved more challenging. However, the improvements have been impressive. In 2006/2007, 95% of PCTs achieved the target, compared to 58% in the previous year. At the end of 2006/2007, 97% of patients began treatment within two months, compared to 75% at the end of 2004/2005.

In Wales, patients referred with urgent suspected cancer should, if diagnosed, start definitive treatment within two months, while other patients not referred as urgent but consequently diagnosed with cancer should start treatment within one month of diagnosis.<sup>140</sup> The latest figures for Wales, for the quarter ending June 2007, show that 91% of patients newly diagnosed with cancer via the 'urgent suspected cancer' route started definitive treatment within two months, and 97% of other diagnosed patients started definitive treatment within one month.<sup>141</sup>

In England, good progress is being made to hit the 2010 target of substantially reducing cancer mortality in people under 75 by at least 20%. Eighty-nine per cent of PCTs were on track to achieve this as measured in 2006/2007, although this is a slight reduction on the previous year.

This year, 97% of PCTs achieved their plans for reducing deaths from cardiovascular disease, in line with the target to reduce

# 97%

of people diagnosed with cancer began treatment within two months

mortality from these diseases by at least 40% by 2010.

Since 2003/2004 the proportion of people suffering a heart attack who received thrombolysis (clot dissolving drugs) within 60 minutes has risen from 49% to 64%. Early data for 2007/2008 continue to show progress. Primary angioplasty services continue to expand as an alternative to thrombolysis.

All patients needing revascularisation, to restore blood flow through blocked arteries, were being seen within three months.

### Treating long-term conditions

An important goal for the NHS is to help people with long-term conditions to play an active part in managing their health. We found that PCTs in England could be doing more in this area. For example, up-to-date practice-based registers of those at risk can help direct the right treatment to people with diabetes or heart disease. It also enables PCTs to effectively identify future requirements. This year, only 60 of the 152 PCTs achieved the practice-based registers part of the target, with as many as 81 (53%) failing it. This is worse than the 40% failure rate recorded last year. The range of performance is wide, with 24 PCTs having no GP practices with a validated register at all, and 37 PCTs achieving more than planned.

Patients with complex long-term conditions often need to use hospital services more frequently if their condition is not managed

well through primary care. People in lower socio-economic groups are more likely to be diagnosed with more than one condition, which can present additional challenges. In 2006/2007, only a third of PCTs met the target for the number of people with long-term conditions under the care of a community matron or case manager, which resulted in 60,000 people not gaining access to these services as planned. This disappointing performance is even worse than last year, when only 39% achieved the indicator. Slightly more encouragingly, PCTs in the most deprived areas outperformed other PCTs (40% on target as against 26%).

In 2006, we reviewed services in England for people with diabetes and for people with heart failure. We were pleased to see that both studies identified areas where trusts are providing a good level of basic care.

In our review of diabetes services, we rated 73% of PCTs as “fair”, 11% as “good” and 5% as “excellent”. Patients in all of these PCTs are being given yearly check-ups and relevant tests, such as for long-term blood sugar levels and blood pressure. Where there were good commissioning arrangements in place, people are more likely to receive the support they need, such as access to education programmes for managing diabetes. However, our diabetes review found that in 85% of PCTs (those rated as “fair” and “poor”), these arrangements were not in place. Education programmes for people with diabetes are recommended by the National Institute for Health and Clinical Excellence.<sup>142</sup>

Our review of heart failure services revealed considerable progress since 2003/2004 in the diagnosis and management of the condition. The majority of communities assessed in the review, comprising PCTs and their affiliated hospital units, were rated as “good” (53%) or “excellent” (9%). Twenty-nine per cent were rated as “fair” and 9% “weak”.

The review found that nearly all patients (92.5%) were having their condition confirmed by echocardiograph, a key diagnostic test that either confirms or refutes a diagnosis of heart failure. However, concern was expressed that a significant number of people with heart failure may not have been identified. For the 204 trusts that provided the data, there were 140,000 fewer people reported as having been diagnosed with heart failure than expected. This could represent problems with recording patient data or a failure to diagnose.

We also found that most communities had some form of specialist service for patients with heart failure – 81.6% had a specialist nursing service and 86.5% of acute services had a lead consultant.

However, both reviews identified unacceptable variations in general practices' achievements within PCTs, meaning some people were getting better care than others. We recommend that PCTs look closely at their general practices, for example through the Quality and Outcomes Framework data, to determine where performance can be improved. (See the case study on differences in primary care opposite.)

We also found that the organisations need to work more closely together to reduce emergency admissions to hospital. In 2005/2006 there were over 75,000 episodes of inpatient hospital treatment with a main diagnosis of diabetes, 62% of which were emergencies.<sup>143</sup>

In addition, there needs to be a closer relationship with the patient when healthcare professionals are planning care for people with long-term conditions. We found that professionals were not discussing their care with patients, or agreeing a joint plan for managing their conditions.

The number of people attending education courses, or being given information to improve their understanding of their condition, needs to increase. For example, we found that while most people with diabetes who smoke were offered advice about how to quit, the number of people with diabetes who had not attended an education course on diabetes care, but would like to, ranged from 16% at one trust to 41% at another.

## Preventative healthcare

Our assessments showed a mixed picture on the progress being made by healthcare services in preventing illness and improving public health.

We found that most PCTs in England have basic disease prevention and health improvement programmes in place to address key public health issues. In 2006/2007 96.7% met this standard, an increase of 3.7% on 2005/2006.

This year we assessed PCTs in England on a developmental standard for public health, as part of a pilot exercise. The standard requires trusts to identify significant public health problems and health inequalities and act upon them. Of the PCTs that reported, 34.3% said their progress was "excellent" (2.8%) or "good" (31.5%), 58% described their progress as "fair" and for 7.7% it was "limited".

This would suggest that while NHS organisations in England are getting the basics right, some PCTs are struggling to address the broader and more long-term health improvement agenda. This is further evidenced by worsening performance on a number of specific public health targets.

Addressing these shortfalls will require greater strategic focus, more effective use of information and much stronger two-way communication with patients, the

Case study

Differences in primary care

This year, the Healthcare Commission conducted a piece of analysis looking at how different types of GP practices performed in relation to key indicators for diabetes and coronary heart disease, and whether GP performance was associated with any changes to hospital admissions.

Practices were grouped as follows\*:

- multi-handed practices with an older patient list
- single-handed with older patients
- multi-handed with a younger patient list
- single-handed with younger patients.

As table 6 shows, GPs serving younger populations tend to be in more deprived areas, as do the majority of single-handed practices. We found that GP practices in these areas, and particularly sole practitioners, performed relatively less well on the Quality and Outcomes

Framework outcome indicators considered (coronary heart disease and diabetes). Although not necessarily causally related, these practices were also more likely to have higher non-elective admission rates for conditions that are related to both diseases.

In recent years, the NHS has made big gains in the information available to describe quality at the most local level of the service: general practice.

The nationally negotiated GP contract is supported by a common dataset, which allows the calculation of measures of performance at GP practice level. These are collectively known as the Quality and Outcomes Framework (QOF). The Healthcare Commission does not regulate general practice, except through our assessment of PCTs, but we are interested in the challenges for PCTs in commissioning and providing

Table 6: Analysis of GP practices by deprivation index

Groups	Number of practices clustered within group	Mean index of multiple deprivation	Median index of multiple deprivation
Multi-handed practice and older patient list	2,926	19.07	15.12
Single-handed practice and older patient list	809	22.76	18.12
Multi-handed practice and younger patient list	2,739	30.27	27.18
Single-handed practice and younger patient list	1,673	34.23	32.61
Ungrouped	103		

Source: Healthcare Commission analysis

\* The groups were clustered together using the following variables: a) the number of full time equivalent partners in each practice, b) the index of multiple deprivation of the practice postcode, c) the practice demographic structure.



## Case study

### Differences in primary care

*continued*

these services. QOF data provides an opportunity for PCTs to monitor quality within their areas and to highlight variations.

Our analysis linked practice level QOF data to practice level data from Hospital Episode Statistics (HES), the national database of NHS inpatient activity, specifically in relation to indicators associated with the care of people with diabetes and coronary heart disease.

Taking coronary heart disease as an example, we found that practices with lower QOF scores for the management of blood pressure and cholesterol were more likely to be more deprived and be single-handed than higher achieving practices. The practices with lower QOF performance were also more likely to have higher hospital admission rates for acute myocardial infarction (heart attack), lower admission rates for planned admissions for angina, higher admission rates for percutaneous coronary intervention (PCI) and lower admission rates for coronary artery bypass grafts

(CABG). Collectively these indications may be indicative of unmet need, although we also recognise that deprivation and other factors (for example ethnicity) present healthcare challenges that may be outside the direct control of GPs.

It is wise to be cautious in drawing broad conclusions from the analysis about the quality of general practice. QOF data are aggregated at practice level, so it is not possible to make any causal link between QOF indicators and HES indicators and we cannot follow an individual patient along their care pathway. However, clearly there are potential benefits of practice level information in understanding and responding to local issues.

Having observed that there appears to be some variation within PCTs, further work at a local level could determine the factors behind these variations. Such work has the potential to drive further improvement in health, and to inform decision making about the commissioning and provision of services in the future.

public and clinicians over decisions about commissioning services.

#### Reducing smoking

In 2006/2007, over half of all PCTs (54%) achieved their goal for the number of patients who had not resumed smoking four weeks after quitting. However, this is a marked deterioration from the previous year, when 67% of PCTs achieved the target. PCTs in the most deprived areas notably

outperformed others nationwide – 64% of them achieved their goal.

Recording smoking prevalence is important for local healthcare providers to enable them to appropriately target future initiatives to get people to stop smoking. Fifty-eight per cent of PCTs met the target they set for GPs recording the smoking status of their patients. At a national level, 23 million people in England had their smoking status recorded, 4.5 million people fewer than planned.

In Wales, the Welsh Assembly Government has established the All Wales Smoking Cessation Service, which is run by the National Public Health Service. In 2006/2007, it had its most successful year to date with 4,757 smokers (51% of those who participated in the treatment programme) not resuming smoking four weeks after quitting.

### Tackling obesity

Success in reducing obesity does not rely on the efforts of healthcare providers alone. It needs an integrated approach over many years, as we outlined in a joint report with the National Audit Office and the Audit Commission.<sup>144</sup> Healthcare organisations, particularly PCTs, have a key role in driving improvement across sectors, as well as ensuring that their commissioning addresses this need. A lack of consistent data made it difficult for us to assess what progress was being made.

What we do know from the data collected is that, in 2007, 66% of PCTs achieved their local target for the number of GPs recording the body mass index (BMI) of 15 to 75 year olds, a deterioration from 2005/2006 when

71% of PCTs met the target. This equates to 12.5 million, or 32% of people registered with a GP in England, having had their BMI recorded in the fifteen months to March 2007, 2.3 million less than was originally planned by PCTs. It is unclear whether the local targets set for recording BMI are appropriate, and how many primary care practitioners subsequently provided advice to their overweight and obese patients.

In 2005, the Welsh Government stated in its *Climbing Higher* strategy that activity levels in Wales should “match the best global standards for levels of sport and physical activity”. The aim is for adult activity levels in Wales to increase by 1% a year until 2025 – equivalent to an additional 20,000 adults every year reaching the 30 minutes/five day a week target. However, a recent Wales Audit Office report raised concerns about the ability to measure progress against these targets.

### Improving sexual health

Through *Choosing health: making healthier choices easier*, the Department of Health made a commitment to improving people’s access to genito-urinary medicine (GUM) clinics, which provide tests and treatment for sexually transmitted infections. Our annual health check in 2006/2007 found that 68% of PCTs hit the target for providing access to GUM clinics within 48 hours, compared to 58% in 2005/2006. This resulted in 61% of people, over 37,000, accessing GUM clinics in England within the 48 hour standard (an increase of 29% on the previous year). We would hope to see continued improvements on these figures next year.

When we carried out a pilot review of sexual health services in England in 2005/2006, we found that gaps in the data available – combined with the complexity of arrangements for commissioning services – made it difficult to track improvements in



sexual health. This lack of data also limits the ability of services to target high-risk groups or allocate resources where most needed.

### Addressing mental health problems

When it comes to providing healthcare for people with mental health problems, many PCTs are struggling to commission the services needed. Although there has been a steady increase in the number of people accessing specialist community mental health services and an improvement in the range and quality of services,<sup>145</sup> PCTs are still falling short on a number of measures.

A small scale study undertaken by the Commission this year found that there was a lack of detailed assessments of local need when it came to mental health services, and that PCT funding was largely based on historical block contracts. The study found that service planning tended to concentrate on the types of service that are to be provided rather than on the appropriate amounts of these services. (See chapter 5 for further details.)

On a more positive note, the joint review of community mental health services that we undertook with the Commission for Social Care Inspection found that local implementation teams (LITs) are a good model for commissioning services.<sup>146</sup> LITs represent all those involved in mental health services, including PCT representatives.

Our annual assessment found that 20% of PCTs did not have an up-to-date local assessment of older people's mental health needs or the services available to meet those needs. A further 15% did have an assessment, but it did not include all of the information it should.

Working in partnership with others, PCTs need to make every effort to understand the demographics and mental health needs of their local population. In particular, it

is of vital importance that they work with partners to improve the pathways of mental healthcare for black and minority ethnic groups. Black people are currently more likely than other groups to enter mental health services through the criminal justice system, rather than being referred from primary care.

In mental health services, PCTs were required to recruit 500 community mental health workers by December 2006 to help improve communication between ethnic minority groups and healthcare services, as laid out in *Delivering Race Equality*. To date, 290 community development workers have been recruited.

PCTs are required to arrange treatment at home for people in crisis, as a means of reducing their need to go into hospital. The target was to provide such treatment for 100,000 people by December 2005. Eighteen months past the target date, it has nearly been met at a national level, partly because some trusts are providing more crisis resolution services than initially planned. Nonetheless, 4,500 people who are seriously mentally ill and were due to gain access to these services did not. Locally, in 2006/2007, 41% of PCTs had not commissioned the required number of crisis resolution home visits to enable them to meet this part of the target.

One in 10 people who suffers from psychosis commits suicide. Early intervention can save lives, so PCTs must ensure that people aged 16 to 24 at risk of psychosis have access to diagnoses and treatment as quickly as possible. In 2006/2007, 7,500 new cases of psychosis should have been treated as part of an early intervention programme. Around 6,900 people were helped in this way during the year – 92% of what was planned.<sup>147</sup> Locally, in 2006/2007, 52% of PCTs had achieved their part of the target, 15% had underachieved and 33% had failed.

## Case study

### Prison health

There are around 80,000 people in prison in England and Wales today. They generally have poorer health than the rest of the population. According to the latest ONS statistics, 90% of prisoners have a mental health problem, a substance misuse problem, or both, and 80% of prisoners smoke.

Prisoners are often moved between prisons due to overcrowding, for security reasons or to take part in rehabilitation programmes. This can disrupt ongoing clinical care and creates particular problems for those with long-term conditions such as diabetes and heart disease.

Before April 2003, the prison service was solely responsible for the primary care services in prisons. In April 2003, a three-year programme was launched to devolve healthcare in publicly funded prisons in England to the NHS. As a result, healthcare in English prisons is now commissioned and funded by PCTs.

The Government's core standards for the NHS apply to prison healthcare although they are inspected against the criteria laid out in HM Inspectorate of Prisons' *Expectations*. A similar process took place in Wales where the *Healthcare Standards for Wales* apply.

During 2006/2007, the Healthcare Commission visited 25 PCTs to discuss the 28 prisons and two youth offending institutions under their remit. We found that:

- Prisons did not always have up-to-date information on the health needs of their communities.
- The use of information by prison services was generally poor. There were few computerised patient records in prisons, making it difficult to monitor clinical information.
- Some good public health initiatives were in place. For example, one prison has an annual health fair.
- The training and development of healthcare workers within prisons needs to improve, especially awareness of mental illnesses and regular resuscitation training.
- Staffing levels need to be assessed by Her Majesty's Inspectorate of Prisons. Some PCTs highlighted that prisoners lacked access to dentists, occupational therapists, counsellors and mental health nurses.
- Some trusts did not have enough information to determine whether their prison health expenditure is increasing or remains unchanged as a percentage of overall spend.
- PCTs said that they were aiming to ensure that the prison population received the same access to healthcare services as everybody else. However, little work had been done by PCTs to assess whether this was taking place.
- The quality of healthcare in prisons is variable. It is better where there is a good partnership between the PCT and the prison. PCTs need to gain a better understanding of the health needs of the prisons they serve, and ensure that the services they provide are both equitable and fit for purpose.

In chapter 1, we highlight the need for people with mental health problems to have better access to psychological therapies. We also point out that people who use mental health services need to be more involved in decisions about their care. It is vitally important that these two issues are addressed if the care and treatment of people with mental health issues is to improve.



## Looking ahead: recommendations and key challenges

Healthcare services have contributed to some dramatic improvements in health of people in England and Wales over the last 20 years. However, we have concerns that the right mix of services are not always available for people with long-term conditions, or at risk of developing such conditions and that the long-term health needs of the population are not being adequately addressed.

Following the introduction of the new Local Area Agreements and in anticipation of the introduction of Comprehensive Area Assessment in 2008, healthcare organisations and local government should take advantage of new opportunities to work together more closely on health and social care services. In particular, we make the following recommendations:

- PCTs need to develop a better understanding of their populations. Information on communities' health and social care needs must be gathered in a more robust and systematic way, working jointly with local partners.

- All local health providers and their partners should work together to tackle the health issues that most affect the life expectancy and quality of life for people within their catchment areas. Tackling the growing gap between the health of people living in the most deprived and least deprived areas will be central to this work.
- PCTs and other commissioners of healthcare services should review their local prevalence of long-term conditions against national predictions, and investigate the reasons behind anomalies. Those providing services for people with long-term conditions should ensure that they all have access to the recommended medication, specialist advice, support and education in line with the NICE guidelines.
- PCTs need to do more to ensure that people with mental health problems are identified early and given appropriate support in order to reduce the likelihood of them needing inpatient care.
- There is an urgent need for comprehensive data on sexual health to allow more effective targeting of services for those who need them most.

# 3 Meeting the needs of children and young people



## There are inequalities in children's health that present long-term challenges. The NHS needs to focus more on the needs of children, and improve young people's experience when moving to adult services.

A person's health in childhood has an enormous impact on their health in later life. A child who is obese, drinks alcohol or has psychological problems is more likely to have health problems as an adult. They are also likely to die younger.

Furthermore, lifestyle habits developed in childhood and adolescence can be difficult to change in adulthood. Ensuring that children and young people are healthy is critically important for healthcare services, if further progress is to be made in improving the nation's quality of life.

Children and young people have different health needs from adults. A key test of the fitness of healthcare organisations is their ability to respond effectively to these needs. To do so, they must work in partnership with other organisations and sectors – local authorities, the probation service, schools and charities. In 2004 the Government launched *Every Child Matters: Change for Children*,<sup>148</sup> setting out an approach to children's wellbeing that is based on strong partnership working and has the aim of "... every child, whatever their background or their circumstances, to have the support they need to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing".

We have devoted a chapter of this report to children and young people for three reasons. First, we have been given a specific duty by Parliament to pay attention to their rights and welfare.

Second, we carry out a range of activities that give us insight into the progress that the NHS has made with child health.

Our work on national targets, our review of services for children in hospital, our contributions to joint area reviews and the inspections of youth offending teams – all of these have been invaluable in understanding the issue.

Third, it is timely. Earlier this year, UNICEF published a study *Child poverty in perspective: an overview of child wellbeing in rich countries*.<sup>149</sup> This ranked 21 industrialised nations on six dimensions of child wellbeing. The UK had the worst average ranking overall, and came in the bottom third for five out of the six dimensions. One of these was 'subjective wellbeing' – children's own perceptions of their health. The UK came in the middle third for only 'health and safety', which includes measures on infant mortality, immunisation and accidents – and this was still below the average for countries within the Organisation for Economic Co-operation and Development (OECD). While it is true that much of the information used in that report is now several years old, the findings are a stark reminder of how much more must be done to secure the future health of children.

The National Service Framework for Children, Young People and Maternity Services was published in 2004<sup>150</sup> and sets out a 10-year programme for improving children's health and services. The framework includes standards relating to health promotion, child-focused services, safeguarding children, children in hospital and children with mental health problems.

In this chapter, we draw on our findings, and those of other bodies and our colleagues



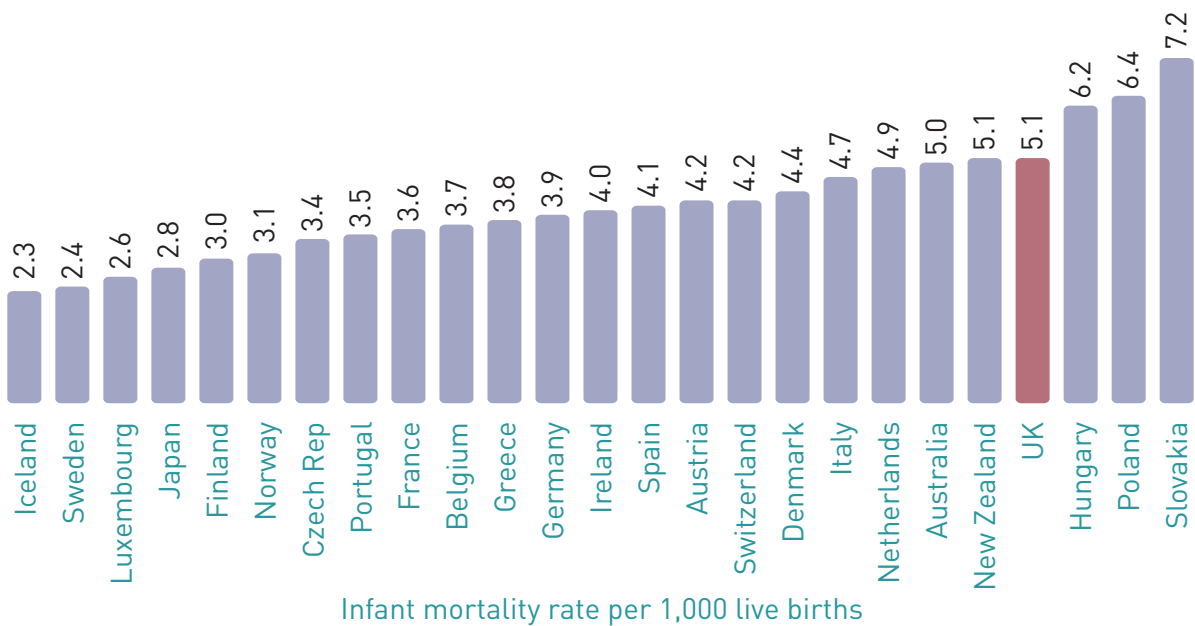
in Wales, to describe progress in some of these areas. We have found that:

- Inequalities in children’s health and outcomes, and the increasing prevalence of obesity, diabetes and problem drinking, present significant long-term challenges for the NHS.
- The quality of acute hospital services for children is variable. The needs of children using these services are generally well met by specialist paediatric and inpatient services, but across the range of acute hospital services, children are less well served. We have found too many areas of weakness and, in a substantial minority of hospitals, levels of activity, training and emergency cover are so low as to put children at unnecessary risk.
- Mental health services for children and young people are developing, but local services are not always fully in place and there are weaknesses in access.
- Partnership working for the health and wellbeing of children is variable. The most vulnerable groups, and those with complex needs, often fail to get the support they need.
- One in 20 NHS trusts in England is not compliant with child protection standards. Levels of training in child protection in acute hospital services are poor and there are weaknesses in child protection arrangements in Wales. We are concerned that these problems could place children at increased risk of serious harm, as instances of abuse may not be detected.
- Young people making the transition from children’s services to adult services are poorly served.

### Widening inequalities

The main measures of health in early childhood – infant mortality and life expectancy at birth – present a mixed

Figure 11: Infant mortality, OECD countries 2005



Source: OECD, 2007

Note: Chart excludes Canada, South Korea and USA (no data) and for reasons of scale, Mexico (18.8) and Turkey (23.6)

picture. The infant mortality rate (death within a year of birth) in England and Wales is at an all-time low. In 2003-2005, it was five deaths per 1,000 live births<sup>151</sup> – as recently as 1976 the rate was 14 deaths per 1,000.<sup>152</sup> Such improvements are common to most developed countries however, and the UK still has a comparatively high rate.

Much of this improvement is due to medical advances, for instance in the care of premature babies. There is a greater awareness of sudden unexpected death in infancy ('cot death'). Parents have a better understanding of nutrition during pregnancy, and of the harmful effects of smoking and drinking.

But while infant mortality rates have improved across all groups in society, the improvement is uneven. In families of people who work in 'routine and manual' jobs, infant mortality rates are down to six deaths per 1,000.<sup>153</sup> This is good news in absolute terms, but things are not improving as quickly for this group as for the population as a whole. This 'inequalities gap' appears to be widening and other gaps can also be seen – for example, infant mortality for babies with mothers under 20 is 60% higher than for babies of older mothers aged 20 to 39. In 2002-2004, the infant mortality rate for mothers under 20 was 7.9 per 1,000 live births.<sup>154</sup>

Life expectancy at birth continues to rise in England. The average for females in 2002-2004 was 81 years; for males it was 77 years. Here also, the inequalities gap is widening. In the 20% of districts with the worst health and deprivation indicators, these figures fall to 79 and 75 years respectively.<sup>155</sup>

The Government has set a target for 2010, restated to the NHS in 2004, to reduce health inequalities by 10%, as measured by infant mortality and life expectancy at birth. Recent trends suggest that neither element of this target is on track to be met.

## Health in infancy

There is strong evidence to show that the health of children is improved if their mothers breastfeed and do not smoke during pregnancy.<sup>156</sup>

Here, the NHS in England is doing better year-on-year. Our target assessments showed an overall breastfeeding initiation rate of 68%, up from 62% in 2004/2005, and the percentage of women who smoke during pregnancy has dropped slightly, from 17% in 2004/2005 to 16% in 2006/2007.

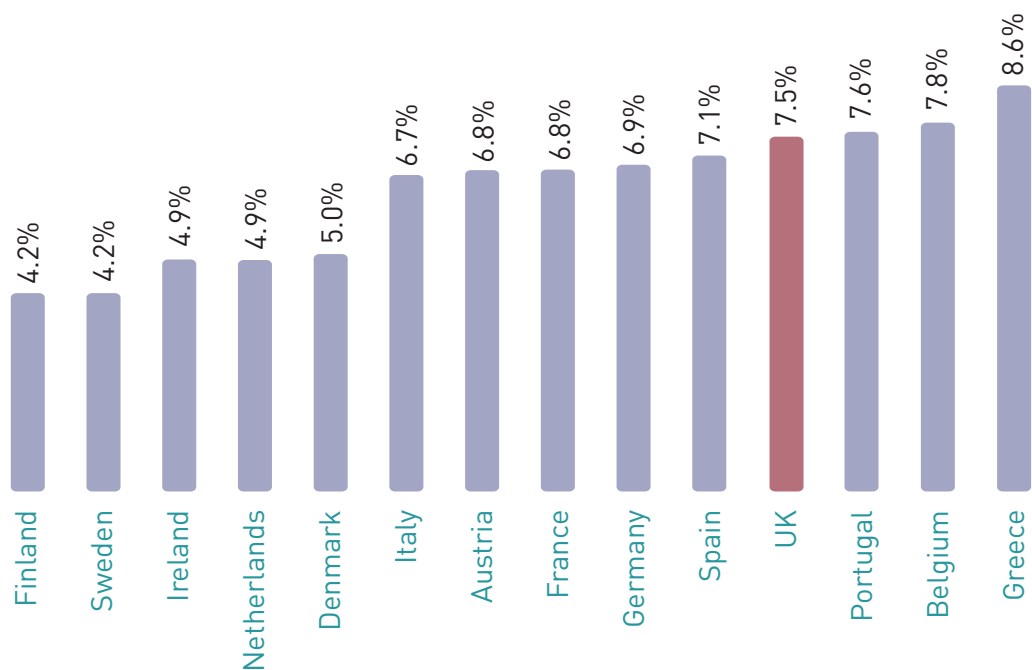
Again, however, there is a clear inequalities gap. For PCTs in the most deprived areas, the breastfeeding initiation rate is 62% and 18% of women smoke during pregnancy. In other PCTs, the rates are 74% and 14% respectively. Although both groups of PCTs are performing well against their local plans, this is within very different contexts.

The length of time that a mother breastfeeds can also have a positive impact on the health of her child, and a period of four to six months exclusively breastfeeding is usually considered ideal. The *Infant Feeding Survey*<sup>157</sup> suggests that up to 78% of mothers in England and 67% in Wales start to breastfeed. Most of these mothers are still breastfeeding at six weeks (64% in England, 55% in Wales) but by four months only a minority are doing so (45% in England, 36% in Wales).<sup>158</sup>

Although the *Infant Feeding Survey* provides extremely valuable information, there is no routine collection of data on actual rates of duration of breastfeeding. This needs to be addressed. While the national target provides a clear incentive for trusts to encourage mothers to start breastfeeding, there is currently no way of testing how well they help mothers to continue.

Babies of mothers who smoke during pregnancy are more likely to be born prematurely, are twice as likely to have a

Figure 12: Low birth weight in 14 EU countries, 2004



Source OECD, 2007

Note: Based on EU15 group, Luxembourg excluded from comparison due to lack of data

low birth weight, and are up to three times as likely to die from sudden unexpected death in infancy. Smoking in pregnancy increases infant mortality by about 40% and is much higher among routine and manual workers. Forty-five per cent of mothers under the age of 20 smoke throughout their pregnancy – a rate that is almost three times higher than for all mothers.<sup>159</sup>

Immunisation in the early years is another key step in the protection of children from damaging and often life-threatening illnesses. Around 93% of children who reached the age of two during 2006/2007 had been immunised against diphtheria, tetanus, polio and other diseases.<sup>160</sup>

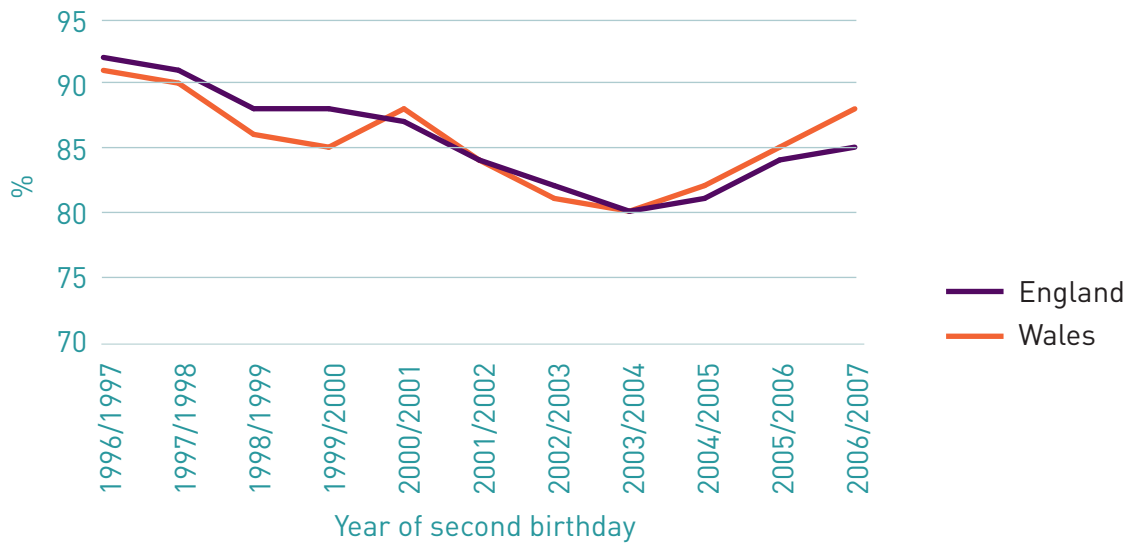
Take-up of the combined measles, mumps and rubella vaccination (MMR) has, for well-documented reasons, been lower in recent years, but rates are increasing again. In England in 2006/2007, 85% of all children aged two had received the vaccine, up from

84% the previous year. This is still short of the peak of 92% in 1996/1997, but continues the upward trend since the low of 80% in 2003/2004. Although this is encouraging, low uptake in previous years has led to a rise in cases of measles in England (480 between January and August 2007, and 756 in 2006, the highest number recorded since the current methods of monitoring began in 1995). At least 90% of children need to be immune in order to halt the spread of measles.<sup>161</sup> The World Health Organisation target for coverage is 95%.<sup>162</sup> 2006/2007 data for Wales shows that MMR uptake at two years old was 88%. Rates of uptake are lowest in mid and west Wales and highest in south east Wales.<sup>163</sup>

### The effects of deprivation

The effects of deprivation are noticeable in many areas of children and young people's health. The rise in obesity (see

Figure 13: MMR immunisation rates, England and Wales 1996-2007



Source: NHS Immunisation Statistics 2006/2007- Information Centre  
National Public Health Service for Wales, National Assembly for Wales

Figure 14: Measles immunisation rates in 15 EU countries, 2004



Source OECD, 2007

below) affects all children but may be more prevalent in children from less well-off backgrounds.<sup>164</sup>

The most recent survey of the mental health of children and young people, carried out in 2004, found that 10% of five to 16-year olds had a diagnosed mental disorder. Taking almost every measure associated with deprivation – low educational achievement, unemployment, receipt of disability benefit – the more deprived the family, the more likely the child is to suffer a mental health problem.<sup>165</sup>

Accidental injuries are a major cause of death in childhood. They kill three children in 100,000 every year, a rate similar to cancer. In England, there are two million accident and emergency (A&E) attendances by children each year, in 2004/2005 there were 120,000 admissions to hospital in the 0-14 age group as a result of unintentional injury.<sup>166</sup>

In 2006, we carried out a review with the Audit Commission looking at prevention of injury to children. Although the overall number of deaths had fallen, we found persistent and widening differences between socio-economic groups. For instance, children of parents who had never worked, or who were unemployed long-term, were 13 times more likely to die from unintentional injury than children of parents in higher managerial and professional occupations.<sup>167</sup>

Teenage pregnancy is another area where there are marked inequalities. The Government launched its teenage pregnancy strategy for England in 1999. This included a target to halve the under-18 rate of conception by 2010. The most recent information available is for 2005: the rate for 15 to 17-year olds has fallen from 46.6 per 1,000 girls to 41.1 per 1,000. This is an overall decline of 12% and the rate is at a 20-year low – but it is some way off meeting the target.<sup>168</sup>



Results from the 2006/2007 annual health check, using 2005 data, show that just 51% of PCTs are on track to deliver their agreed 2010 reductions. The remaining 49% are either falling short of the reductions needed or are showing increased rates. However, just 44% of the PCTs in the most deprived areas are on track, compared with 57% in the rest.<sup>169</sup>

## Obesity

Obesity in childhood is increasing and is forecast to get worse. This is a very serious problem. There is a strong association between obesity and the major causes of premature death in adulthood, such as heart disease, stroke and certain cancers. Obesity can also be a contributory factor in other serious conditions, such as type 2 diabetes.

Data from the Health Survey for England show that among boys aged two to 15, the proportion that were obese increased from 11% in 1995 to 18% in 2005, and among girls from 12% to 18%. Around a third of both boys and girls aged two to 15 are overweight or obese.

Children from less well-off backgrounds are more likely to be overweight or obese. If both their parents are obese or overweight, they are more likely than other children to be obese or overweight themselves.

In 2004 the Government set a national target for England to “halt the year-on-year rise in obesity among children under 11 by 2010”. Current forecasts estimate that among boys aged six to 10, obesity will rise from 17% in 2005 to 19% in 2010, and among girls of the same age from 14% to 24%.<sup>170</sup> Late in 2007, the Government announced a new long-term ambition to replace this target, aiming to ‘reverse the rising tide of obesity and overweight in the population’ with an initial focus on children and by 2020 reducing the proportion of overweight and obese children to 2000 levels.<sup>171</sup>

The problem of childhood obesity is compounded by difficulties in getting an accurate picture at local levels. The Government has established a National Child Measurement Database in an effort to track the problem, but the database is still developing and is not yet a robust source of information on prevalence (though coverage has improved greatly since the database was established in 2005/2006).

## Diabetes

The Government report *Making Every Young Person with Diabetes Matter* states that all types of diabetes are increasing among children and young people. Type 1 diabetes is increasing in all age groups, but particularly in the under-fives. The rising proportion of children with type 2 diabetes is probably linked to higher levels of obesity.<sup>172</sup>

The management of diabetes in children and young people is significantly different and more complex than it is for adults. The National Institute for Health and Clinical Excellence (NICE) clinical guidelines state that for children and young people with type

1 diabetes, the target for long-term blood sugar control is an HbA1c level of 7.5% “without frequent disabling hypoglycaemia”. The 2005/2006 National Diabetes Audit, covering both England and Wales, suggests that this is achieved for only 17% of under-16s with diabetes. The audit also found that only 16% of 12 to 15-year olds with diabetes received eye and foot examinations, and just 17% had their cholesterol checked in the audit year.<sup>173</sup>

In 2007, DiabetesE (a national audit tool used by two-thirds of PCTs) reported that, in nearly all PCTs, long-term care of children and young people with the disease is managed by a paediatrician with a special interest in diabetes. However, it found that access to other support services and specialist advice was variable. Children and young people with diabetes are given access to a trained paediatric psychologist or counsellor in only 55% of PCTs. In a third of PCTs, children and their families do not have access to a structured education programme.<sup>174</sup>

In its report *Your Local Care 2005*, the charity Diabetes UK found that provision was stretched, with an average caseload of 100 children for each paediatric diabetes nurse. The maximum recommended ratio for many models of care is 70 patients per full-time nurse. The charity also found that up to half of PCTs did not have adequate systems for transferring young people to adult care.<sup>175</sup>

## Drinking alcohol

Drinking is becoming more of a problem for a minority of children. Generally children aged 11-15 are now less likely than five years ago to be regular drinkers, and a higher proportion of children aged 11-15 report that they have never drunk an alcoholic drink (46% in 2006 compared with 39% in 2001).

However, between 1990 and 2000, the average weekly consumption for drinkers

in this age group almost doubled. In 2006 it stood at 11.4 units (roughly equivalent to five and a half pints of beer at 4% abv). Among child drinkers aged 11-13, average weekly consumption has increased from 5.6 units in 2001 to 10.1 units in 2006. In 2005/2006, 4,060 children under the age of 16 were admitted to NHS hospitals with a main diagnosis that was alcohol-related – an increase of 29% since 1995/1996.<sup>176</sup>

### Smoking and drug use

There has been a welcome reduction in the proportion of children who smoke. Figures for 2006/2007 suggest that the Government has achieved its long-term target for England for reducing smoking among 11 to 15-year olds to 9% well in advance of the 2010 target date.

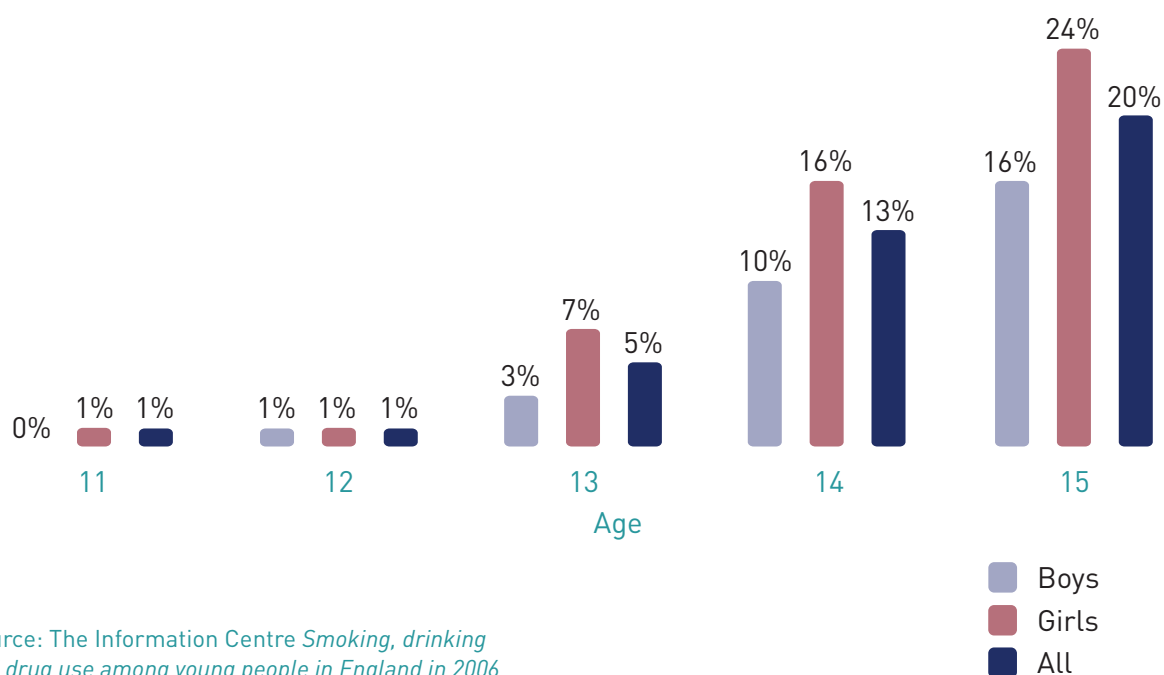
In 2006, 9% of young people aged 11-15 smoked at least one cigarette a week. This percentage has been steady since 2003. In 1996, the percentage was 13%. In 2006, 61% of 11-15s said they had never smoked,

compared with 47% in 1982. Smoking remains more prevalent among girls than boys, with the most recent figures standing at 10% for girls and 7% for boys.<sup>177</sup> There is a sharp increase in smoking as children get older, as illustrated in figure 15. In 2007, the legal age for the sale of tobacco products was increased from 16 to 18 years old.

The proportion of secondary school children who report that they have taken drugs has fallen slightly since 2001. In 2006, 17% of pupils said they had taken drugs in the preceding year, compared to 20% in 2001. The proportion that reported taking class A drugs in the preceding year was 4%, unchanged since 2001. Unsurprisingly, drug taking increases with age, from 6% of 11-year olds to 29% of 15-year olds.

Regular drug taking, defined as at least once per month, also seems to be unchanged or decreasing, from 6% in 2003 to 4% in 2006. It is particularly positive that among pupils who truanted or were excluded, the decline is sharper, from 20% in 2003 to 11% in 2006.<sup>178</sup>

Figure 15: Proportions of pupils who were regular smokers, England 2006



## Specialist hospital services

During 2005/2006, the Healthcare Commission carried out a review of NHS hospital services for children in England, to check that acute hospital trusts were meeting or making progress towards key requirements of the hospital standard of the Children's National Service Framework (NSF).<sup>179</sup> We published our report in February 2007 and followed up work with those organisations with the greatest need for improvement.

We found that although nearly all hospital trusts had made some progress in providing child-friendly environments – such as children-only areas, appropriate security and play areas – the NHS is still struggling to meet NSF standards. The most challenging problems occur when children are treated by non-paediatric services.

While 71% of inpatient services were providing care that could be described as “good” or “excellent”, the overall quality of services for children across the range of acute hospital services was mostly “fair”, indicating that most organisations still need to improve. For both emergency and day case services, 28% of trusts scored “weak”, and 48% of trusts scored “weak” for outpatient services.

Progress in meeting the broader needs of children, including the need for play, sensitive communication and involvement in decisions about their care, was generally poor. We found a lack of training of staff in communication, and variable access to staff that specialise in play.

At a small number of trusts, our review highlighted serious concerns about the quality and safety of care, with some surgeons and units not carrying out enough work with children to maintain their skills. In a large number of services, we found that too few staff were trained in alleviating pain in children.

In 12% of hospitals, there was insufficient cover during the day to ensure that effective paediatric life support was available in serious emergencies. For night cover, this figure rose to 18%. We followed up our concerns with these hospitals.

## Mental health services

Progress has been made on mental health services for children and young people. However, local services are not always fully in place, and weaknesses in access are frequently highlighted in local inspections.

The Children's NSF estimates that in the UK around 1.1 million children and young people under 18 would benefit from specialist mental health services, and that up to 45,000 young people have a severe mental disorder. The NSF suggests that around 40% of children with a mental disorder are not currently receiving any specialist service.

In 2002, the Government set a national target of a comprehensive child and adolescent mental health service (CAMHS), to be available to anyone who needs it. The date for delivery was December 2006, and we assessed trusts against this target in the 2006/2007 annual health check. They were asked to report their progress with implementing three key services:

- 24-hour, seven days a week (24/7) cover to meet urgent needs
- a full range of CAMHS services for children and young people who have a learning disability
- a full range of CAMHS services for 16 and 17-year olds.

Generally, PCTs performed well against the target. Ninety-five per cent reported that they met the requirement for 24/7 cover, 87% delivered CAMHS for children and young people with a learning disability



and 91% provided a full range of CAMHS services for 16 and 17-year olds. Eighty-one per cent of PCTs said they commissioned all three elements.<sup>180</sup>

Other information suggests that these services are not fully established in many areas. The 2006 Children's Health and Maternity Services mapping exercise, sponsored by the Department of Health, enables us to look at the situation by local authority area.<sup>181</sup> This shows that while almost all areas have progressed beyond the planning stage and have at least some of the required services in place, they may be some way from full implementation. Only 57% of local authorities reported having 24/7 cover fully in place, 41% had services for 16 and 17-year olds fully established and just 25% were meeting in full the requirement to provide services for children and young people with a learning disability.

Joint area reviews (JARs) of children's services have in the past found weaknesses in access to services, and long waiting times for young people with both acute and moderate levels of need.<sup>182</sup> This is still an issue. JARs also highlight gaps in services for young people making the transition to adult services, and some underdevelopment of services for children and young people with learning disabilities.

The 2006 Children's Health and Maternity Services mapping exercise provides some additional data on waiting times, and this suggests that many children experience long waits for CAMHS. The data give a snapshot of the situation in November 2006 and show that while just over half of those children seen had waited four weeks or less, more than one in 10 waited 14 weeks or more. Of those still waiting to be seen, almost a quarter had been waiting 14 weeks or more, and one in 10 of the children had been on the list for six months or more. Waiting times for CAMHS services are not included in the Government's waiting times targets.



The Healthcare Commission in 2007 carried out a small-scale study of value for money in child and adolescent mental health services in England. This suggests that the NHS is not commissioning CAMHS in an 'informed' way. We have found that assessments of local needs are limited and do not seem to address in detail any gaps between local needs and local services. Plans appear to be based on perceived shortfalls in individual services, rather than an overview of all services and their relative contribution. Development of services is more driven by providers than would be expected, given the separation in the NHS between commissioners and providers, and this has led to a complex set of services which may not always make sense to their users.

We have found little evidence of clear and effective management of caseloads and costs. There is also evidence of a wide variation in spending, caseloads and workloads, one that is not explained by variation in needs. Some information on outcomes is collected, but there is little sign that it is used to allocate resources and increase value for money.<sup>183</sup>

## Case study

## Experiencing child and adolescent mental health services

While preparing this report, we asked a group of young people in the South West of England to tell us about their experiences of mental health services. The group was fairly small, and so we can't conclude that all of their experiences are typical, but the issues they raised help us to understand better how services can feel from a user's perspective.

### On first getting help:

"I had a major breakdown at 16 and was referred. The doctor told me there was nothing wrong with me and I should go back to school. I couldn't face going and I had a self-harm issue... I didn't want to know [about services], I didn't want to break silence. When I did go, there were four people and I had no idea who they were – suited and booted with notebooks... I felt paranoid and scared."

"We were not told what services were available. I just had to deal with it with my mum. I didn't know anything about psychosis until I went to the early intervention unit."

"I was 12 when my mum first said I needed to see someone – it took eight months before I did."

### On dealing with mental health professionals:

"You have to tell your story over and over – it makes you feel worse."

"They don't understand that what you're feeling is very real to you... they just say you're imagining it."

"I phoned my CPN [community psychiatric nurse] because I wasn't feeling well. I am supposed to see her every week, but haven't for four months. She just sent me a list of agencies and said 'see if one of these can help you'."

"My CPN asked which things were getting me down most and dealt with those first."

"She's [support, time and recovery worker] part of the mental health team, but more social than clinical... you could talk to her like a friend – someone who helps you get back on your feet."

### On medication:

"When I went to the doctor, no information [about the medication] was really given to me, but when I went to early intervention they had a list of medications and side effects."

"It was horrible – the early intervention team took me off my medication and I was just hearing aliens talking to me... I was sleeping in the day, walking around at night; I kept getting picked up by the police... I got sectioned... they let me out after a week, but then I was arrested again a week later."

### On counselling:

"I was offered lots of stuff, but I didn't take anything because I didn't understand. After my diagnosis they just forgot about me."

"I got chucked into it. I didn't really want it."



## Case study

# Experiencing child and adolescent mental health services

*continued*

### On family:

“One psychiatrist threw my mum out – my mum was furious. That was my security gone and I had to tell my life story all on my own.”

“When I saw my psychiatrist I had my CPN there and my mum.”

“My parents were given a social worker, but they don’t see her anymore because according to them I’m getting better... but I don’t feel like I’m getting better.”

### On being involved:

“The school referred me. I was being talked about, but no-one was talking to me.”

“I would have liked to be asked my opinion about my own treatment. I feel my parents have been told by my psychiatrist not to trust me.”

“They decided to discharge me, but they didn’t tell me that was going to happen.”

### On inpatient wards:

“Everyone was older than me. I was 18. I couldn’t relate to the other people.”

“I didn’t feel I could talk to them [staff]. They just leave you for hours. One of the other patients threatened to kill me – I locked the door and they came and unlocked it.”

### On the physical environment in CAMHS services:

“Always smells like a hospital – they could get some bean bags or something and make it more homely.”

“There’s bars on the windows – it’s like saying ‘you’re not getting out of this!’ Doors all have combination locks – it’s like you’re a risk already.”

“The room was very clinical and I felt very paranoid as there was a two-way mirror and I felt someone was watching me.”

### On moving into adult mental health services:

“They’ve got child services and then adult – there’s nothing in between. There needs to be someone to help.”

“I’m treated as being more grown up than I am. I was expected to know why I feel what I do, asked when I first started going downhill... I can’t answer questions like that.”

“I had moved away from [home town] because of family problems. They gave me a list to give to my new GP and expected me to sort out my support, they moved me to adult services with no support.”

The lack of clear information on outcomes in CAMHS is a long-standing issue. The Department of Health and the Information Centre for Health and Social Care are developing a new national minimum data set for CAMHS, which should, in future, provide valuable information on the quality of services and the outcomes experienced by young people using these services.

### Working in partnership

The Healthcare Commission takes part in two inspection programmes that focus on partnership working for the wellbeing of children. These are the inspections into youth offending teams (YOTs) led by HM Inspectorate of Probation and the joint area reviews (JARs) of children’s services led by Ofsted.

### Youth offending teams

Children and young people who offend usually have more health needs than those who do not. In the 31 YOT inspections that took place during 2006/2007 we found that around a third of children and young people with physical or emotional health needs, and around a quarter of those misusing drugs or alcohol, did not appear to have been referred to the appropriate services.<sup>184</sup>

In 2006/2007, we saw some improvements in health services’ involvement in the management of YOTs, though this was still inconsistent. Health priorities for

children and young people were much more likely to be reflected in wider plans for children’s services, as outlined in our 2006 report *Let’s talk about it*, published jointly with HM Inspectorate of Probation. However, at an operational level, YOT workers and health professionals have in many cases successfully developed working relationships.

Our inspections in 2006/2007 have continued to find problems with the sharing of information between YOTs and health workers. Separate file systems and unnecessary restrictions placed on access to information were clearly hampering communication. In some instances, our inspections found that health staff were being used to manage generic cases, or were given additional duties that undermined their specialist role of ensuring that children and young people who offend have access to healthcare services. We also found that good working practices were being undermined by longstanding vacancies and lengthy recruitment processes.

Assessment and intervention relating to physical health needs is still a problem. This was too often seen as a low priority, resulting in potentially significant needs remaining hidden. We found that where physical health assessments were done, they were often cursory and carried out by workers who were not qualified or who had not had enough training.

**Table 7: Youth offending team inspections, 2006/2007**

	Evidence of need	Evidence of appropriate referral
Physical health needs	15%	67%
Emotional or mental health needs	41%	70%
Drug misuse	40%	
Alcohol misuse	35%	74%

Source: HM Inspectorate of Probation

We have found continued under-resourcing by health services in a substantial minority of YOTs – a quarter of those inspected during 2006/2007 were not resourced to the levels expected by the Youth Justice Board. It is also concerning that, in too many areas, there are inadequate or non-existent service level agreements and protocols between YOTs and health providers.

### Joint area reviews

Led by Ofsted, JARS look at the ways in which local services, such as health, education and social services, contribute to the wellbeing of children and young people. The reviews relate to the five outcome areas defined in the Government's *Every Child Matters* initiative, with the Healthcare Commission contributing to the 'Being Healthy' area.

In April 2007, Ofsted published a summary report based on the findings of the first 37 JARS carried out before the end of March 2006.<sup>185</sup> These found that local councils and their partners were generally making good contributions to improving the health of children. In the very best areas, services were working well together to bring a clearer focus to tackling health inequalities and targeting the needs of vulnerable people. The National Healthy Schools Programme was being widely adopted, with more schools achieving the National Healthy Schools Standard.

However, the report highlighted a common area of weakness: the inequality of provision between different areas and different groups of children and young people. This includes, in many areas, poor monitoring and assessment of the needs of vulnerable groups – in particular disabled children, looked after children and young offenders, especially as they make the transition to adulthood. The report also noted that partnership working had yet to demonstrate improvement in key health outcomes, such

as reducing obesity levels, although there was some evidence of progress in reducing teenage pregnancies.

The JARS carried out since March 2006 have tended to echo these earlier findings. They have also highlighted other strengths, in school-based health education programmes and the provision of more accessible sexual health services for young people. In the better areas, joint working has improved mental health services, with a single point of access resulting in more effective support for children and young people.

Unfortunately, there are still too many examples of weakness in CAMHS. There are continuing problems with access, including long waiting times and gaps in provision for young people moving from CAMHS to adult services. Furthermore, CAMHS for children and young people with learning disabilities are frequently underdeveloped.<sup>186</sup>

### Palliative care for children

In 2006, the Government requested an independent review of services in England for children and young people who have life-limiting conditions and require palliative care.<sup>187</sup> The review showed that they and their families are being failed in this important area. Individual instances of good practice and provision aside, the system is characterised by a poor understanding of young patients' needs and ineffective working between the agencies responsible for providing care and support.

# 5%

of NHS trusts in England were not compliant with the main child protection standard

The review suggests that there are huge variations in the availability of palliative care services across England. There is a lack of access to 24/7 community-based support, leaving children and their families with little option but to make unplanned use of A&E and inpatient hospital care. The support and care available at the end of life is similarly patchy. Despite the clear preference of most families for their child to be supported in dying at home, three-quarters of them die in hospital.

Inter-agency working was identified as an area of weakness. Families and the children and young people themselves are often subjected to multiple assessments, but then receive no resulting service. Families too often found themselves falling into the gap between health services and social care. The review also raises concerns about the lack of services to manage the transition from paediatric to adult services. This becomes increasingly important as advances in medical care mean that children and young people with such conditions are living longer.

## Child protection

The protection of children is getting better, but we still have concerns.

In England, core standard C2 requires that “healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations”. For 2006/2007, compliance with this was 95%. Core standard C10a requires that NHS trusts assure themselves that they undertake criminal records bureau (CRB) checks for all staff and students. In 2006/2007, 95% of trusts were compliant. This still leaves around one in 20 trusts that are not compliant with child protection standards.

For the independent sector in England, national minimum standard C13 sets out

to ensure that children receiving treatment are protected effectively from abuse. Across all providers, 2.5% were not compliant with the standard. This rises to 5.1% for acute providers.

Standard 17 of the *Healthcare Standards for Wales* requires healthcare organisations to “comply with national child protection and vulnerable adult guidance within their own activities and in their dealings with other organisations”. During 2007, for the first time, all NHS organisations in Wales were required to make a self-assessment and public declaration against this standard.

Safeguarding and promoting the welfare of children requires good joint working at a local level. Local safeguarding children boards (LSCBs) are designed to help ensure this happens. They include local authorities, health organisations, the police and others. As part of our annual health check, we invited LSCBs to comment on the declarations made by NHS trusts against standard C2.

Of the third of LSCBs to respond, the majority (88%) supported trusts’ declarations of compliance. However, they raised issues around the involvement and representation of trusts on LSCBs, particularly the lack of seniority of some representatives. The child protection training delivered by LSCBs was another theme, including the involvement of trusts in interagency training and training uptake. There were concerns around staff not being released for training, particularly where this was due to financial pressures or staffing issues.<sup>188</sup>

## Training in child protection

All NHS staff in England should be receiving basic (level one) training in child protection, including knowing whom to contact with concerns about the welfare or treatment of a child, and annual training updates. Our 2006 review of NHS hospital services for

children<sup>189</sup> found that the levels of training were often not up to standard. Ideally, 95% of nurses in any one service should be trained. However, just 60% of nurses had up-to-date training in basic child protection and 58% (632) of services nationally did not meet the standard.

Levels of basic training among surgeons and anaesthetists working with children were generally poor, with an unacceptably high proportion of trusts reporting that none of their surgeons or anaesthetists was trained:

- 62% of trusts reported that none of their general surgeons were trained in basic child protection
- 53% of trusts reported that none of their orthopaedic surgeons were trained
- 58% of trusts reported that none of their ear, nose and throat surgeons were trained
- 46% of trusts reported that none of their anaesthetists were trained.

Some members of staff require intermediate (level 2) training. This equips staff to recognise the signs and symptoms of abuse. Ideally, 95% of nurses in inpatient and A&E departments, and one nurse on each shift in day case and outpatient care, should be trained to level two. However, across all services in which children are seen, just 37% of nurses had received level two training and 70% of services did not meet the standard. We are particularly concerned about the situation in A&E, given the nature of the work, where 85% of departments were not up to standard.

The level of training among paediatric staff, who usually lead on child protection issues, was comparatively good: 71% of paediatricians (consultants, specialist registrars and nurse consultants) had received relevant training in child protection to level two or above.

In general, we found significant and unexplained variations in the delivery of child protection training across trusts in England. Given the findings of the inquiry into the death of Victoria Climbié, published in 2003, this is a real cause for concern.

In 2005/2006, Healthcare Inspectorate Wales (HIW) carried out a review of child protection arrangements across NHS Wales.<sup>190</sup> Their national report, published in March 2007, concluded that “the protection and safeguarding of young people is taken very seriously across NHS Wales” and praised the commitment and enthusiasm of NHS Wales staff, “who applied the principles of child protection in their everyday working practices”. The review found that the physical security in place in children’s wards and maternity units was generally good, and that inpatient facilities for young children were also good.

However, the HIW’s review identified a number of areas for improvement. These included weaknesses in relation to enhanced CRB checks and training, poor information sharing between A&E departments and difficulties in accessing the child protection register out of hours. Also, commissioners of children’s specialist services “relied on the provider’s stated arrangements for protecting children and did not follow up placements with a visit to check on child protection arrangements”.

The review highlighted particular issues relating to the protection of adolescents. With the exception of three NHS trusts with dedicated facilities, adolescents had to choose between staying on a children’s ward and an adult ward. This is especially problematic for adolescents with mental health problems, and the HIW review team noted that staff on mental health wards had not always received child protection training. The placement of adolescents on children’s wards has potential safety implications for the care of other children in the ward.

Where child protection training programmes had been implemented, staff who had been in post for many years did not always take up the training. For example, some medical staff, of varying grades, were found to have not attended child protection training, even when it was mandatory.

### Looking ahead: recommendations and key challenges

While we have found instances of good or excellent healthcare for children and young people, the quality of services is still much too uneven. We therefore make the following recommendations:

- NHS trusts need to do more to ensure that they have good systems for the protection of children, including comprehensive and up-to-date training for staff working with children.
- NHS trusts, PCTs and their partners should carry out work to:
  - Evaluate the experience of young people with continuing care needs who make the transition from children's services to adult services.
  - Improve the experience of transition.
- NHS trusts, PCTs and their partners should do more to understand and meet the needs of the most vulnerable children and young people, and those with the most complex needs.



# 4 Developing a culture of safety



## The safety of patients and staff is vital, but healthcare providers have yet to fully embrace a culture of safety. The NHS is making some headway in the fight against MRSA and *C. difficile*.

The safety of patients and staff should be a central consideration for organisations that commission and deliver healthcare services. It is a major focus for the Healthcare Commission.

Managing risks, and informing patients about them, is an integral part of the day-to-day work of doctors, nurses and other healthcare professionals. Patients are safer in organisations that support staff in the constant challenge of minimising risk and that are keen to learn from their mistakes.

Our understanding of safety in healthcare comes from a number of sources. These include our assessments against national standards, mandatory collections of data on healthcare associated infections, surveys of patients and staff, inspection visits under the new 'hygiene code', our investigations into serious service failures, and data from our partner organisations such as the National Patient Safety Agency (NPSA), the NHS Litigation Authority and the Health and Safety Executive.

In our *State of Healthcare 2006*, we urged healthcare organisations to place a more consistent emphasis on safety. Since then, the Department of Health has published *Safety First*, a major review of the NHS's approach to safety, and we have stepped up our activity in the area. In this chapter, we present an overview of current safety issues in healthcare and set out what progress is being made towards a strong culture of safety. Overall, we have found that:

- In healthcare the culture of safety is showing signs of progress, but is not yet

strong enough, and we are concerned that there are still barriers, either real or perceived, for staff in reporting incidents that affect the safety of patients or staff.

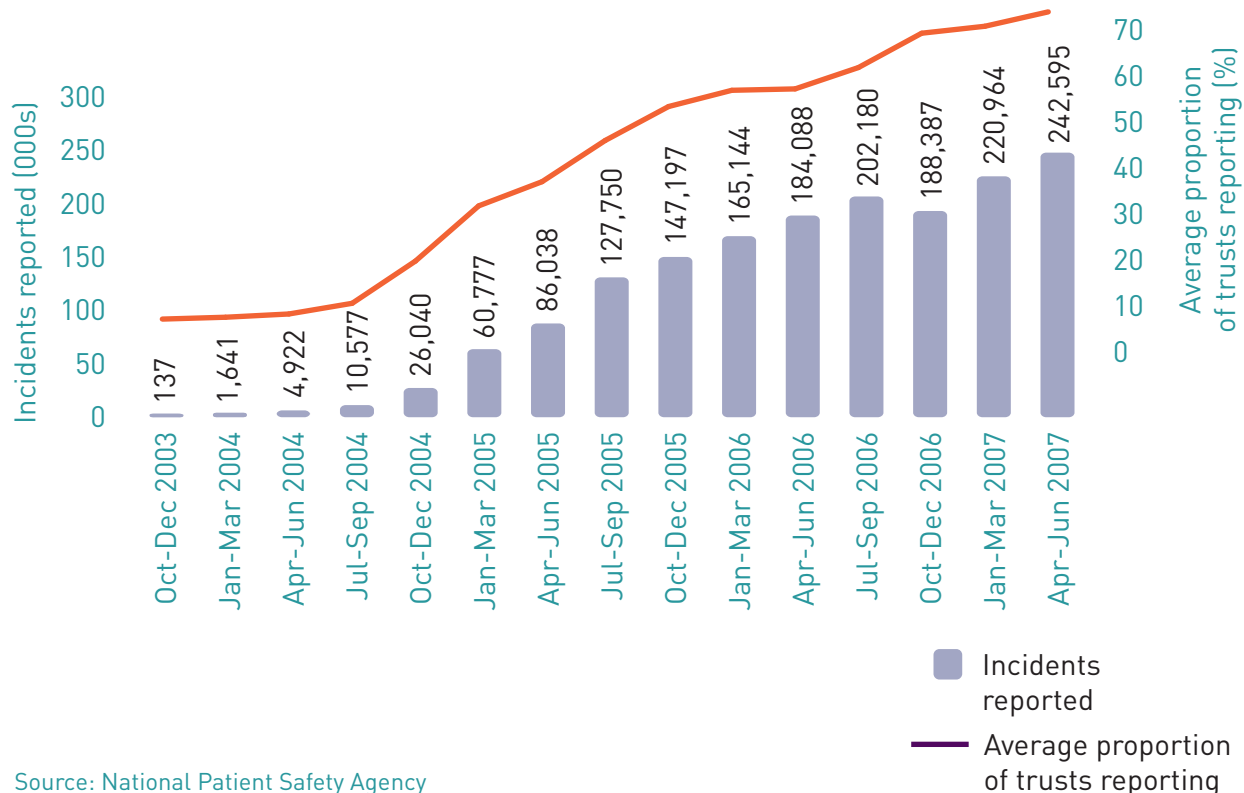
- Infection control remains an area of concern. The NHS must remain vigilant and follow best practice for tackling healthcare associated infections. However, there are grounds for cautious optimism that the NHS is having an impact on MRSA and *Clostridium difficile*.
- Arrangements for keeping vulnerable adults safe from abuse are too often weak.
- Levels of violence and abuse remain too high and are too often tolerated, but the situation in mental health wards for adults of working age appears to be getting better.

### Culture of safety

All serious incidents can lead to improvements in safety and care, through a process of learning and education. This depends on a strong and positive culture of safety – one in which staff are able to recognise risks, know how to report them, feel confident that they will be supported by their employers and see their organisations learning from the experience.

More patient safety incidents are being reported by trusts. The NPSA operates the National Reporting and Learning System (NRLS), through which NHS trusts are encouraged to report incidents. Since the NRLS began operating in 2003, the number of incidents reported has increased each year – at 30 June 2007, the total

**Figure 16: Incidents reported through the National Reporting and Learning System, October 2003–June 2007**



number reported since inception was 1,668,437. Of these, 727,736 occurred during 2006/2007.<sup>191</sup> To put this in context, in the same year there were 11 million inpatient admissions to the NHS, close to 19 million visits to accident and emergency departments and over 13 million outpatient attendances. The increase in reported incidents is not necessarily indicative of an increase in actual incidents. More likely it is that reporting is catching up with reality.

Although reporting is still uneven, some consistent themes are emerging. By far the most common type of incident reported is 'patient accident'.

The NPSA helps to improve patient care by analysing and feeding back the information it receives. Recent examples include its advice on safer care for critically ill patients, based on an analysis of deaths

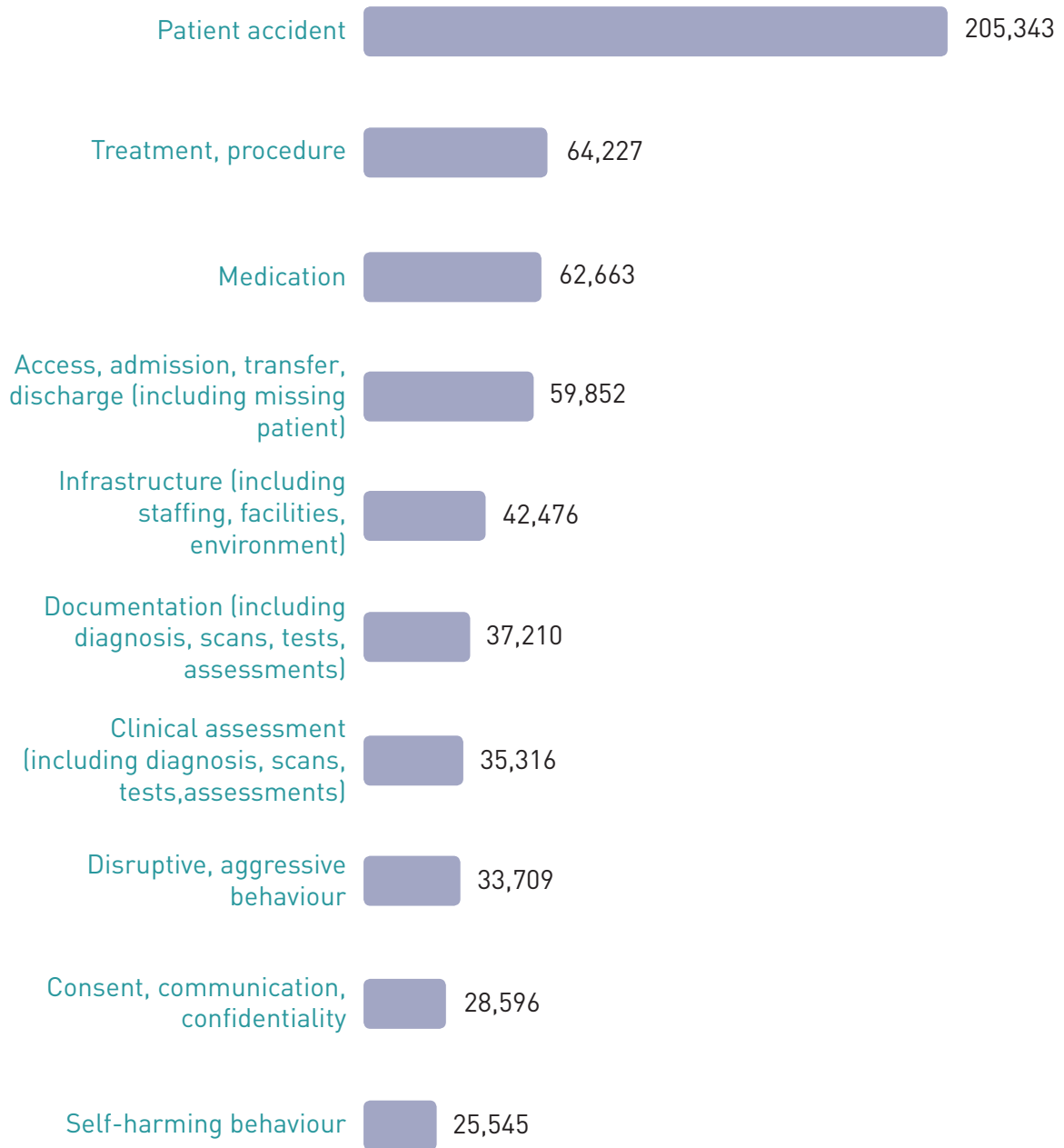
reported to the NRLS, and an analysis of incidents concerning medication with five related patient safety alerts. The NPSA also collates examples of good practice.

The vast majority of incidents reported during 2006/2007 occurred in acute and general hospitals. Reporting from ambulance services, general practice and community pharmacy is notably low (see figure 18).

Most incidents do not result in harm to patients, although there is a small minority that result in severe harm or death (see figure 19).

On 1 November 2006, the Healthcare Commission became responsible for inspecting incidents under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R), which govern the use of equipment in radiology, radiotherapy

**Figure 17: Most commonly reported incident types, April 2006-March 2007**



Source: National Patient Safety Agency

## Case study

### Learning from incidents

In March 2007, the NPSA wrote to all maternity units to alert them to an emerging theme from trust incident reports, concerning infant resuscitation equipment used at birth – known as ‘resuscitaires’. Resuscitaires are usually stocked with a range of ‘kit’, including masks, oxygen tubing, stethoscopes and laryngoscopy equipment.

Prior to this, the Jessop Wing at Sheffield Teaching Hospitals NHS Trust had conducted a review of its own incident database. They found 14 incidents and picked up similar themes to those subsequently highlighted by the NPSA, including poorly stocked resuscitaires, empty oxygen cylinders, equipment that was not connected to an oxygen supply and inadequate checking. The unit commissioned an audit and identified a number of factors leading to incidents:

- More kit was stored on the resuscitaires than would typically be used (some equipment would only be required for premature or very sick babies). This made cleaning and restocking the resuscitaires a time-consuming exercise.
- Traditionally, midwives had been responsible for cleaning and restocking, but staffing levels meant that they were not always best placed to undertake routine daily checks and cleaning.
- At times resuscitaires were inadequately stocked because items of kit were unavailable. Mainly, this was due to the disposal (in error) of non-disposable items of kit, and the fact that stock levels had not been increased to match increased use.

In response to these findings, the amount of kit routinely stored on the resuscitaires was reduced, with an emergency trolley introduced for cases where additional kit was required. Stock levels of kit were increased and changes in the type of kit stored were accompanied by training for all support staff in checking and cleaning the resuscitaires.



These actions improved things, but didn't entirely resolve the issue. In particular, there was still a problem with the availability of resuscitaires – there were two in the theatre complex but these were remote from the labour ward, and only one in the midwifery-led care area of the labour ward.

New resuscitaires were purchased for the midwifery-led care area, based on a business plan put together by staff. Disposable kit was purchased for both the obstetrics and neonatal units. This proved to be both cost effective and beneficial to patient safety, as the kit matched that used in regional newborn life-support ▶

## Case study

### Learning from incidents

*continued*

courses and was familiar to staff. The amount of kit on the resuscitaires was again reduced, and the equipment checklist was changed to make it more user-friendly. Resuscitation training became multidisciplinary.

The Clinical Risk and Complaints Co-ordinator in Jessop Wing commented afterwards: "Identifying and addressing the root causes of problems with

resuscitaires could not have progressed further without multidisciplinary teamwork led by two enthusiastic members of the neonatal team and given the full support of their midwifery and support staff colleagues. The result is that the midwifery and neonatal staff have worked together to reduce the number of resuscitaire incidents and improve the safety of babies."

and nuclear medicine. In the year since the Commission assumed this responsibility, we have held stakeholder meetings, assessed the risks in medical radiation and announced a programme of inspections in radiotherapy departments to test compliance against IR(ME)R. This programme is ongoing, with nine inspections carried out in our first year, and another 14 scheduled to be completed before the end of March 2008. In general, compliance with regulations in this high-risk area has been assessed to be good.

In addition, we receive notifications from medical establishments of exposures much greater than intended, where, for example, the wrong patients are given diagnostic x-ray examinations or the wrong parts of the body have received treatment. There have been 275 such notifications to us in our first year, which can be set against the estimated 45 million radiological examinations and treatments delivered in England annually.

In order to promote learning, we intend to publish the outcome of our first year of these responsibilities and work with professional groups to help develop their own guidance in areas of mutual interest.<sup>192</sup>

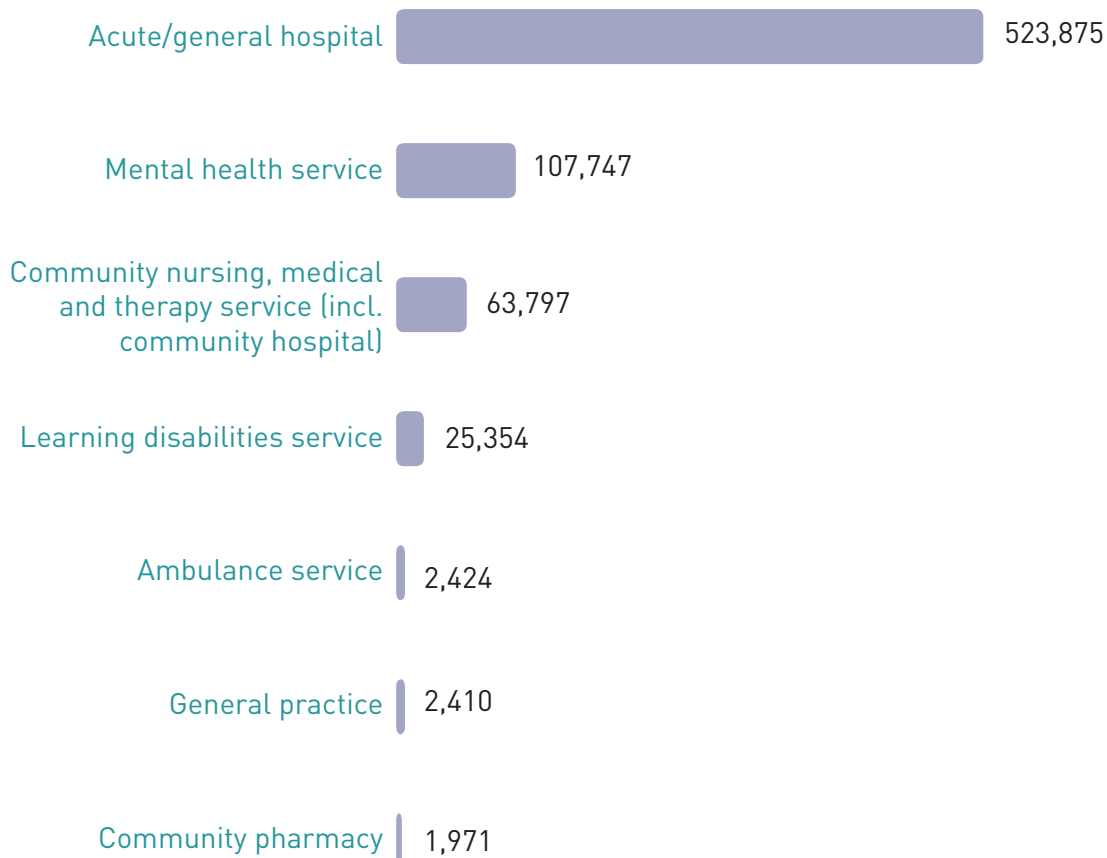
### Awareness and reporting

Findings from our 2006 NHS staff surveys suggest that fewer staff are witnessing errors, incidents or near misses that could hurt patients, service users or staff.<sup>193</sup> However, this may not necessarily be positive news, as a high rate of awareness of incidents tends to be associated with a positive safety culture. We also found that the proportion of staff who know how to report incidents has gone down since 2003. These findings applied across all types of trust, and are a cause for concern.

Staff in ambulance trusts are the most likely to witness incidents but, with the exception of ambulance paramedics and technicians, are the least likely to know how to report them. Among all frontline NHS staff, doctors are the least likely to say they have witnessed an incident involving patients or staff, and also the least likely to say that they know how to report such incidents. Staff in mental health trusts showed the sharpest fall in awareness of the need to report incidents and how to do so – from 93% to 83%.

The survey also provided valuable information about how staff view their

Figure 18: Care setting of incident reports, April 2006-March 2007



Source: National Patient Safety Agency

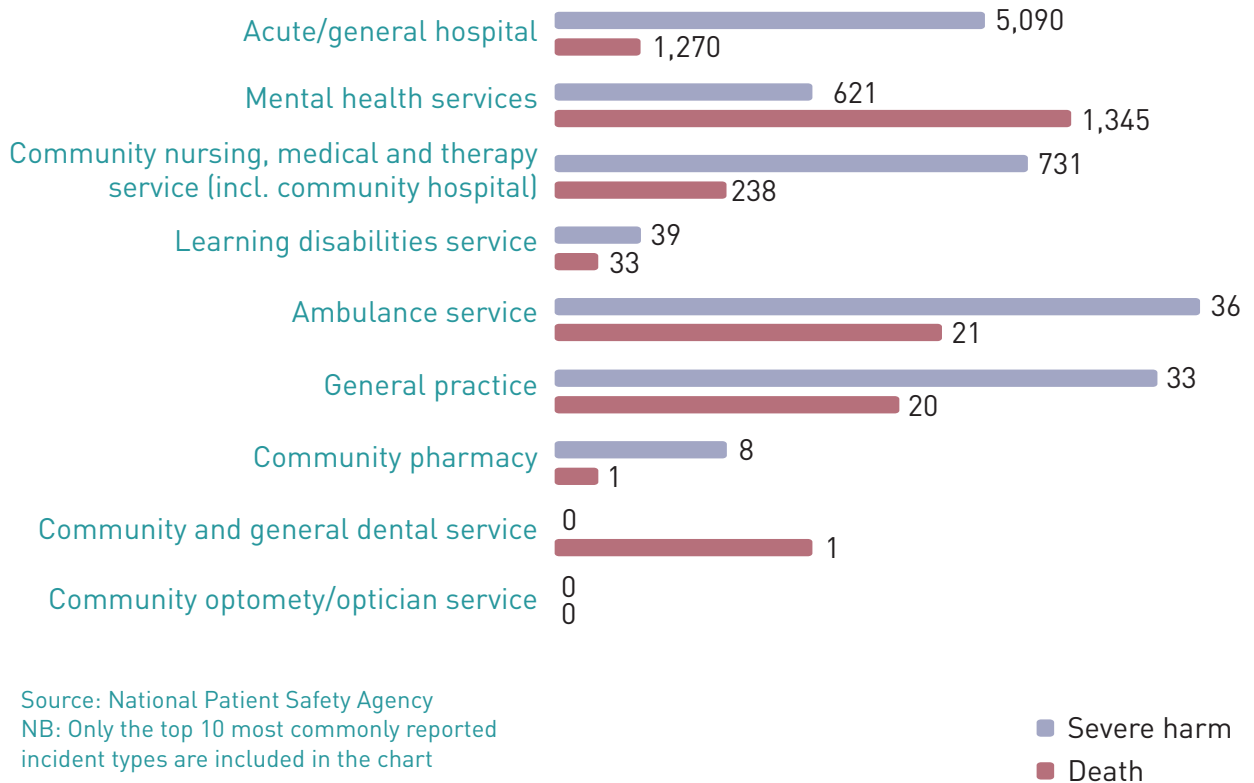
Note: Only the top 10 most commonly reported incident types are included in the chart

employer's response to errors. Overall, 42% of staff agreed, or strongly agreed, with the statement "my trust treats fairly staff who are involved in an error, near miss or incident". Given that only 6% actively disagreed with this statement, this leaves a majority of staff with a neutral response. Asked whether "my trust blames or punishes people who make errors, near misses or incidents", 38% disagreed, 10% agreed and 52% neither agreed nor disagreed. Fifty-two per cent of staff agreed

that "my trust treats reports of errors, near misses or incidents confidentially". Presented with the statement "when errors, near misses or incidents are reported, my trust takes action to ensure that they do not happen again", 49% agreed, 8% disagreed and 43% were neutral.

These relatively low levels of positive perception of the employer's response are worrying, particularly as 76% of staff agreed that "my trust encourages us to report

**Figure 19: Incidents reported that resulted in severe harm or death, April 2006–March 2007**



errors near misses or incidents”. This suggests that most staff are aware that the reporting of incidents is a corporate priority for their trust, but not all are convinced that such reporting is problem-free, or indeed useful.

### Basic standards of safety

All healthcare organisations in England and Wales are expected to meet the required standards for managing safety and risk. For the NHS in England, these are part of the Government’s *Standards for Better Health* – usually known as the ‘core standards’ – which we use in our annual assessment of NHS organisations. The independent sector in England is assessed against the Government’s national minimum standards. In Wales, each NHS organisation must

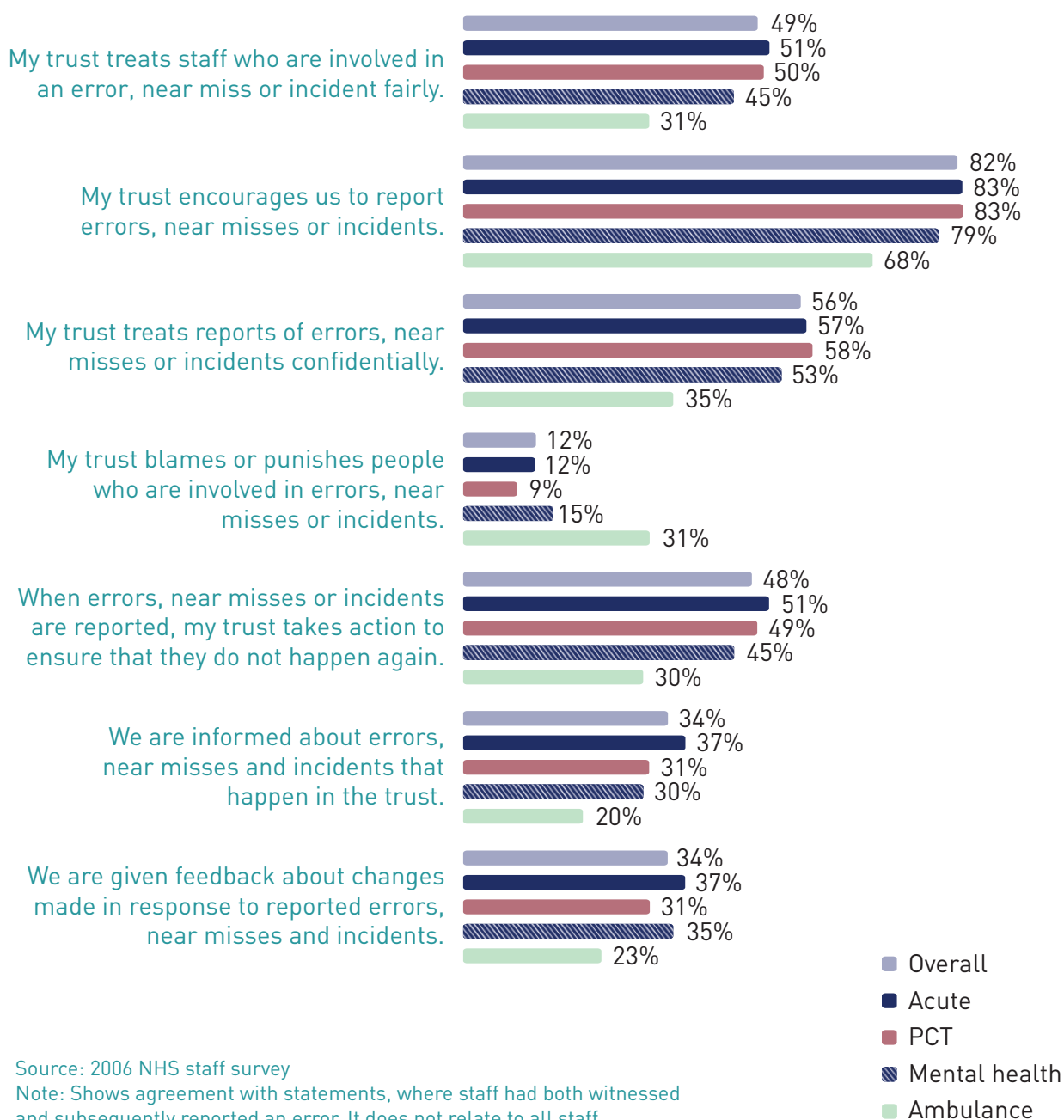
assess itself against the new *Healthcare Standards for Wales*.

In England in 2007, 58% of all NHS trusts were compliant with all applicable core standards relating to safety. Sixty-four per cent of acute trusts and 46% of PCTs were compliant with all nine of the core standards relating to safety. Seventy-seven per cent of mental health trusts and 58% of ambulance trusts were compliant with each of the eight safety standards applicable to them.<sup>194</sup>

In addition to the core standards, there is a ‘developmental’ standard relating to safety. Developmental standards outline the ways in which NHS organisations should be seeking to improve services and care above and beyond minimum requirements. The safety developmental standard is that “healthcare organisations continuously



Figure 20: Staff perceptions of employer response to incidents

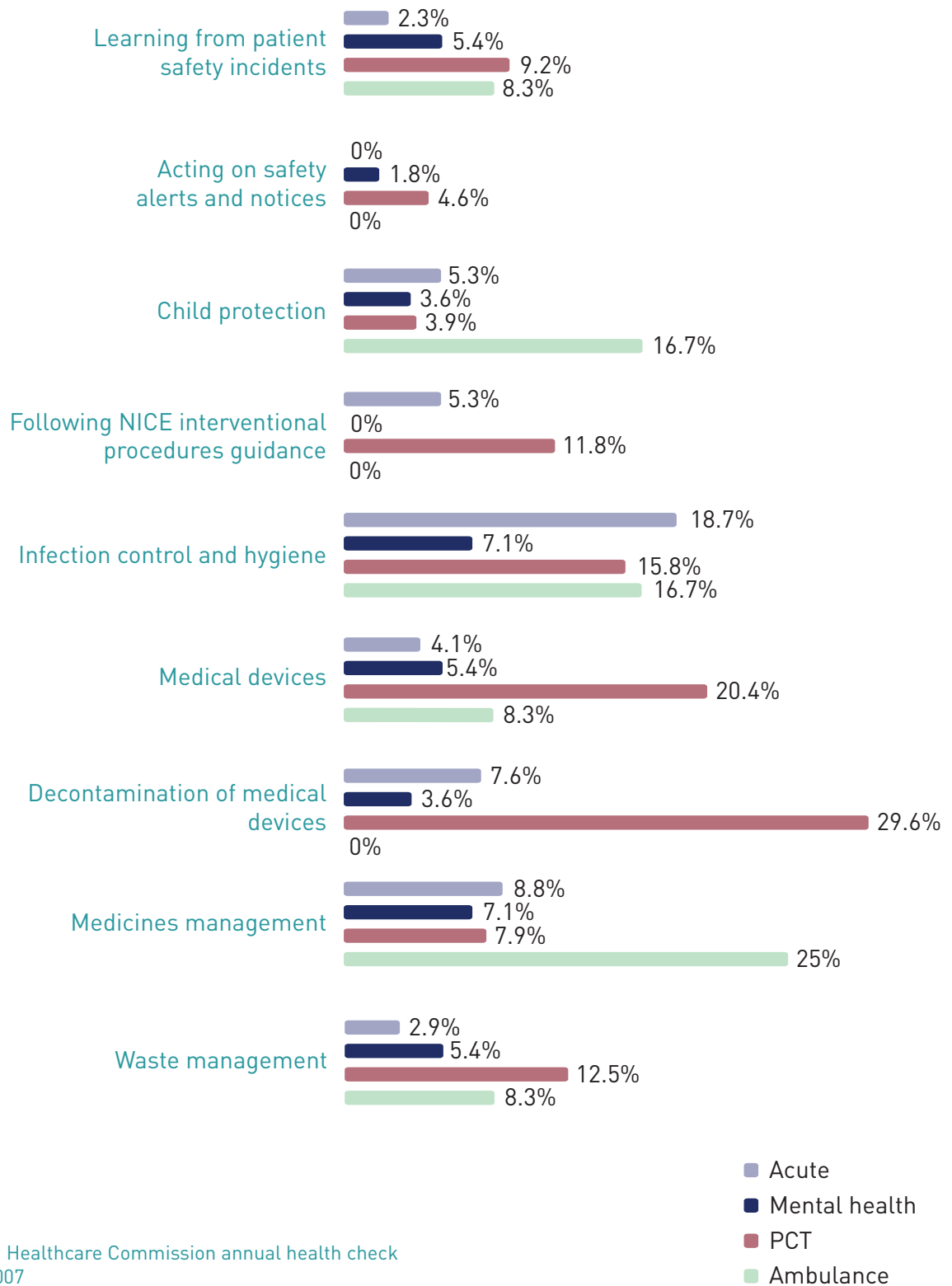


and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another”.

In 2007, as a pilot exercise, we assessed acute trusts on their progress against this. Three per cent were assessed as having made excellent progress, 32% good, 40% fair and 25% limited progress.

*Healthcare Standards for Wales* were published in 2005 and in 2007, for the first

**Figure 21: Proportion of trusts either “not met” or with “insufficient assurance” against safety core standards, 2006/2007**



Source: Healthcare Commission annual health check 2006/2007

time, NHS trusts in Wales were required to self-assess against them.

2006/2007 saw the majority of independent providers reporting that they met most of the national minimum safety standards.<sup>195</sup> Moreover, there has been a year-on-year improvement in the proportion of independent providers assessed as meeting both core minimum standards on safety and safety standards that apply to their specific types of healthcare.

The number of independent providers assessed as meeting the service-specific standard for decontamination, which requires that services have clear lines of accountability for all parts of the decontamination cycle, increased. Some are still finding this standard challenging, however, and 17% of independent acute hospitals did not meet it. There was a similar picture for endoscopy services – despite overall improvement, nearly 15% of them failed to meet the standard.

Similarly, there has been year-on-year improvement across the mental health standards on risk assessment and management, suicide prevention and the management of patients displaying aggressive and violent behaviour. However, just over 10% of mental health establishments are still failing to meet these standards.

Independent providers of mental health services need to focus more on ensuring patients are appropriately and safely restrained. Just under 9% of services failed to meet this standard in 2005/2006. This figure has risen to 17% for 2006/2007.

## Healthcare associated infections

Healthcare associated infections (HCAs), of which the two best known are meticillin resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*), continue to be a matter of great public concern.

They are the focus of concerted action by Government, national agencies and local healthcare organisations.

We assess what healthcare organisations in England are doing to tackle HCAs through the annual health check. We also enforce the *Code of Practice for the Prevention and Control of Healthcare Associated Infection* – known as the hygiene code – with which all NHS trusts in England must comply by law.

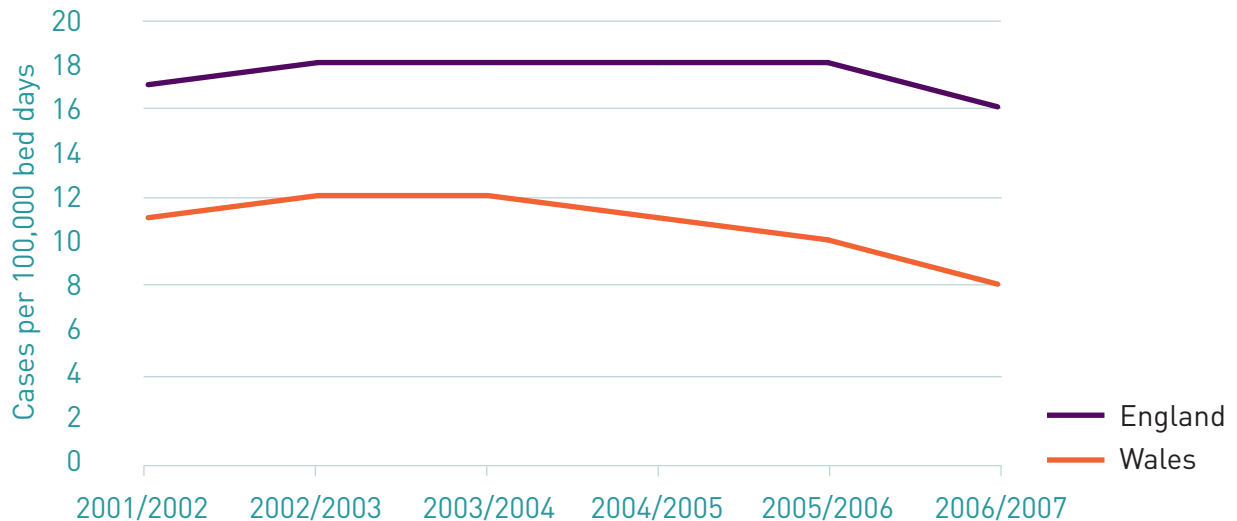
## MRSA

The most recent full-year data from the Health Protection Agency (HPA) provides positive news on MRSA in England. Cases of MRSA bloodstream infections fell by 10%, from 7,096 in 2005/2006 to 6,381 in 2006/2007. The rate of infection fell from 18 to 17 cases per 100,000 bed days.<sup>196</sup> The biggest decreases were in London, which previously had the highest number of cases, and in acute teaching trusts.

At a local level, our assessments suggest mixed progress towards meeting the Government's 2008 target for reducing infections. For 2006/2007, just 44% of NHS hospital trusts were on track to meet their reduction targets, down from 53% in 2005/2006.<sup>197</sup> This is not out of line with an overall reduction, but it does mean that many trusts have not reduced their rates by as much as had been hoped. It is therefore too early to say that the NHS is getting on top of MRSA. However, data published by the HPA in November 2007, for the period April-June 2007, showed continuing reductions in the number of infections. This gives some grounds for optimism that NHS hospital trusts will be in a much stronger position at the end of the 2007/2008 financial year.

In Wales, the rate of infection was around half of that in England, and was decreasing faster. Figures reported to the National

**Figure 22: Estimated MRSA bacteraemia rate, England and Wales  
April 2001-March 2007**



Source: Health Protection Agency, National Public Health Service for Wales, 2007

Public Health Service showed that the rate fell from 10 cases per 100,000 bed-days in 2005 to eight per 100,000 bed days in 2006. This continues the downward trend since 2002, when the rate was 12 per 100,000 bed days.<sup>198</sup>

### ***Clostridium difficile***

*C. difficile* presents a more troubling picture than MRSA. Annually surveillance data continue to show an increasing incidence in people aged over 65, with the latest figures showing a 7% increase in cases from 2005 to 2006. There were 55,620 reports of *C. difficile* in 2006, compared to 51,829 in 2005. However, this is a slower rate of increase than the 16% that was observed between 2004 and 2005. The rate for 2006 was 2.38 patient infections per 1,000 bed-days, up from 2.23 in 2005 and 1.92 in 2004.

From April 2007, mandatory surveillance of *C. difficile* infections was extended to cover patients aged less than 65. Data published by the HPA in November 2007, for the period

April-June 2007, showed a reduction in the number of infections against the previous quarter and an apparent reduction in infections against the same period in the previous year. It is to be hoped that this is an early sign of a downward trend, but data for subsequent quarters will be needed to confirm this.

In January 2005, the Welsh Assembly Government introduced mandatory surveillance of *C. difficile* in inpatients aged over 65. By 2006, the national rate per 1,000 patient admissions was 14.84, a small increase on the 2005 rate. Although rates for England and Wales are not directly comparable (English rates are calculated using patient bed days, Welsh rates using patient admissions), recent estimates suggest that *C. difficile* is less prevalent in Wales, at 1.1% of acute inpatients compared with 2% in England.<sup>199</sup>

### **Hygiene in hospital**

In 2007, we began a programme of unannounced visits to acute trusts to check

on hygiene. Where we find serious breaches of the hygiene code, we have the power to issue a statutory notice requiring trusts to make improvements.

To date, our inspections against key duties of the code suggest that trusts are taking the code seriously, and by and large are compliant. It is too early to tell what impact this work might be having on rates of infection.

By the end of October 2007, we had undertaken 87 of the 120 planned visits. We were encouraged by our findings, including the fact that only one trust needed to be issued with an improvement notice. Yet there were some areas that demand attention:

- Better governance, so that boards fully understand their responsibilities and the code is embedded in trusts' performance monitoring systems.
- Improved compliance with policies and procedures, and of staff training requirements and uptake of training.
- Provision of adequate isolation facilities.
- Compliance with policy, procedures and practices when staff are managing and caring for patients with infections or at risk of infection.

Our 2006/2007 annual health check included an indicator for non-acute trusts, testing whether they had in place basic structures and processes required under the code. Ninety-two per cent of ambulance trusts, 97% of mental health trusts and 88% of PCTs achieved the indicator.<sup>200</sup>

### Controlling infection

In July 2007, the Healthcare Commission published *Healthcare associated infection: What else can the NHS do?*, following our national study on the topic.<sup>201</sup> The study predates the introduction of the hygiene code, but our findings provide useful information on how well the NHS was

tackling HCAs up to this point. Our study showed that trusts with the highest levels of cleanliness had lower MRSA and *C. difficile* rates. However, while cleanliness is crucial, we found that other factors may well play an equally important part in tackling infections

For example, trusts with designated 'link practitioners' were likely to have lower rates of *C. difficile*. These individuals work across different clinical areas to link managers with frontline staff and ensure that policies are in place on wards. We were pleased to find that they were well established in the majority of trusts.

Trusts who gave staff 'protected' time to concentrate on infection control tended to have lower rates of HCAs. Those that shared information with their clinical teams about local rates of infection were also more likely to have lower rates of *C. difficile*. Our study also found that most trusts were acting on the results of their own internal audits – making changes to clinical protocols, to the prescribing of antibiotics and to the care environment, including arrangements for cleaning.

We nevertheless found a range of problems. Many trusts had difficulty reconciling the management of HCAs with national waiting-time targets for inpatients and those attending A&E. Others had difficulty balancing the costs of infection control with financial targets. This is a worrying echo of our investigation reports into deaths caused by *C. difficile* outbreaks (see below), where we found that managing the clinical risk of infection was given lower priority than other managerial imperatives, particularly the national targets set by Government.

There was much room for improvement in the systems trusts used to manage the risk of infection. Many did not have programmes to check that important policies on cleaning were being followed at ward level. We are also concerned that, although every trust

trained its nursing staff in the management of infection, only 11% provided equivalent training for medical staff or non-clinical staff working in clinical areas.

Trusts also need to learn more from incidents of infection. Less than half of trusts said they reported all incidents of HCAI to the National Patient Safety Agency and almost one fifth of trusts said that they did not report any. Eighty-eight per cent of trusts blamed limited IT infrastructure for restricting their ability to draw important lessons from incidents of infection.

Our annual surveys of NHS staff provide useful information on how well the NHS in England is approaching hygiene. In 2006, just 63% of staff in acute trusts said that they had hot water, soap, paper towels and alcohol rubs available to them when needed, with 55% of staff telling us that these items were also always available to patients. Although 78% of staff told us that they had received training in infection control, only 58% had received training in the preceding 12 months. In ambulance trusts, 52% of staff reported that hand-washing facilities were always available to them; 67% said they had received training, but only 36% had received it within the last year.

### Infection control in Wales

During January 2007, Healthcare Inspectorate Wales (HIW) carried out a series of unannounced spot checks to test hospitals' approach to infection control.<sup>202</sup> The inspectorate visited five NHS hospitals,

**63%**

the proportion of staff in acute trusts who said they had hot water, soap, paper towels and alcohol rubs available when needed

across four trusts, in Wales and four independent healthcare providers. They found that "while the effective management of HCAs will always be a challenge, and there is evidence of good practice in both the NHS and independent sector in dealing with HCAs, more needs to be done".

There was a high level of commitment and enthusiasm among the specialist infection control staff, and some innovative approaches to infection control procedures and wider staff training. All the organisations visited included infection control in their mandatory training programmes.

However, the review identified a number of areas for improvement. Most of the organisations felt that they needed more domestic cleaning hours. Many ward managers were unhappy at not having direct responsibility for the cleaning services on their wards. There was a general lack of administrative support for infection control, leading to specialist staff being diverted by administrative tasks. The facilities for cleaning staff to decontaminate their hands were universally poor, with basic items such as liquid soap, paper towels and alcohol gel not always available.

The HIW review is complemented by the Wales Audit Office report *Minimising Healthcare Associated Infections in NHS Trusts in Wales*.<sup>203</sup> The report notes that NHS trusts in Wales have developed frameworks within which HCAs can be managed effectively. This includes taking infection control seriously at a corporate level and putting in place the structures set out in the Welsh Assembly Government's strategy for HCAs. The report also found that screening for HCAs was being carried out in all trusts according to protocols and that most trusts were increasing their audit activity around HCAs and infection control. The report makes clear that more can be done to reduce the risk of infection, including improved collection and use of

information, better reporting arrangements and more isolation facilities. The report notes that trusts need to ensure that more staff receive high quality and appropriate training in the prevention and management of infections.

**Deficiencies in care**

The Healthcare Commission has now completed two investigations into outbreaks of *C. difficile*, at Stoke Mandeville Hospital (part of Buckinghamshire Hospitals NHS Trust) and at Maidstone and Tunbridge Wells NHS Trust. Our findings revealed a number of similarities.<sup>204</sup>

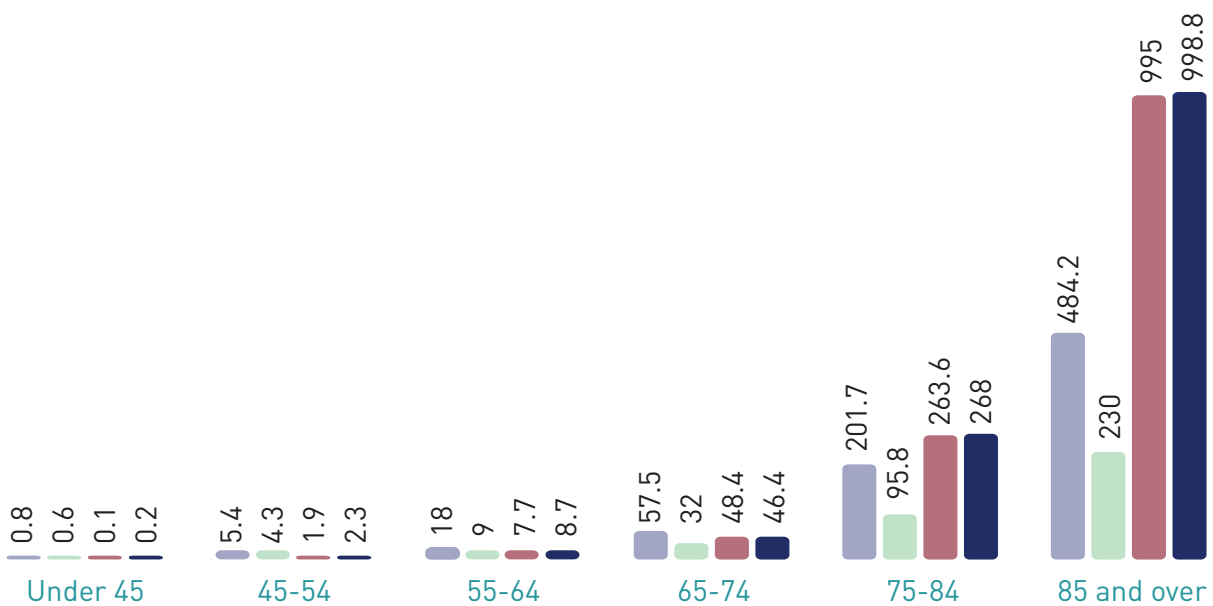
Both trusts had undergone difficult mergers. In both cases, we found a preoccupation with finances and much management time given over to issues of reconfiguration and the private finance initiative (PFI). Financial

pressures led to reductions in nursing staff and bed numbers. These reductions, coupled with pressure to meet targets relating to access, led to higher levels of bed occupancy and the use of short-term beds in unsuitable environments without adequate staff support. This seriously compromised the control of infection and the quality of clinical care.

We found poor environments and observed unacceptable examples of contamination and unhygienic practice. In both trusts, patients and relatives complained about the quality of nursing care. In the case of seriously ill patients, poor care around hygiene, medication, nutrition and hydration may have adversely affected the outcome for the patients.

The lessons of these investigations need to be taken on board by all trusts, in particular the need to prescribe antibiotics appropriately, the need for effective isolation,

**Figure 23: England & Wales mortality rates for MRSA and *C. difficile*, 2001–2005**



Mortality rates per million population

- MRSA men
- MRSA women
- C. difficile* men
- C. difficile* women

Source: ONS Health Statistics Quarterly 33, Spring 2007

the importance of scrupulous cleanliness and the need to provide high quality care to patients infected with *C. difficile*.

In both instances, managers took their eyes off the ball and neglected infection control. Having to manage competing priorities is at the heart of all management and cannot serve as an excuse for neglecting safety because of other demands.

### Recording of deaths linked to healthcare associated infections

It is not easy to estimate how many deaths are the direct result of MRSA or *C. difficile*. Those who die with these infections are usually patients who already have an illness. The most recent figures for England and Wales show that there has been an increase in the number of deaths where MRSA or *C. difficile* was reported as the underlying cause or a contributory factor. Between 2001 and 2005, mentions of MRSA on death certificates rose from 734 to 1,629. During the same period, mentions of *C. difficile* rose from 1,214 to 3,807.<sup>205</sup> A recent national study of deaths following MRSA infection, which also involved a review of case notes, found that death certificates did not always reflect the contribution of MRSA or other infections to the patient's death.<sup>206</sup>

Older patients tend to have longer stays in hospital and so are at increased risk of infection by MRSA. More than three-quarters of reported cases of MRSA bloodstream infection occur in those aged 60 or over.<sup>207</sup> Analyses of death certificates show that most deaths linked to MRSA were of people of 65 years and over, with rates increasing dramatically for both men and women over 75 years. It is more difficult to identify incidence of *C. difficile* by age group. Until April 2007, the mandatory reporting regime in England applied only to infections in the over-65s. However, there is some evidence of age-based patterns in death rates similar to those for MRSA.



### Violence and abuse

Violence, abuse, harassment and bullying are still big issues in healthcare. While we have seen some improvements in 2007, our investigations, surveys and audits describe persistent issues in this area – issues that have a negative impact on both patients and staff.

Our investigations have found examples of failing systems for safeguarding adults from abuse.<sup>208</sup> Nationally, there appears to be a poor understanding of adult protection procedures among NHS healthcare providers. We are concerned that incidents of patient-to-patient assault are too often tolerated or accepted as customary in some NHS settings, particularly in services for older people with dementia and in learning disability services.

Our investigations have also highlighted the issue of institutional abuse. Because staff can become used to ways of working that they do not recognise as abusive, it can be hard for new staff to challenge it or for unqualified staff to recognise it as poor



**Table 8: Experiences of challenging/violent behaviour in working-age adult mental health wards**

Group	Had been upset/distressed by a patient's severely challenging/violent behaviour	Threatened/made to feel unsafe	Had personally been physically assaulted
Nursing staff	58%	72%	46%
Clinical staff	37%	44%	13%
Non-clinical staff	27%	33%	8%
Patients	45%	34%	18%
Visitors	17%	14%	3%

Source: Healthcare Commission National Audit of Violence, 2007

practice. It is critical that those working with vulnerable people maintain their skills and keep up to date with best practice. We have seen instances where a failure to do this has led to poor practice, with sad consequences for the people receiving care.

Our investigations into services for people with learning disabilities prompted a larger piece of work looking at services across England. This found that less than half the units had adequate arrangements for safeguarding vulnerable people.<sup>209</sup> This is troubling. Also, while 73% of units declared that their staff knew how to make referrals to child or adult protection services, our visits did not support this level of confidence. This suggests that a substantial proportion of these organisations have an inaccurate perception of their staff's knowledge. Our visits also found mixed evidence about whether details of new staff were checked with the Criminal Records Bureau or the Protection of Vulnerable Adults Scheme.

In the audit questionnaires, the units declared low levels of reporting under whistle-blowing procedures: 537 units reported no incidents, 46 units reported one incident and just seven units reported two or more.

Our 2006/2007 National Audit of Violence<sup>210</sup> in inpatient mental health services found improvements in the capability of working-age adult services to deal with violence, though levels of violence were still high. Forty-six per cent of nurses reported that they had been physically assaulted, and 72% said they had been threatened or made to feel unsafe.

Many of those who responded to the audit reported not only the increased frequency of incidents of violence, but also the increased severity. However, when compared with data from the previous phase of the audit in 2004, the way in which staff deal with violence, both between patients and towards staff from patients, has improved in the eyes of all groups.

The audit showed that many wards had addressed environmental shortfalls, for example by improving their alarm systems (80% of nurses in acute wards rated their systems as satisfactory, compared with 55% in the previous audit), and by providing adequate space (55% of nurses in acute wards felt they had enough space, compared with 44% in 2004). However, more still needs to be done to minimise the risk of violence through reducing contributory environmental factors – too many wards lack basic safety features or are inappropriately designed,

**Table 9: Perceptions on how well staff deal with violence**

Group	Staff deal well with violence between patients (% 'yes')		Staff deal well with violence towards staff from patients (% 'yes')	
	2004	2006	2004	2006
Nursing staff	89%	93%	82%	85%
Clinical staff	83%	92%	79%	89%
Non-clinical staff	80%	96%	76%	93%
Patients	76%	81%	72%	86%
New national targets	77%	86%	72%	90%

Source: Healthcare Commission National Audit of Violence, 2007

for example with long corridors or blind spots. Too often services are provided from unsuitable buildings, either not built for their current purpose and offering little scope for improvement, or more worryingly, built recently but without taking account of the best information on safe environmental design.

More needs to be done to ensure that people living, working or spending time in wards receive the right support. Staff generally felt supported within their teams, indeed levels of satisfaction with team communication were improved for all staff groups. However, the support on offer to patients and visitors in

relation to incidents of violence was generally poor. Although the majority of serious incidents seem to be reported, less severe incidents, including threatening behaviour, may not be. Access to training for staff was found to be variable, particularly training for nursing staff in undertaking searches, training in the recording of incidents, ongoing competency training in observation for nurses and training for nurses in the use of rapid tranquillisation. Some staff were missing out on essential training due to staff shortages and funding difficulties, potentially leaving them unequipped and at risk in volatile environments.

**Table 10: Experiences of challenging/violent behaviour in older people's mental health wards**

Group	Had been upset/distressed by a patient's severely challenging/violent behaviour	Threatened/made to feel unsafe	Had personally been physically assaulted
Nursing staff	54%	66%	64%
Clinical staff	26%	30%	20%
Non-clinical staff	30%	30%	23%
Patients	29%	14%	6%
Visitors	11%	10%	5%
Carer/next of kin	43%	26%	14%

Source: Healthcare Commission National Audit of Violence, 2007

# 12%

of staff said they had experienced physical violence from patients and other users of services

It was, however, clear that recent national policies and guidance emphasising the use of prevention and de-escalation, rather than physical intervention, were more firmly embedded in practice on the wards. Staff, patients and visitors were aware of this changing culture and were responding positively to it. In the majority of wards, patients believe that staff are communicating effectively with them regarding ward procedures and the patient pathway in general. The overall picture of ward culture was one of cohesive staff teams, well-structured communication systems and strong working across different disciplines.

On older people's mental health wards, almost two-thirds of nurses reported that they had been physically assaulted by patients. A similar proportion had been threatened or made to feel unsafe. One in five clinical staff and almost one in four non-clinical staff said that they have been assaulted. Around one in 20 patients reported that they had been assaulted.

Our audit found an unacceptable level of violence, with a constant and intolerable impact on staff, patients and visitors. It was clear that the nursing staff were bearing the brunt of this and they should be applauded for the job they do in protecting others. Their work was often made more difficult by having to provide care in unsuitable environments, staff shortages, lack of access to training including in rapid tranquillisation and hands-on restraint, and lack of meaningful activities for patients.

These problems are compounded by the increasingly complex mix of residents, particularly the challenges of caring for people with dementia alongside people with functional disorders, or nursing frail older people alongside those who are relatively fit and perhaps challenging. We found that, while staff were generally part of strong teams at ward level, many did not feel adequately supported by senior managers. Supervision, or advice and support from senior colleagues, is vital. Our audit showed that there was considerable variation in the quality of this senior supervision.

The NHS staff survey told us that more than one in 10 staff have experienced physical violence from patients and service users. This proportion has changed little over the past four years. Staff in ambulance trusts and mental health trusts experience the highest levels of violence. Just under half of the ambulance paramedics and technicians who responded had experienced violence from patients in the previous 12 months, and more than one in four had experienced violence from patients' relatives. A third of registered mental health nurses and almost half of nursing and healthcare assistants working in mental health trusts said they had experienced violence from patients. Staff working in mental health trusts are among the most likely to report incidents of violence, whereas staff working in ambulance trusts are the least likely to do so. Overall, only about two-thirds of staff who experienced physical violence had reported the incident.

Incidents that affect the health and safety of staff are reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). During the period April 2003 to March 2005, there were 3,127 RIDDOR reported incidents relating to violence and aggression towards NHS staff in Great Britain.<sup>211</sup>

However, during 2005/2006 there were nearly 60,000 incidents of assault reported to the NHS Security Management Service from trusts in England. This roughly equates to one incident for every 27 members of NHS staff. Given the prevalence of violence reported in our NHS staff survey (12%), this suggests that incidents of violence and assault are under-reported both within trusts and at a national level.<sup>212</sup>

### Looking ahead: recommendations and key challenges

While there are some encouraging signs of improvement in the culture of safety in healthcare, and some grounds for optimism in relation to healthcare associated

infections, organisations can do more to protect staff and improve safety still further:

- NHS trusts must do more to promote greater awareness and confidence among staff in their safety reporting systems, and explore at a local level possible reasons for low levels of incident reporting.
- Healthcare organisations need to sharpen their focus on hygiene and the control of infection, to avoid further serious outbreaks of healthcare associated infections.
- Healthcare organisations should review their systems for safeguarding vulnerable adults from abuse, and carry out further work to reduce levels of violence experienced by patients and staff.

# 5 Improving quality and effectiveness



## While the quality of services provided by the NHS and the independent sector is getting better, the NHS in England needs to ensure that its staff keep their skills up to date and manage patients' records more efficiently.

Measuring the quality and effectiveness of healthcare is vitally important, both to check that patients and people who use services are receiving the best possible care and to promote improvement where services are found to be lacking.

It can be difficult to measure the results or 'outcomes' of many procedures and treatments because a clear measure of success cannot always be agreed or determined.

In common with other regulators and healthcare experts, the Healthcare Commission uses indicative measures – such as waiting times or compliance with national guidelines – to provide insight into the effectiveness and quality of particular services. Where possible, direct measures of effectiveness – for example death rates following a complex procedure – are also used.

Good systems for assessing clinical quality and effectiveness, such as regular participation in audit, can enable healthcare organisations to identify poor or less effective practice and take appropriate steps to bring about improvement.

In this chapter, we look at what we know about the quality and effectiveness of healthcare services in the NHS and independent sector in England. We then take a more in-depth look at specific service areas: services for people with heart problems, services for people with cancer, services for people who have had a stroke and ambulance and maternity services in Wales.

The key messages we wish to convey are:

- Most NHS trusts in England met the standard for ensuring that they were taking into account appraisals from the National Institute of Health and Clinical Excellence and nationally agreed guidance.
- The number of NHS trusts in England that could state that staff were receiving all mandatory training was not as high as it should be. However, the picture was far more positive when it came to trusts meeting the standard for ensuring that clinical staff have their skills updated.
- Not enough NHS trusts in England could state that they were managing patient records well. This was a particular concern in relation to PCTs and ambulance trusts.
- Standards in the independent sector have improved over the past year, but more work is needed in the independent mental health sector.
- There has been impressive progress in the provision of heart failure services.
- Despite improvements in people's access to cancer services, there is still wide variation in the level of care offered to patients.

### Quality and effectiveness in NHS services

#### Acute hospital trusts

In the 2006/2007 annual health check, 19% of acute hospital trusts achieved the top score of "excellent" for their quality of

services, compared to 7% last year. The proportion of trusts scoring “fair” or “weak” was similar to 2005/2006.

In our assessment of trusts against the Government’s core NHS standards, compliance against most standards exceeded 95%. However, there are some areas where further work is needed. Compliance against the standard relating to hygiene and the control of infection is discussed in chapter 4. Compliance against the standard for ensuring that staff participate in mandatory training was comparatively low at 87.7%, although it was 98.8% for acute trusts against the standard for ensuring that clinical staff continually update their skills.

The National Institute for Health and Clinical Excellence (NICE) sets best practice guidance for preventing and treating ill health. Over 93% of acute trusts were meeting the standard for taking into account NICE appraisals and nationally agreed guidelines.

Participation in clinical audit is an important way for healthcare organisations to benchmark their performance against other similar providers and to assess where they need to improve. Over 98% of acute trusts met the standard for ensuring that clinicians participate in regular clinical audit and review.

Waiting times can be used as an indicative measure of efficiency. Acute trusts generally performed well against targets for waiting times. This was most notable for people with suspected cancer (see chapter 2 for more detail).

The NHS was also on track to deliver the 2008 target for a maximum waiting time of 18 weeks from GP referral to treatment, though there was room for improvement in waiting times for diagnostic services. Acute hospital trusts performed well against the target of limiting time in

accident and emergency departments to four hours.

The cancellation of operations can reduce the efficiency of services, partly because of the resources required to cancel and reschedule operations. However, there are times when operations must be cancelled – for example, when operating theatres are needed for more urgent cases or because of lack of consultant cover. Only half the acute trusts met the target for cancelled operations, which looks at both the proportion of operations cancelled and whether patients are offered a new date within 28 days.

In 2007, for the first time, acute NHS trusts in England were asked to declare their progress against a ‘developmental’ standard on clinical and cost effectiveness. The standard addresses three main questions:

- Are trusts implementing national service frameworks or other national policies defined as best practice?
- Are trusts implementing relevant NICE guidance?
- Are trusts providing care for patients in line with their individual needs and preferences?

Fifty-three per cent of acute trusts said they were making “fair” progress, indicating that they met the requirements of one or two of the questions but not all three. Nine per cent declared that they had either made “limited” progress or were “ineligible”, having not met the linked core standards in full. This suggests that acute hospital trusts are either still some way off full implementation of nationally agreed best practice, or are not taking every step to ensure that services are provided in line with NICE guidance.

## Case study

## Value for money in mental health services in England

In 2007, we carried out a small-scale study of value for money in mental health services for adults of working age in England. This study was carried out alongside our study of children and adolescent mental health services outlined in chapter 3.

National policy and guidance, particularly the national service framework for mental health and guidance issued by NICE, have driven improvements in service development and funding and set a clear direction for mental health services. However, our study suggests that the scale of this development is variable and its effectiveness not easily demonstrated.

Across each of our study locations, we found that services were not based on detailed assessments of local need. Funding was largely based on historical block contracts and planning tended to

concentrate on the types of service to be provided rather than on the appropriate amounts of these services.

Efficiency and effectiveness were not well monitored, as data collection was limited and inconsistent across mental health services. We have found no evidence of a consistent approach to the use of information to achieve better value for money.

Overall, we found that the key stages in effective commissioning were not being followed consistently. The NHS can be confident that mental health services are broadly heading in the right direction, but can have less confidence at a local level that the scale and pace of change are appropriate, or that the right amounts of services are being effectively and efficiently delivered.<sup>213</sup>

### Mental health trusts

Mental health trusts were the best performing sector in the 2006/2007 annual health check for quality of services, and the most improved since 2005/2006, with over half scoring “excellent”. We recognise that there were relatively few targets applicable to mental health trusts, including just one in the existing national targets component. However, this is still a very positive result.

Overall, compliance with core standards was relatively high, but a number of mental health trusts have struggled with the core standards on staff participation in mandatory training, as did other types of trust. Around 82% of mental health trusts met this standard, although 98%

met the standard for ensuring clinicians continuously update their skills.

Around 93% of mental health trusts met the standard for taking into account NICE appraisals and nationally agreed guidance. All met the standard for ensuring that clinical staff participate in regular audits.

### Primary care trusts

In 2006/2007, just two PCTs were rated “excellent” for quality of services. The majority (62%) were “fair”, which indicates a level of service that is adequate, but with much room for improvement.

Although comparison is difficult, given the reconfiguration of PCTs during 2006/2007,



performance against core standards deteriorated between 2005/2006 and 2006/2007. Only 38% of PCTs fully met the standards for 2006/2007, compared with 50% the previous year.

PCTs showed high levels of compliance with the standard on arrangements for staff whistle-blowing (98%) and the standard requiring that all professionals abide by relevant codes of practice (100%).

Like other trusts, PCTs struggled with the core standards on staff participation in mandatory training – less than 80% met this standard, although 93% met the standard for ensuring clinicians continuously update their skills.

Around 82% of PCTs met the standard for ensuring that they conform to NICE appraisals and take into account nationally agreed guidance. Ninety-two per cent met the standard for ensuring that clinical staff participate in regular audits.

Good management of patient records is integral to delivering a high quality and effective service. PCTs performed poorly on the standard relating to records management – only 68.4% met the standard.

When it comes to waiting times, all PCTs met the target for a maximum two-week wait from urgent GP referral to outpatient appointment for suspected cases of cancer, and also the target for a maximum one-month wait from diagnosis to treatment. Ninety-five per cent of PCTs achieved the target for a maximum two-month wait from referral to treatment. All PCTs achieved the outpatient waiting times milestone for the 18-week maximum waiting time target.

Many PCTs are struggling to meet the mental health needs of their populations. Forty-seven per cent of PCTs failed or underachieved against the indicator for commissioning crisis resolution and

home treatment services, and 48% failed or underachieved against the indicator for commissioning services for early intervention in psychosis. A third of PCTs did not have up-to-date local assessments of the needs of, and services for, older people with mental illness.

### Ambulance trusts

Although no ambulance trusts received a score of “excellent” for the quality of services in 2006/2007, compliance exceeded 90% for most of the core standards. There were, however, several where compliance was worryingly low. Just three-quarters of ambulance trusts met the standard on medicines management. Only two-thirds achieved the standard on records management.

Around 83% of ambulance trusts met the core standards on staff participation in mandatory training, although all met the standard for ensuring clinicians continuously update their skills.

All ambulance trusts met the standard for ensuring that they conform to NICE appraisals and take into account nationally



**Table 11: Ambulance trusts – performance against existing national targets 2006/2007**

	Category A calls meeting the eight-minute target	Category A calls meeting the 19-minute target	Category B calls meeting the 19-minute target	Thrombolysis: 60-minute call to needle time
Achieved	62% of trusts	85%	31%	55%
Underachieved	38%	15%	69%	45%
Failed	0%	0%	0%	0%

Source: Healthcare Commission

Note: Figures are based on results for 13 organisations. Isle of Wight PCT also provides ambulance services.

agreed guidance. Over 83% met the standard for ensuring that clinical staff participate in regular audits.

Ambulance trusts are measured against a series of targets which act as indicators of the efficiency of the service. Their targets largely measure speed of response to urgent situations. Our review of urgent care, which we plan to publish in 2008, will add to the picture.

Table 11 above sets out the performance levels achieved for the four existing national targets for ambulance trusts.

Looking at what these figures mean for patients at a national level, just under 75% of patients were reached within the eight-minute target and 97% were reached within 19 minutes. This is broadly in line with Government expectations.

**Table 12: Volume of inspected and 'risky out' services, 2006/2007**

Type of provider	Total number of services	Number of inspection visits	% visited by service type	Total number of 'risky out' services	% 'risky out' by service type
Acute hospitals	279	243	87.1%	36	12.9%
Mental health	192	189	98.4%	3	1.6%
Private doctors	351	265	75.5%	86	24.5%
Hospices	178	85	47.8%	93	52.2%
Lasers and lights	883	695	78.7%	188	21.3%
Endoscopy	2	2	100%	0	0%
Hyperbaric oxygen chambers	43	25	58.1%	18	41.9%
IVF	17	12	70.6%	5	29.4%
Termination of pregnancy	11	11	100%	0	0%
Dialysis centre	41	29	70.8%	12	29.2%
Total	1,997	1,556	77.9%	441	22.1%

Source: Healthcare Commission

Note: Categories are overarching, and therefore while each registered establishment may provide more than one of the above types of services, they feature only once in this table.

**Table 13: Independent sector (all providers) compliance with core national minimum standards, 2006/2007 and 2005/2006**

	Met (including 'risky out' and almost met) all 32	Met (including 'risky out' and almost met) 29 or more	Failed five or more
All independent healthcare services 2006/2007	63.2%	93.4%	5.0%
All independent healthcare services 2005/2006	50.0%	85.0%	10.0%

### Quality and effectiveness in the independent sector

The *State of Healthcare* report is the only place where we publish the national data for performance in the independent sector. In *State of Healthcare 2006*, we set out our findings based on inspection visits to all registered independent sector providers in England. Since then, we have developed our methods and now target for inspection those providers that we think are at risk of not meeting particular standards or not complying with particular regulations. On this basis, in 2006/2007 we inspected 78% of registered independent healthcare establishments. Table 12 shows the numbers and proportions of providers visited and 'risky out' (that is, not visited, because we had no reason to believe they were at risk of not meeting the standard).

Independent healthcare providers are assessed against the Government's core national minimum standards. Given our move to a more risk-based approach this year, there can be no exact comparison with the results for 2005/2006. Nevertheless, we are able to draw some conclusions and identify emerging themes. Table 13 shows that overall levels of compliance with the core national minimum standards were good in 2006/2007 and appear to have improved compared to last year. The proportion that

failed five or more standards fell by half – from 10% in 2005/2006 to 5% in 2006/2007. The proportion of independent providers that met (including those that were almost met or 'risky out') all 32 standards increased from 50% in 2005/2006 to 63% in 2006/2007.

If we break these results down further by sector, we can see that independent hospices have the highest proportion of core national minimum standards either met or almost met, while independent mental health providers have the lowest proportion (see table 14). The detailed table in the appendix shows how each sector performed against each core national minimum standard.

On the basis of these assessments, we have some concerns about independent mental health services, although there has been improvement since 2005/2006. It is worth noting that around 85% of beds in independent mental health hospitals are funded by the NHS.<sup>214</sup>

More than one in 10 mental health providers did not meet the core standards on: monitoring and ensuring the quality of treatment and services (12.1%); the recruitment and training of qualified staff (14.6%); and patients receiving treatment in premises that are safe and appropriate (14.8%). In the service-specific standards, similar proportions of independent mental health providers did not meet the standards

**Table 14: Independent sector compliance with core national minimum standards, 2006/2007 by sector**

Type of provider	Met (including 'risky out' and almost met) all 32	Met (including 'risky out' and almost met) 29 or more	Failed five or more
Acute hospitals	63.2%	93.4%	5.0%
Mental health providers	41.9%	80.8%	13.6%
Private doctors	74.2%	94.4%	2.8%
Lasers and lights	73.9%	93.6%	3.6%
Hospices	81.5%	98.3%	1.2%

Source: Healthcare Commission

Note: Categories are overarching. Each provider organisation features only once in this table.

Percentage figures related to proportion of standards, not providers

on: risk assessment and management; the protection of patients from self-harm; and the management and restraint of patients displaying aggressive and violent behaviour.

In independent acute services, only 0.8% of providers failed to meet the standard for ensuring that patients are treated in line with the relevant clinical guidelines. When it came to assuring that the quality of treatment and care is monitored, 3.5% of acute providers did not meet the standard.

The core standard for infection control was not met by just over one in 20 acute hospital services. See chapter 4 for more information on how independent acute providers performed on decontamination and safety.

### Independent sector treatment centres

Independent sector treatment centres (ISTCs) were created to help cut NHS waiting times, provide choice and encourage innovation. They are registered with the Healthcare Commission. The centres provide a range of planned, non-emergency surgery and diagnostic services. In our review of 23 of these centres we were able to offer some reassurance about the quality

of their services. Patients treated by ISTCs gave them a high rating in our survey (see chapter 1 for more details on the experience of patients in ISTCs). We have not carried out any in-depth reviews for other independent acute sector providers.

Our inspections and visits found that, in general, the systems that ISTCs use to identify and address problems and to monitor care, function well. We found some problems when patients move from ISTCs to NHS organisations, and vice versa, including arrangements for follow-up after discharge and the transfer of information about their care. Expert observation by experienced NHS consultants suggests that procedures in the centres broadly match those in the NHS, and that clinical practice during surgery was of a good quality. However, in some places we found evidence of poor relationships between ISTCs and local NHS organisations, with some ISTC contracts inflexible and not reflecting local needs.

Because of gaps in the information routinely collected by ISTCs, we were unable to compare their quality of care with that of the NHS. As far as we were able to tell, ISTCs have fewer emergency readmissions and shorter lengths of stay in hospital than NHS

establishments. This is consistent with their mix of patients, which excludes those with the most complex health needs.

A particular problem was the submission of poor quality and incomplete data to Hospital Episode Statistics, the national database of hospital activity that provides information on the care provided by NHS hospitals and NHS patients treated in ISTCs. There were major gaps in details of patient diagnoses and procedures undergone, and also in the recording of data on the ethnicity of patients. We have made detailed recommendations for improvements to the information collected and submitted by ISTCs. We are currently working with the Department of Health, the NHS Information Centre and independent providers on the development of new datasets to be collected to common standards across the NHS and independent sector.

### Quality and effectiveness in specific services

#### Services for people with heart problems

In its 2007 report, the Myocardial Infarction Audit Project set out some improvements in the treatment of heart attack patients. Generally, patients were receiving clot-dissolving drugs (thrombolytic treatment)

faster than in previous years. In both England and Wales, a greater proportion of patients are being given these drugs within an hour of calling for help (64% in England, 41% in Wales).

Paramedics are giving more treatment to patients before they reach hospital and more patients are being treated by primary angioplasty (an intervention that opens up arteries in the heart). The prescribing of secondary prevention medication (aspirin, beta-blockers and statins) continues to exceed national targets. These improvements have been matched by a fall in the percentage of heart attack patients who die within 30 days of admission to hospital.<sup>215</sup>

Our annual health check includes targets for healthcare organisations on the care and treatment of people with heart-related illness. On most of these measures, trusts are showing improvements.

In England, facilities for patients with acute coronary syndromes have improved since 2000. There are 69% more cardiologists, 125% more specialty registrars and more cardiac nurses. In 57% of hospitals heart attack patients are managed under the care of a cardiologist, compared with 25% in 2000, resulting in better outcomes. There has also been a 77% increase in the number of hospitals that can provide angiography (the x-ray examination of heart arteries) and

**Table 15: 2006/2007 annual health check targets relating to heart health**

	Waiting times for rapid access chest pain clinic (acute trusts)	Patients waiting longer than three months for revascularisation (acute trusts)	Thrombolysis: 60-minute call to needle time (acute trusts)	Thrombolysis: 60-minute call to needle time (ambulance trusts)
Achieved	88% (79%)	94% (95%)	62% (47%)	55% (34%)
Underachieved	7% (18%)	6% (2%)	36% (44%)	45% (66%)
Failed	5% (3%)	0% (2%)	3% (9%)	0%

Source: Healthcare Commission annual health check 2006/2007  
 Note: Figures are rounded. 2005/2006 figures in brackets

facilities for angioplasty. There are now 35 hospitals providing a primary angioplasty service compared with 11 in 2000, with 21 providing this for other hospitals.<sup>216</sup>

In August 2007, the Healthcare Commission, in partnership with the Society of Cardiothoracic Surgeons, published survival rates for the two most common heart operations, covering 38 surgery units and 186 individual surgeons. There were 20,773 bypass operations in the UK and 98.4% of patients survived – above the expected range of 97.74% to 98.32%. The survival rate for the 3,504 patients undergoing aortic valve operations was 98.03%. This was within the expected range of 96.63% to 98.20%.<sup>217</sup>

Nationally, 85.2% diagnosed by their GPs as having coronary heart disease and left ventricular dysfunction are recorded as being treated with an ACE inhibitor or A2 antagonist, in line with NICE guidance. The Healthcare Commission's review of heart failure services found that while this is positive at a national level, there is some variation in the average achievement in each PCT, and further still at practice level.<sup>218</sup>

Guidance from NICE also recommends beta-blockade therapy after the initiation of ACE inhibitor therapy. Unfortunately, there is no nationally available data on this for patients with heart failure due to left ventricular dysfunction. However, our acute hospital portfolio review of admissions management in 2005/2006 included a survey of patients discharged following a diagnosis of heart failure. Only 33.4% of patients were prescribed beta-blockers, with figures for individual trusts ranging from 11.1% to 66.7%. Clearly, this leaves considerable room for improvement.

The *National Service Framework for Coronary Heart Disease* states that systematic care should include proactive follow-up of people admitted to hospital with heart failure by specialist nurses and others in order to provide education and support before they

are discharged from hospital. The review found that the multidisciplinary nature of heart failure clinics advocated by the national service framework is being adopted in most places.

Despite over 80% of communities having some access to specialist heart failure nurses in primary or secondary care, only 24.4% of the patients included in the acute hospital portfolio survey were referred to a heart failure service following admission with heart failure, with averages for trusts ranging from 0% to 94%.

These data suggest that while many communities have some specialist staff, few of the patients admitted to hospital as a result of their heart failure get access to them. This may be due to limited capacity and the criteria allowing access to services.<sup>219</sup>

### Services for people with cancer

The Healthcare Commission sponsors a number of cancer audits, including an audit on the care of patients with lung cancer (LUCADA), a head and neck cancer audit (DAHNO) and a bowel cancer audit (NBOCAP). These audits aim to provide casemix-adjusted information about outcome and to audit trusts against key aspects of NICE guidance, national service frameworks or other national guidance.

Both the head and neck cancer audit and the lung cancer audit showed some shortfalls in multidisciplinary working. The head and neck cancer audit, published in March 2006, showed that care for a third of patients was not recorded as having been discussed at a multidisciplinary team meeting, despite NICE guidance identifying this as the cornerstone of good practice. As care for patients with voice box and mouth cancer is complex and involves many specialists, these results suggest that decisions about some patients' treatment were made in a less than ideal way. For lung cancer patients the picture was somewhat

better, but still one in five patients were not recorded as having their treatment options discussed by a multidisciplinary team.<sup>220</sup>

The percentage of patients who have had their lung cancer confirmed by a histological test is a good indicator of the overall quality of care patients receive. The lung cancer audit shows that the percentage of patients for whom there is a histologically confirmed diagnosis, has increased slightly to 67%. However, lung cancer specialists believe that the optimal confirmation rate is around 80-85%.

The audit also reports an overall surgical resection rate for lung cancer of 9% of recorded cases; this figure remains unchanged from the 2006 audit report. Patients who undergo surgery have better survival outcomes. However, for most patients the disease is too advanced at presentation for surgery to be possible. This resection rate is low in comparison to European and American figures.

For patients with suspected bowel cancer, NICE recommends that a minimum of 12 lymph nodes should be collected from each patient with a likely diagnosis of bowel cancer, to help assess the stage to which the disease has progressed. The bowel cancer audit is able to report against this requirement. Although the audit is still new and many trusts are not yet auditing the implementation of NICE guidance, the audit found that the average number of lymph nodes collected ranged from around two to 24.

### Services for people who have had a stroke

The results of the 2006 National Sentinel Audit for Stroke, carried out by the Royal College of Physicians' Clinical Effectiveness and Evaluation Unit, covered all of eligible hospitals in England and Wales. The audit found that patients spent more time in stroke units, but there were still unacceptable waits for brain scans and



before starting treatment. Results for hospitals in Wales fell behind those in England.

Patients treated in stroke units have much better results than patients looked after in other settings – they are much more likely to have had their ability to swallow checked, to have started aspirin within 48 hours, to have been assessed by therapists within the recommended times, to have rehabilitation goals documented, and for a visit to be made to their home before they are discharged. The audit found that 62% of patients were admitted to a stroke unit at some point in their stay, compared to 46% in 2004. Fifty-four per cent of patients spent over half their stay in a stroke unit, compared to 40% in 2004. This is a significant and welcome improvement.

The most dramatic rise in stroke units was in England, which improved from 82% of eligible hospitals in 2004 to 97% in 2006. But even with this increase in the number of units, the audit found there was still a lack of capacity – 76% of patients with minor stroke in hospital for less than two days were not being managed on specialist units.

These patients have a high risk of having another stroke and should receive expert care and investigation.

Early access to a stroke unit has improved since 2004, but only 15% of patients were admitted to a stroke unit on the same day that they arrived at hospital, and only 12% of patients were admitted directly to a stroke unit (that is, within four hours of arrival).

Only 42% of patients had brain imaging to confirm their diagnosis within 24 hours of the onset of symptoms. This figure needs to improve. Patients need a brain scan to determine if it is appropriate to prescribe aspirin – if given within 48 hours of the stroke this can save lives and reduce disability.

Only 9% of patients were scanned within three hours of stroke. If not scanned on the day of admission, patients normally have to wait until the next working day – this is a particular problem if they are admitted at the weekend as very few scans are performed outside the hours of 8am to 6pm.

Problems remain with stroke patients getting access to therapists and social workers. A third of patients who had difficulty swallowing had not been assessed by a speech and language therapist within 72 hours of admission, or within seven days for those having difficulty communicating. The situation is similar for physiotherapy and for occupational therapy.

In Wales, the late launch of a national service framework in 2006 appears to have delayed the development of specialist stroke services in Wales. At the time of the audit, only nine eligible hospitals (45%) in Wales had a stroke unit – the same figure as in 2004. Only three sites (15%) had acute stroke unit provision. Given the evidence for the benefits of stroke units, the very low rate of stroke unit provision and admission was deemed to be unacceptable.

In response to this audit, the Welsh Assembly Government, the Chief Medical Officer in Wales and stroke clinicians have recognised the need to improve their clinical services and have made significant progress in raising the profile of the disease and setting a clear agenda for improvement. In England, the Department of Health's national stroke strategy will be published in 2008 and will set the agenda for further improvements in England.

### **Maternity services in Wales**

We will publish our review of maternity services in England in early 2008 and the *State of Healthcare 2008* will include detailed commentary on this.

In response to concerns about maternity services in England (following our investigations), Healthcare Inspectorate Wales (HIW) decided to carry out a national review of maternity services in Wales. It published its report in August 2007, and found that overall maternity services in Wales were being delivered in a safe and effective way. The review also found that the different teams and professions that care for women were working effectively together and that staff felt comfortable with the support offered to them by their organisations and senior colleagues. The majority of organisations developed care plans in partnership with women and, where appropriate, women had a named midwife.

The review highlighted a number of areas for improvement. More action is needed to ensure that all healthy women with normal pregnancies are cared for using the principles of the All-Wales Clinical Pathway for Normal Labour. The review estimated that 60% of women giving birth in Wales would be suitable to be started on the pathway, but on average only around 30% were on it.

To ensure the safe management of maternity services, and to set out clearly



the procedures staff should follow during an increase in activity in the unit or reduced staffing levels, trusts should have 'escalation' policies in place. The review found that all organisations had developed a policy, but some of these were in draft and needed to be approved, or needed expansion, and in some units staff were not sufficiently aware of the policies. Very few organisations were found to have audited the effectiveness of their escalation policy.

Some trusts had shortfalls in consultant obstetrician cover, and although audits have found staffing to be adequate in two-thirds of organisations, some units had significant shortages. Staff were generally clear about their roles and responsibilities, but felt that communication to and from senior managers could be improved.

While all organisations had policies for reporting incidents in place, and staff were reporting a wide range of incidents, in around a third of organisations there were no or only limited examples of medical staff completing incident forms. Also, while organisations had arrangements in place to review incidents and make improvements, the review found limited evidence that incident trends were collated, discussed and acted on.

Finally, the review highlighted issues relating to information. While all organisations were regularly collecting information on their maternity services, only a minority were using this information to plan services, predict busy periods, share information or learn lessons. The HIW has made a specific recommendation to the Welsh Assembly Government that a "coherent and integrated national data set for maternity services" should be developed.

### **Ambulance services in Wales**

NHS ambulance services in Wales are provided by a single organisation, the Welsh

# 71%

of people in Wales who needed an ambulance in a serious emergency were reached within 10 minutes

Ambulance Services NHS Trust. There are response time targets in Wales, although these differ in some respects from those in England.

In 2006/2007, 79% of responses to all emergency calls arrived within the target times. Fifty-six per cent of first responses to immediately life-threatening emergency (category A) calls arrived within eight minutes, 67% within nine minutes and 71% within 10 minutes (the target is for 60% of responses to arrive within eight minutes). At a regional level, just one of the three Welsh regions, North Wales, had, in the final quarter of 2006/2007, achieved the 60% target for category A calls.<sup>221</sup>

Both the HIW and the Wales Audit Office (WAO) published major reports on ambulance services in Wales in 2006/2007. They carried out this work in parallel and in cooperation, following two adverse incidents and public debate about the efficiency and effectiveness of the Welsh Ambulance Services NHS Trust. Concerns included a claim by a former chief executive of the trust that 500 lives had been avoidably lost as a result of the way the service operated.

The WAO inquiry concluded that there were longstanding and severe problems throughout the service, but that these could be resolved over time and that the trust board was addressing key weaknesses.<sup>222</sup> It confirmed that the service's poor performance was more than a matter of not meeting targets – it could also have compromised patient care. And while

the WAO highlighted “very considerable strengths” including the trust’s frontline staff, it found weaknesses in “all the key aspects of good business management”.

The HIW’s special assurance review focused on clinical governance, patient care services and the claim of 500 lives lost avoidably.<sup>223</sup> The review found that the weaknesses identified by WAO were generally also true of the trust’s patient care services and that its clinical governance arrangements were also variable. However, the staff’s commitment to providing good patient care and the new leadership at the trust gave grounds for optimism. It was not possible to verify the ‘500 lives’ estimate and so the review called for improvements to trust information systems, to allow proper measurement and benchmarking of the services it provides.

## Conclusions

There have been some notable areas of good practice and improvement in relation to the quality and effectiveness of care and services provided in England and Wales during 2006/2007.

However, we recommend attention in the following areas to help promote further improvement:

- Healthcare providers in both the independent sector and NHS need to do more to assess the quality of their services against other similar organisations through benchmarking and audit.
- PCTs and ambulance trusts in England need to take further steps to ensure that they are managing patient records effectively.
- Mental health trusts and PCTs need to work together to gain a better understanding of the effectiveness of mental health services and ensure services are commissioned in keeping with local need.
- The information available to assess the quality of services in the independent sector needs to improve, and the work currently underway to address this issue must be taken forward.
- Although there have been improvements, the independent mental health sector needs to further consider why its establishments fall behind other types of provider in meeting standards, and take steps to bring about improvement.

# Appendix

## Our assessments of the independent healthcare sector in England

The following table shows the levels of non-compliance for the core national minimum standards against which independent healthcare providers are assessed. For each

major category of provider, it sets out the proportion of providers where the relevant standards were assessed as “not met” in our inspections during 2006/2007.

**Rates of non-compliance with core national minimum standards, 2006/2007**

		All providers	Acute hospitals	Mental health	Private doctors	Termination of pregnancy	Prescribed techniques (all)	Hospices
C1	Patients receive clear and accurate information about their treatment and its likely costs	2.5%	1.6%	3.5%	2.4%	0.0%	3.6%	0.6%
C2	The treatment and care provided are patient-centred	1.5%	3.5%	5.1%	0.4%	0.0%	1.2%	0.0%
C3	Treatments provided to clients are in line with the relevant clinical guidelines	1.2%	0.8%	6.1%	0.4%	0.0%	1.1%	0.0%
C4	Clients are assured that monitoring of the quality of treatment and care takes place	5.6%	3.5%	12.1%	7.7%	30.0%	5.8%	2.9%
C5	The dying and death of patients is handled appropriately and sensitively	0.1%	0.0%	0.5%	0.0%	0.0%	0.1%	0.0%
C6	Patients' views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients	4.3%	2.3%	7.1%	5.2%	10.0%	5.6%	1.2%

## Rates of non-compliance with core national minimum standards, 2006/2007

		All providers	Acute hospitals	Mental health	Private doctors	Termination of pregnancy	Prescribed techniques (all)	Hospices
C7	Appropriate policies and procedures are in place to help ensure the quality of treatment and services	3.7%	5.8%	11.1%	2.8%	10.0%	3.1%	1.2%
C8	Clients are assured that a fit person runs the establishment	1.8%	1.9%	2.5%	1.6%	0.0%	2.5%	0.6%
C9	Clients receive care from appropriately recruited, trained and qualified staff	5.4%	5.4%	14.6%	3.6%	0.0%	5.5%	4.0%
C10	Clients receive treatment from appropriately recruited, trained and qualified healthcare professionals	2.7%	6.2%	6.1%	2.4%	10.0%	1.6%	3.5%
C11	Clients are treated by healthcare professionals who comply with their professional code of conduct	0.7%	0.4%	2.5%	0.4%	10.0%	0.8%	0.0%
C12	Patients and healthcare professionals are not infected by blood borne viruses	1.0%	0.0%	6.6%	0.0%	10.0%	0.7%	0.6%
C13	Children receiving treatment are protected effectively from abuse	2.5%	5.1%	2.0%	1.6%	10.0%	2.8%	1.7%
C14	Patients have access to an effective complaints process	1.4%	0.4%	6.1%	1.2%	0.0%	1.2%	0.6%
C15	Patients receive appropriate information about how to make a complaint	1.2%	0.4%	2.5%	1.2%	0.0%	1.7%	0.0%

## Rates of non-compliance with core national minimum standards, 2006/2007

		All providers	Acute hospitals	Mental health	Private doctors	Termination of pregnancy	Prescribed techniques (all)	Hospices
C16	Personnel are freely able to express concerns about questionable or poor practice	0.9%	0.0%	1.5%	1.2%	0.0%	1.5%	0.0%
C17	Patients receive treatment in premises that are safe and appropriate for that treatment	3.0%	4.7%	14.8%	0.4%	10.0%	1.2%	4.0%
C18	Patients receive treatment using equipment and supplies that are safe and in good condition	1.3%	1.2%	2.5%	0.8%	0.0%	1.8%	0.6%
C19	Patients receive appropriate catering services	0.3%	0.4%	2.0%	0.0%	0.0%	0.1%	0.0%
C20	Patients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately	3.8%	5.4%	8.6%	3.6%	0.0%	3.2%	4.0%
C21	The appropriate health and safety measures are in place	2.2%	3.1%	5.6%	1.6%	0.0%	2.3%	0.6%
C22	Measures are in place to ensure the safe management and secure handling of medicines	1.9%	3.1%	7.6%	3.6%	0.0%	0.2%	2.3%
C23	Medicines, dressings and medical gases are handled in a safe and secure manner	1.7%	2.3%	6.6%	2.8%	0.0%	0.6%	1.7%

## Rates of non-compliance with core national minimum standards, 2006/2007

		All providers	Acute hospitals	Mental health	Private doctors	Termination of pregnancy	Prescribed techniques (all)	Hospices
C24	Controlled drugs are stored, administered and destroyed appropriately	1.3%	3.1%	3.5%	1.6%	10.0%	0.3%	1.7%
C25	The risk of patients, staff and visitors acquiring a healthcare associated infection is minimised	2.8%	5.1%	7.6%	1.2%	10.0%	2.1%	2.9%
C26	Patients are not treated with contaminated medical devices	1.2%	5.1%	0.0%	0.8%	0.0%	1.0%	0.0%
C27	Patients are resuscitated appropriately	3.4%	1.9%	17.2%	3.6%	0.0%	2.1%	1.2%
C28	Contracts ensure that clients receive goods and services of the appropriate quality	1.3%	2.3%	4.0%	0.0%	10.0%	1.2%	0.0%
C29	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations	2.2%	3.1%	2.5%	2.0%	10.0%	2.7%	0.6%
C30	Clients are assured of appropriately completed health records	2.7%	5.8%	6.6%	1.6%	0.0%	2.5%	0.6%
C31	Clients are assured that all information is managed within the regulatory body to ensure confidentiality	1.3%	0.0%	2.5%	0.8%	10.0%	2.1%	0.0%

**Rates of non-compliance with core national minimum standards, 2006/2007**

		All providers	Acute hospitals	Mental health	Private doctors	Termination of pregnancy	Prescribed techniques (all)	Hospices
C32	Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any patients involved, in line with published guidance on the conduct of research projects	0.9%	0.8%	1.0%	1.6%	0.0%	1.1%	0.6%



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ISBN 978-0-10-295155-4



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