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Healthcare Commission

State of **Healthcare** 2008

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Ordered by the House of Commons to be printed on 10 December 2008.

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.

HC 11 London: The Stationery Office £26.60

In this final report from the Commission on the state of healthcare, we are pleased to identify sustained improvement in the healthcare provided to patients. There have been improvements in health and life expectancy, reductions in deaths from the 'big killers' – stroke, heart disease and cancer – reductions in rates of infection and dramatic improvements in waiting times. These are things to be celebrated.

Credit, of course, lies with those who look after patients up and down the land. We would like, however, to think that the role we played as the regulator was not inconsiderable. We introduced a radical new approach to regulation, founded on the collation, analysis and publication of information, supplemented by focused inspections. Our inspections were based on an assessment of the degree of risk that patients might be exposed to, as measured against the levels of performance that could properly be expected. We developed our approach in collaboration with patients and professionals, so that the things we measure are what they tell us are important. We did so with the fundamental commitment to place the needs and experience of patients at the centre of our efforts, taking particular account of the circumstances of those less able to speak up or fend for themselves without help.

The result, as this report shows, is the 'richer picture' of the performance of the NHS that we promised when we set out on our journey. And the painting of this richer picture has led boards of trusts to concentrate ever more intensively on what matters – helping to usher in the improvements that we report. We recognise, of course, that there have been many other forces, individually and together, that have also contributed to these improvements. But modern regulation, as practised by the Commission, has had a part to play.

The Commissio

Of all our varied activities, our investigations into serious failings deserve mention in this context. Through them, and with the active participation of patients and clinicians, we have changed the face of whole areas of care, making good on the promise that good can come from bad. After our report on Maidstone and Tunbridge Wells, the control of infection will never be relegated to a low priority. After Northwick Park, maternity services have undergone massive change, led by professionals and the views of mothers. After Cornwall, the care of those with learning disabilities can no longer be neglected.

You would not expect a report such as this to be free from caveats. We mention two here. First, there remain pockets of performance that so far have not improved sufficiently. There is a small number of trusts which are trapped at a level of performance that is unacceptably poor. Action is being taken, but the problem requires urgent and sustained effort: it is not good enough to leave some patients without the level of care that they are entitled to.

There also remain groups of patients whose interests are not yet sufficiently well served by the NHS. They include those with mental health needs – we have seen some real improvement in the services for adults and in care in the community, but the care of adolescents and young people remains a concern. They include older people, where matters of dignity, privacy and just human interaction warrant greater emphasis. They include children, for whom we have a special

statutory responsibility, who, outside specialised units, still do not always get the attention they need and deserve. And there remain areas of service that across the board have some improving to do – the care of those with learning disabilities, some aspects of public health, and maternity services (which now may be beginning to turn the corner).

Secondly, from our perspective, we recognise that 'what gets measured gets done'. It is of crucial importance, therefore, that the regulator measures the right things. We have worked very closely and successfully with patients and professionals to identify what will tell us whether a service, a unit, a hospital or a trust is performing well. We are sure that the product of this work will be integrated into the regulatory approach adopted by the body that succeeds us, the Care Quality Commission. The emphasis needs to be on measuring the safety and quality of care, its outcome, and the experience that patients have of it.

We should say that we draw attention to the less good as well as the good – not to carp, but to dispel false confidence or complacency, and to meet our statutory duty to encourage improvement. Our job is to serve by being independent and describing what the evidence tells us. We would be failing in that job if we did not say that the journey of improvement has definitely made some ground but there is still more to do.

ners' view

The Healthcare Commission will cease to exist on 31 March 2009. We have every confidence that independent regulation – led by information, based on risk assessment, informed by the views of patients and professionals, supplemented by visits where necessary, and making public on a regular basis the levels of performance of all sectors of healthcare – is here to stay. We wish the Care Quality Commission every success. For our part, it has been a remarkable experience. We express our warmest possible thanks to our staff, who have translated a vision of modern regulation in the public sector into reality with such skill and commitment.

Professor Sir Ian Kennedy
Chair
On behalf of the Commissioners

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Foreword

This is our fifth and final report to Parliament on the state of healthcare in England and Wales. From April 2009, the new Care Quality Commission will replace the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission, joining up the regulation of health and adult social care in England. Healthcare Inspectorate Wales will continue to lead on the inspection of healthcare services in Wales.

This report is mainly about our findings for the financial year 2007/08. However, we believe that this is also the right time to reflect on the progress that has been made in healthcare over the past five years, and to think about the challenges that remain. Throughout the lifetime of the Healthcare Commission, we have published groundbreaking and detailed work on a wide range of topics in health and healthcare. This report is both a distillation of that work and an opportunity to think about it as a whole.

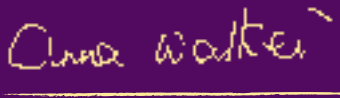
We have adopted a new approach this year, giving our take on the state of healthcare in, we hope, a more simple and direct way. Our report presents six pictures of the state of healthcare – for mothers, for children and young people, for people with mental health needs, for people with a learning disability, for people needing urgent and hospital care, and of the support offered to enhance people's health and wellbeing in the community.

We look at how well healthcare services are doing in their efforts to meet the Government's standards and to improve safety. And we look at the progress made in putting patients and the users of services right at the heart of healthcare, ensuring that their rights

“This is the right time to reflect on the progress that has been made in healthcare over the past five years, and to think about the challenges that remain.”

are respected, that they are able to make meaningful choices and decisions about their care, and that they are able to influence the shape of healthcare in the future.

This report celebrates improvement, but does not draw back from highlighting areas where we have concerns. This balanced approach has, I believe, been one of the characteristics of our work since 2004.



Anna Walker CB
Chief Executive

Summary

This is our final report to Parliament on the state of healthcare in England and Wales. We have used the opportunity to look afresh at our findings over the last five years, and what they tell us about healthcare as it is provided, and experienced, in 2008.

This summary, and our report as a whole, has been organised to reflect the balance of our work over the past year. The topics that we have selected present a good overview of where we are in health and healthcare today. Some issues cut across these topics however, and so are highlighted in our summary.

The backdrop for this report is a health service that is receiving more money than ever before, that employs more staff than ever before and is providing more care than ever before. There is much about the NHS that is very positive. This is recognised by those who use it and reflected in the satisfaction they express through our surveys.

Our assessments show that the NHS as a whole is getting better at using and managing its resources, and that it is performing better against the wide range of national targets it has to deliver and the core standards it has to meet.

Over the last few years, the NHS has made some dramatic progress. The work towards meeting the maximum waiting time of 18 weeks from referral by a GP to treatment in hospital has been particularly significant. This is a considerable achievement. We have also seen improvements in the speed with which ambulance services are able to respond to people in emergencies. Community mental health services such as 'crisis resolution home treatment' and 'assertive outreach' are now in place across the country and are delivering care to thousands of people.

We can also see falling rates of death from the big killers such as cancer and heart disease and a continuing improvement in life expectancy. Good progress has been made in tackling some of the major challenges to public health, for example levels of smoking have decreased and rates of teenage pregnancy continue to fall.

Importantly, we are starting to see a real shift in the attention given by healthcare organisations to the safety of care. Safety is now on the agenda, arguably as never before. This is shown by, for example, the concerted effort to tackle the problem of healthcare-associated infections, such as those caused by MRSA and *C. difficile*.

All of this is good news, and we do not underestimate the effort it has taken. Staff working in healthcare should be congratulated.

Alongside this picture of improvement, however, there are inevitably areas of concern.

While overall measures of life expectancy and premature deaths are heading in the right directions, inequalities in health status between those in the richest and the most deprived parts of England are persistent and, in some cases, growing wider. Obesity, excessive alcohol consumption and sexually transmitted infections remain a major concern and are storing up health problems for the future.

While we are pleased to report that the safety of healthcare has a higher profile than in previous years, we continue to have concerns about the ability of healthcare providers to collect good information on the safety of care and to use it to

improve their services and to protect patients. Stronger leadership in this area is still needed in all healthcare organisations to ensure that safe care is their first priority. More attention needs to be given to a wider range of matters relating to patients' safety: better reporting of incidents; more systematic learning from incidents and implementation of improved practices; and better information to compare performance in the provision of safe care. Everyone needs to recognise that improved safety is the first step towards a better health service.

While we have seen improvements in the performance of healthcare organisations, there remains a need for better information on the outcomes that people experience from the care they receive. This is the case across all sectors of care, from acute to primary, and all groups of patients. There is a great deal of work underway, often led by the Government, that seeks to address this shortage of information. We look forward to seeing it have an impact on the quality of healthcare.

We are concerned by the variable picture of quality that our in-depth reviews and studies have revealed. Our national reviews of maternity services, mental health services and of urgent care all showed a wide variation in performance. They provide a benchmark against which organisations can measure their progress and test the quality of their services against that of other providers. To do this successfully, healthcare organisations need to collect, analyse and disseminate information of good quality on the care they provide. Too often, we have found that the systems in place locally to gather and use information about care are either not there or not good enough.

One of the biggest challenges facing the NHS in England is getting the purchasing (commissioning) of healthcare right. Our work has give us a limited view of the quality of commissioning, but enough to suggest that more attention is needed.

We have continuing concerns about the ability of healthcare organisations to meet the needs of the more vulnerable in our society. Our work, and the work of others, show that too often people with learning disabilities are not well provided for. There are clear barriers to them gaining access to mainstream services for both physical and mental health problems.

Our work looking at services for children provides a mixed picture. While we have found evidence of very good practice, particularly in specialist hospital services, we have concerns about care in more general settings. We also have concerns about the care received by children and young people with complex needs. Finally, we have concerns about the arrangements in healthcare for the safeguarding of children.

We continue to have concerns about care for older people. Our work has highlighted the importance of dignity and respect, but we are yet to see substantial improvement in the experiences that people report to us.

Looking more broadly at the experience of patients and users of services, it is clear that levels of satisfaction are high, but further progress is needed to ensure that patients really are at the centre of care. Patients tell us that they want to be able to make meaningful choices, be fully involved in decisions about their care, and have the information they need, when they need it.

The big picture

Health

The overall picture is positive, with targets relating to the health of the population either met or on the way to being met:

- Life expectancy is increasing.
- Rates of premature death due to cancer and circulatory disease are falling.

However, there are underlying concerns. Inequalities in health status are persistent and, in some cases, are widening, despite targets aimed at reducing inequality.

The experience of patients

While overall satisfaction remains high, we have seen little change in the scores that trusts get for the experience of patients.

Finance

Funding has increased substantially in recent years, and the NHS receives a level of funding comparable to that in other similar countries.

NHS organisations are managing their resources better. The Audit Commission's annual assessments (reflected in our annual health check) show year-on-year improvements in this area.

Activity and workforce

The NHS in both England and Wales is busier than ever before. There have been major increases in consultations in primary care, admissions to hospital, visits to A&E, the use of community mental health services, and take-up of newer services such as NHS Direct and walk-in centres.

The NHS is also employing more people than ever before, with an increase of around 26% between 1997 and 2007.

Value for money

The available measures of value for money do not yet include enough information on quality of care and outcomes for patients to allow any robust view of how the NHS is doing. Better information on quality and outcomes is vital, if in future we are to have good measures of value for money.

Performance

Our annual health check of NHS organisations in England has shown year-on-year improvement in performance in meeting core standards and national targets.

Policy and reform

The NHS in England is in the middle of a period of extensive reform, aimed at radically improving commissioning, giving organisations more local flexibility and developing 'patient choice'. It will take time for the full impact of these changes to work through. Significant changes are also planned in Wales, including the ending of the split between commissioning and provision of care.

Assurance & reassurance

Meeting standards

- The NHS in England has made year-on-year improvements in meeting the national standards set by the Government.
- Relatively high levels of compliance with core standards are good news ahead of the new system of registration for the NHS in England in 2010.

- However, more than a third of trusts still only achieve a score lower than "fully met", and more work is needed, particularly in the domains of 'safety' and 'governance'.
- We have adopted a new approach to inspecting independent providers of healthcare, which allows us to focus our attention on those establishments which cause us the greatest concerns. Our work suggests that there has been some improvement overall.

Providing safer care

- Our work shows that the safety of patients has noticeably moved up the agenda for providers of healthcare and that there are some examples of good practice.
- Only around half of trusts in England comply with all of the Government's core standards relating to safety.
- There is a growing body of evidence about what works to improve safety. Our work shows the importance of leadership and of making safe care the core of the organisation's activity. Wider agreement is needed on what 'good' safety looks like.
- Our assessments show that effective systems are not always in place to understand safe care and risk, report and act on individual incidents, and analyse and act on wider lessons. The new registration requirements for health and social care should include such systems.
- Organisations still need to do more to encourage a culture of openness in identifying and reporting in the case of untoward events.
- More systematic reporting is needed particularly from GPs.
- Better comparative information about safe care needs to be generated at national, organisation and service level, to give confidence that good practice is being followed and risks are being addressed.

- A national database of serious untoward incidents should be compiled with clear responsibilities as to who should take what action in relation to them.

Tackling healthcare-associated infections

- The NHS has made a major impact on reducing MRSA infections, and the national target for reducing infections has been met. But almost half of trusts did not meet their individual targets for reducing or minimising MRSA infections during 2007/08.
- *C. difficile* is still a major problem for the NHS, but there are encouraging signs of recent improvement in dealing with it.
- Trusts are clearly tackling infection prevention and control vigorously. However, few trusts fully comply with the hygiene code, but we have found few breaches of the code that posed an immediate risk to patients. Trusts do need to ensure they have comprehensive systems in place to maintain the decrease in infection rates.
- Healthcare providers need to ensure that they improve their systems to tackle all infections, and not just focus on MRSA and C. difficile. This should be underpinned by agreement at a national level on what infections should be measured and how.

Six pictures of healthcare

A picture of health and healthcare in the community

- A greater focus on commissioning is evident from both Government and PCTs. We welcome the work that is underway, but all would recognise that there is some way still to go. This is very important for local people, because in our in-depth reviews we have often found that where services are poor, this is because commissioning is poor. Our reviews have also identified many high-performing organisations, showing that progress is possible.
- It is clear that people trust and value their GPs, but also want more flexible access to them. We welcome both the Government's proposed introduction of regulation for GP's practices, and their efforts to resolve issues of access in primary care.
- We have seen progress in some areas of public health including smoking, teenage pregnancy and access to sexual health clinics. However, progress has been more limited in other areas, such as obesity, alcohol misuse and sexually transmitted infections such as chlamydia. The greatest progress has been made where there are clear objectives and targets.
- Our annual health check has highlighted some improvement in the ability of PCTs to understand and meet the needs of people with long-term conditions. But too many organisations have not delivered all that they planned in this area.
- There is a lack of robust information about how well community services are performing.

A picture of urgent care and care in hospital

- The level of activity in A&E departments is increasing.
- The ability of the NHS to respond quickly to urgent need has improved.
- Both NHS acute hospital trusts and ambulance trusts have shown year-on-year improvements in our assessments of the quality of their services.
- However, more work is needed on measuring outcomes for patients.

- Our review of urgent and emergency care has highlighted a lack of integration between the services provided locally by a wide range of organisations.

The picture for mothers

- The number of births in England and Wales has risen by 16% since 2001, putting additional pressure on maternity services. Providers and commissioners face real challenges in meeting the needs of a growing, mobile and diverse population.
- Most women are satisfied with their maternity care, but we have found wide variations in the quality of services offered by the NHS in England and women do not always get the level of care to which they are entitled.
- In the least well-performing organisations, we have found a pattern of lower levels of staff, poorer access to training for staff, poor relationships between professional groups and problems in collating and using information about maternity services.
- Essential data about maternity services is not always routinely collected, making it difficult for local heath services and national bodies to assess the quality of care provided, and to make the right changes to improve services. We welcome and support efforts by the Department of Health to make the national minimum dataset for maternity services a reality.
- During 2008, the Government has announced additional funding for the improvement of maternity services, and new standards for maternity services have been issued by the relevant Royal Colleges. Both of these developments are to be welcomed.

The picture for children and young people

- While children are generally healthy, inequalities in health linked to deprivation persist, including death in infancy. Other key challenges in relation to children and young people include obesity and sexual health.
- While death in childhood is uncommon, there are too many cases involving avoidable factors.
- Although the overwhelming majority of NHS organisations declare that they comply with the core standard for child protection, we have some underlying concerns about the priority given, in some organisations, to issues relating to children, the levels of essential training in child protection among clinicians, and lines of accountability and responsibility for child protection. At the Government's request, we will carry out a national review of arrangements in the NHS for the safeguarding of children.
- Children and young people with complex needs, including children with disabilities or those in situations that make them vulnerable, do not always get the attention and care from healthcare services that they need.
- Our work on acute hospital services has shown that children receive better care in settings where they are the main focus (such as inpatient paediatric units) than in more general settings.
- However, our work in acute hospitals also found some evidence of failure to recognise serious illness in children, due to a lack of training in paediatrics or a lack of supervision.
- Services for children with mental health needs have improved, but are still patchy.
- As for other services, there is a lack of good data with which to measure children and young people's access to services, and the outcomes they get.

The picture for people with mental health needs

- Compared with other trusts, specialist mental health trusts have tended to perform best in our annual health check.
- Good progress has been made towards the national target for reducing suicide.
- Substantial progress has been made in expanding the range of community-based services. People using these services report high levels of satisfaction.
- We have seen progress in inpatient services, helped by national initiatives.
- However, the quality and safety of both community and inpatient services vary enormously from area to area.
- There continues to be a greater representation of inpatients from black and minority ethnic groups than in the wider population, suggesting the need for better understanding of what could be done to avoid admissions for this group.
- Major work is underway to expand access to talking therapies for people who experience depression and anxiety, but access to a range of therapies for all with mental health needs could still be improved.
- There are major gaps in the availability of information about the quality of mental health care.

The picture for people with a learning disability

- We have concerns about the commissioning of health services for people with learning disability. We are carrying out further work in this area and will report on this in 2009.
- Specialist healthcare services for people with learning disabilities are generally safe. However, they do not always adequately meet the wider needs of those people using them.
- There are still barriers for people with a learning disability in gaining access to mainstream services, and so their physical health needs are too often poorly addressed. Within mainstream services, staff lack an awareness of how to respond to someone with a learning disability.
- We have too little information about care for people with both a learning disability and mental health needs, but we have concerns and so we have included in the annual health check for 2008/09 a measure of performance in this area.

How does it feel for patients?

- Patients and users of healthcare services are generally very positive about the care they receive from the NHS, but they also want:
  - More flexible access to their GPs
  - Better information
  - Greater involvement in decisions about their care
  - Meaningful choice
  - Respect for their dignity.
- Waiting times for acute hospital care have fallen in both England and Wales.
- We continue to have concerns about access to mental health services, particularly access to talking therapies and out-of-hours crisis care.

the big picture

The big picture

Here we provide some context for our report, including an overview of the progress made in improving people's health, the growth in investment in the NHS, and recent changes in the levels of activity in the NHS and independent sector. We also look at the performance of the NHS overall and the direction of the Government's policies on health.

Health

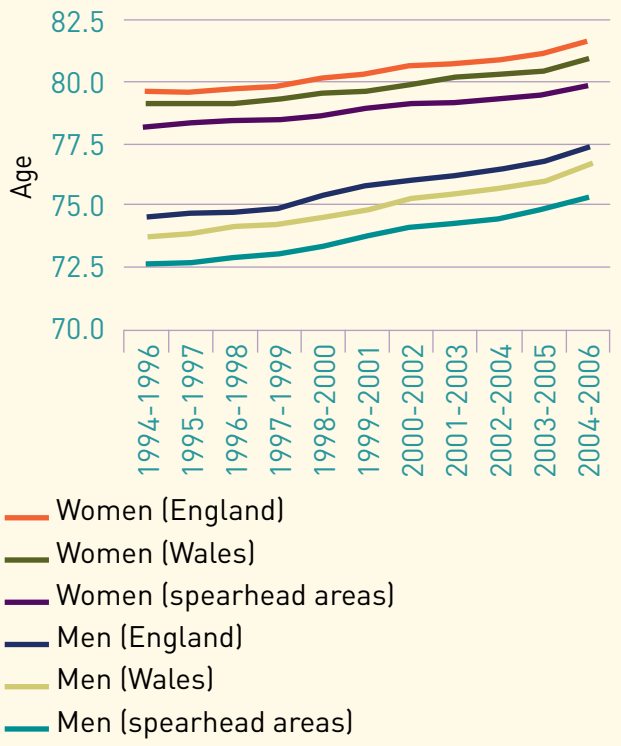
Overall, life expectancy is increasing for both men and women. In the period 2004-2006, life expectancy at birth in England was 77.3 years for men and 81.6 for women. In Wales, it was slightly lower at 76.6 years for men and 81.0 for women (see figure 1).

The rate of premature death (that is, before the age of 75) from all cancers in England and Wales in 2006 was 116 deaths per 100,000 people, a fall of more than 18% in 10 years.[2] Early deaths from coronary heart disease have decreased sharply. The rate for England and Wales in 1996 was 91 deaths per 100,000 people. By 2006, this had gone down to 45 per 100,000. Early deaths due to stroke have also fallen markedly, to 15 per 100,000 people – a reduction of 44% in 10 years (see figure 2).

These reductions are excellent news, and they should also be seen in the context of international reductions in deaths from cancer and circulatory diseases (see figure 3). Death rates in the UK are decreasing, and while there is still a gap between rates in the UK and those in comparable European countries, the recent trend is for a narrowing of this gap.

In England, the Department of Health has set targets for improving life expectancy and reducing early deaths from the 'big killers'. These targets run to 2010, and the aim is not only to improve the position overall, but also to reduce the impact of deprivation on life expectancy. The differences in life expectancy and rates of death between the fifth of areas with the worst health and deprivation (the 'spearhead' group) and the population as a whole, are known as 'inequalities gaps'.

FIGURE 1: Life expectancy at birth, England and Wales 1996-2006



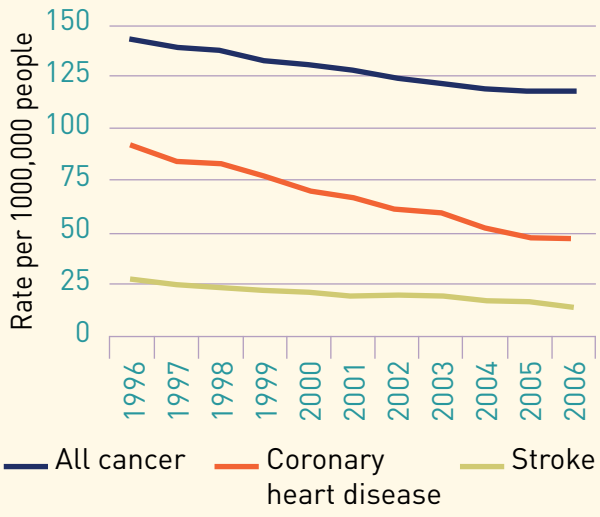
Source: Office for National Statistics[1]

Note: The spearhead areas are the fifth of local authorities in England with the worst indicators of health and deprivation.

The first of these targets is to increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women, and to narrow the gap in life expectancy by at least 10%. The overall target is on track but, although life expectancy in the spearhead areas is also rising, the rate of increase is slower and the gap between these areas and the average for England is widening.[4,5]

The overall target for deaths from circulatory diseases, a 40% reduction, has already been met.[6] The target for reducing the inequalities gap by 40% has almost been met, but the relative gap has increased from 26% in 1995-1997 to 30% in 2005-2007.[7]

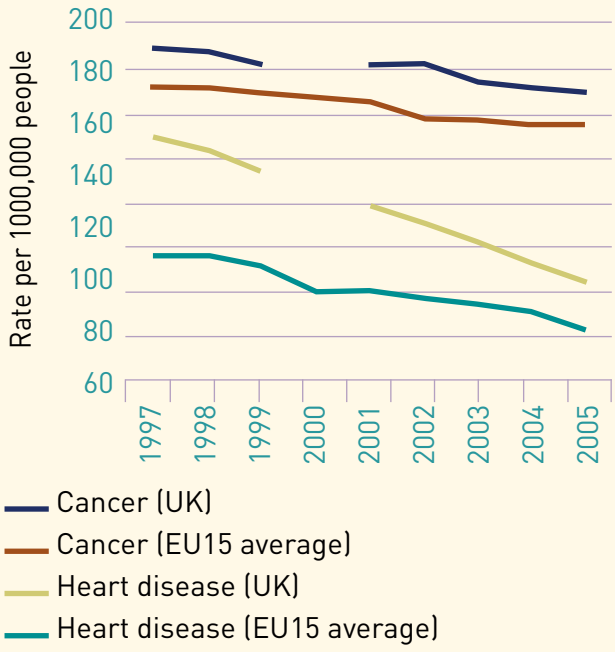
FIGURE 2: Early deaths from the three 'big killers', England and Wales 1996-2006



Source: Compendium of Clinical and Health Indicators[3]

The target for cancer, a decrease of at least 20% in the overall death rate, is on track to be met if current trends continue.[8] The absolute gap has narrowed, but the relative gap has increased from 15% in 1995-1997 to 16% in 2005-2007.

FIGURE 3: Deaths from heart disease and cancer, 1997-2005 , all ages



Source: OECD 2008. Note: Includes break in data series for UK. Figures shown are for all deaths, not just premature.

The target for infant mortality is to reduce, by at least 10%, the gap in mortality between people in the 'routine and manual' group and the population as a whole. This gap has widened since the period 1997-1999.

However, there has been a narrowing of the gap since 2002-2004. The infant mortality rate for the population as a whole in 2005-2007 was 4.7 deaths per 1,000 live births, and the rate for those in the routine and manual group was 5.4 deaths per 1,000.[9]

It is important to note that improvements in health and reductions in inequality take time to achieve. The current picture is very mixed, with good progress overall, but less encouraging news when looking at inequalities. Inequalities in health will continue to be a critical issue for the NHS in the years to come.

The experience of patients

Our measures of the experiences of patients show some improvement at a headline level. In our surveys of NHS patients in England, we have found consistent levels of satisfaction with services. In the most recent, 92% of acute inpatients and 78% of people using community mental health services described their care as "excellent", "very good" or "good". However, responses to more targeted questions that ask about things on which patients are expert, including questions relating to dignity, involvement and choice – the issues that patients and users of services feel most strongly about – reveal a mixed picture. We explore this in more detail in the section "How does it feel?". Our annual health check includes an indicator, based on our surveys, that looks at the experience of patients. Progress on this is illustrated in table 1.

TABLE 1: Indicator scores for the experience of patients in NHS acute trusts in England, 2006/07-2007/08

2006/07	2007/08	Number of trusts
Satisfactory	Satisfactory	144
Below average	Satisfactory	6
Poor	Satisfactory	1
Satisfactory	Below average	2
Below average	Below average	4
Poor	Below average	2
Satisfactory	Poor	1
Below average	Poor	3
Poor	Poor	2

Source: Healthcare Commission annual health check

Funding

Total UK funding for the NHS in 2007/08 stood at £104 billion.[10] This has risen substantially in recent years, with annual increases above the rate of inflation. The aim has been to raise the proportion of GDP spent on healthcare to levels that are similar to other developed countries. In 2007/08, Government expenditure on health was estimated at 7.3% of GDP, compared with 5.4% in 1997/98.[11]

In the autumn of 2007, the Chancellor announced the outcome of the Comprehensive Spending Review, covering the period 2008/09 to 2010/11. NHS funding for these three years will increase by an average of 4% a year above inflation.[12] This will take NHS expenditure in England from £89.6 billion in 2007/08 to £109.6 billion in 2010/11.[13]

To put this into an international context, the most recent figures allowing us to compare the spending of different countries, those for 2006, show that the proportion of GDP spent on healthcare from the UK public purse is broadly in line with other countries with predominantly state-backed health systems (see figure 4).

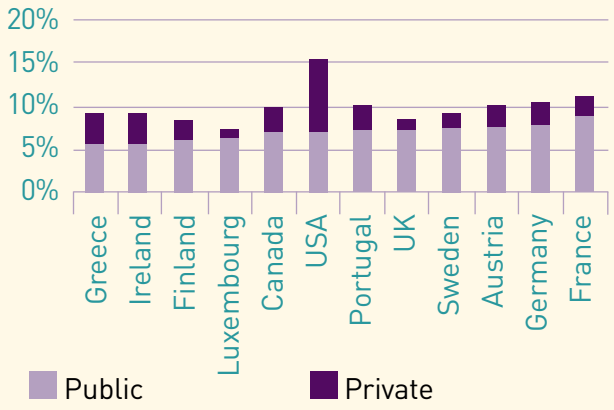
Around 80% of NHS funding in England is channelled through primary care trusts (PCTs), the organisations responsible for understanding the health needs of local people, and planning and purchasing services for them – a job known as 'commissioning'. The calculations used to share out funding among PCTs are complicated, but take account of such things as age, deprivation, need and local geography. In previous *State of Healthcare* reports, we have looked in detail at the funding formula. This is currently being revised and a new formula is expected for 2009/10. In recent years, additional

funding has been made available to all PCTs, with some targeted towards those serving 'spearhead' areas – those with the challenge of closing the inequalities gaps described above.

Activity and workforce

In both England and Wales, the vast majority of people who use healthcare services do so in the community – through their local health centre or GP, or through services such as community midwifery, community nursing and health visiting.

FIGURE 4: Health expenditure as a proportion of GDP, 2006

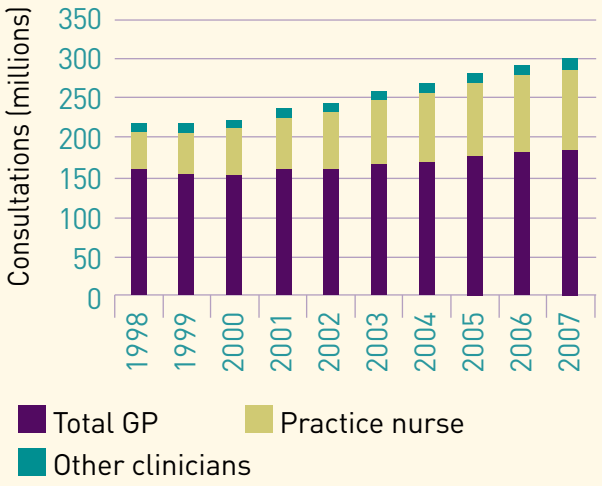


Source: OECD 2008

Note: Selected countries in EU15 and G8

Between 1998 and 2007, the number of GP and other consultations in England rose from around 219 million to nearly 300 million (see figure 5). The average rate of consultations in a year rose from 4.0 per person in 1998 to 5.4 in 2007.[14] The number of GPs (excluding GP registrars and GP retainers) in England grew from 57.6 per 100,000 people in 1997, to 65.7 in 2007.[15]

FIGURE 5: Number of consultations in England, 1998-2007



Source: Information Centre

In 2006/07, GPs held, on average, 87 surgery and 17 telephone consultations in a week, and made five home visits.[16] The average length of each surgery consultation was 12 minutes and telephone consultations lasted seven minutes. This compared with eight and 11 minutes respectively in 1992/93.

Demand for urgent and emergency healthcare has also increased. Between April 2007 and March 2008, there were more than 19 million attendances (first and follow-up) at A&E departments in England (including minor injury units and walk-in centres).[17] This compares with 14 million attendances in 2002/03. During this period, there were 7.2 million emergency and urgent calls for ambulance services.[18] Eighty-one per cent of these (5.9 million calls) resulted in an emergency response arriving at the scene of the incident. There were 4.9 million emergency calls in 2002/03 (this figure does not include urgent calls).

In Wales, attendances at A&E in 2007/08 were just under one million, around the same level as in 2002/03.[19] In addition, there were just over 300,000 emergency calls in 2007/08, compared with 231,000 in 2002/03.[20,21]

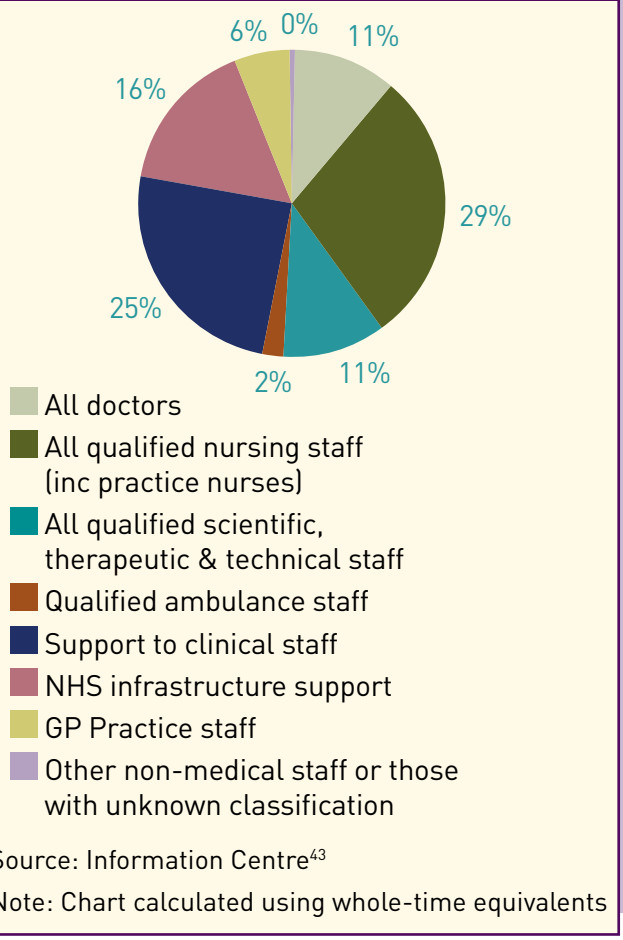
There were 4.5 million emergency admissions to acute hospitals in England in 2007/08.[22] Emergency admissions to all hospitals stood at 4.6 million in 2007/08, compared with 3.9 million in 2002/03.[23,24] In Wales, there were 341,963 emergency admissions in 2006/07, compared with 325,760 in 2002/03.[25]

Newer services such as NHS Direct and walk-in centres, designed to reduce some of the pressure on emergency services and GPs, have seen a huge take-up by patients. There are now around 90 NHS walk-in centres in England, including six near to major railway stations that are aimed at commuters.[26] In 2007/08, PCTs with walk-in centres reported around 2.3 million attendances (this figure does not include walk-in centres provided by acute trusts). This includes 127,386 attendances at NHS walk-in centres with a focus on commuters during 2007/08.[27]

During 2007/08, NHS Direct answered 4.9 million calls on their local-rate 0845 number. They had over 30 million unique visits to their website, a 10-fold increase in five years, and their digital TV services reached into more than 18 million households.[28]

During 2007/08, there were over 14 million first outpatient attendances in England. Subsequent attendances totalled more than 31 million.[29] First attendances have risen by about one million in the last five years, although subsequent attendances have fallen slightly. In Wales, there were just over three million total attendances at consultant-led outpatient clinics in 2007/08, compared with over 2.8 million in 2002/03.[30] In England, there were more than seven million elective admissions in 2007/08, a rise from 5.6 million in 2002/03.[31,32] Elective admissions in Wales totalled 236,791 in 2006/07, up from 220,408 in 2002/03.[33]

FIGURE 6: NHS levels of staff, 2007



Source: Information Centre[43]

Note: Chart calculated using whole-time equivalents

In the independent sector in 2006, around 1.2 million inpatient, day-case and surgical outpatient procedures were carried out in independent hospitals. A further three million outpatient visits are estimated to have taken place.[34]

In NHS mental health services, there were around 112,000 admissions to inpatient care in 2007/08, a decrease of around 70,000 since 2002/03.[35,36]

Community mental health services for adults of working age in England have a total caseload of around 308,000, and dedicated access and crisis services have a caseload of 49,000 people.[37] Activity in 2007/08 included more than 105,000 episodes of home treatment.[38]

The NHS has grown as an employer over the past 10 years. The number of people working for the NHS in England has increased by almost 26% between 1997 and 2007.[39] There are now more than 1.3 million people working in the NHS in England and some 88,000 staff in Wales.[40,41] In England, over three-quarters of the workforce are either professionally qualified clinical staff or people who provide clinical support. Just over 3% of NHS staff are classified as managers.[42]

Value for money

Value for money in healthcare is difficult to measure accurately. The latest productivity measures for the NHS show both inputs and outputs increasing, but with inputs increasing at a faster rate. The result of this is a decrease in productivity of 2% between 2001 and 2005.

These figures should be interpreted with some caution. We have better measures of health inputs than we do of outputs, and it is outcomes that count when thinking about value for money. While it is relatively straightforward to measure increases in activity (for example, consultations and prescriptions), the quality dimension of output is more difficult to measure.

Current calculations include factors such as short-term survival, health gain, waiting times, outcomes in primary care and the experience of patients. But other evidence, such as the fall in deaths from diseases that are amenable to medical intervention, is not yet fully incorporated into the calculations. Estimates of value for money need to be interpreted alongside other forms of corroborative evidence, since a single measure is unlikely to capture all the costs and benefits of healthcare.

Further work to improve these measures is underway. This work will be increasingly important as the pace of increase in funding for the NHS starts to slow, and the NHS faces still greater pressure to show that resources are being used wisely and effectively.

Organisations providing healthcare

In 2007/08, the NHS in England included:

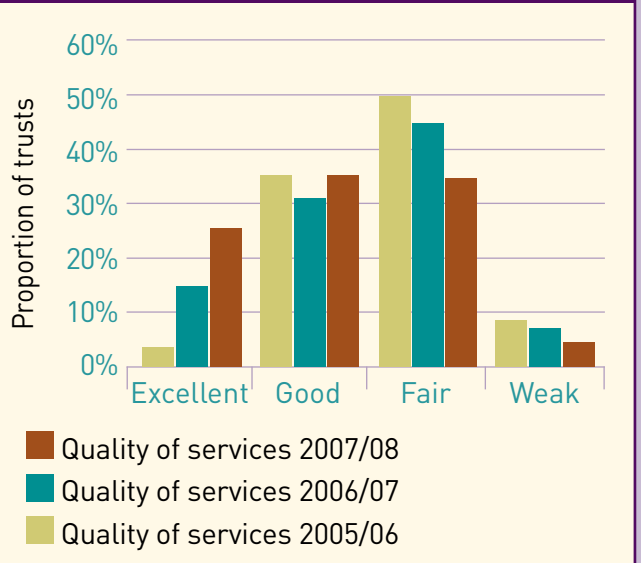
- 152 PCTs, working with approximately 8,300 GP practices. The size of PCT population ranges from under 100,000 to over one million, with an average of around 334,000.
- 169 acute and specialist acute hospital trusts.
- 11 ambulance trusts.
- 59 trusts providing specialist services for people with mental health needs and/or learning disabilities. In addition, 12 PCTs acted as the main provider of mental health services for their area.
- 10 health authorities, overseeing the work of trusts and PCTs (but excluding 89 trusts that had achieved foundation trust status*).

90

Number of NHS walk-in centres in England, including six aimed at commuters

* Foundation trusts are NHS trusts with greater managerial and financial freedom than other trusts, including freedom from central Government control and local health authority performance management.

FIGURE 7: Comparison of performance for quality of services over the lifetime of the annual health check



Source: Healthcare Commission annual health check

In Wales, there were:

- 10 NHS trusts, providing acute hospital, community and mental health services.
- One ambulance trust covering the whole of Wales.
- 22 local health boards, with 495 GP partnerships comprising 1,900 family doctors.[44]

In the independent sector, there were 2,108 registered establishments in 2007/08 (compared with 1,997 in 2006/07). Of these, 310 were acute hospitals and 178 were hospitals for people with mental health needs and/or learning disabilities. There were 372 private doctors, 180 hospices, three maternity establishments and 11 establishments offering terminations of pregnancy. In the prescribed techniques group (which includes lasers and lights, endoscopy, hyperbaric oxygen chambers, IVF and dialysis services), there were 1,054 establishments in total.

Performance in the NHS in England

Our annual health check of the NHS in England provides an assessment of the performance of each trust, both on the quality of the services they commission or provide, and on the use they make of the resources available to them. On each count, we score the organisation "excellent", "good", "fair" or "weak". The ratings are calculated from the trusts' performance against national targets and core standards, and have existed in their current format since 2005/06.

The most recent assessment, for 2007/08, shows continued improvement in meeting the Government's standards and targets and in the use of resources. Since the first annual health check, for 2005/06, we have seen dramatic increases in the proportion of trusts scoring excellent and marked reductions in the proportion assessed as weak. (see figures 7 and 8).

There has been particularly notable improvement in the performance of acute trusts, and in the "existing national targets" component of the assessment of quality of services. This reflects the progress made by the NHS in tackling issues of waiting times for acute care. The significant gains made in recent years in dealing with access to

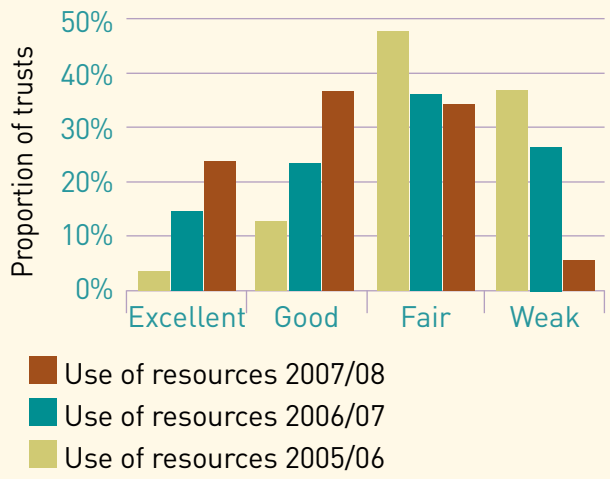
89

Number of trusts in England in 2007/08 that had achieved foundation status

care should not be underestimated. Waiting times for inpatient and outpatient care have improved dramatically, as have those for diagnosis of, and treatment for, cancer.

It is also encouraging that the levels of performance for quality of services and use of resources now have a more similar distribution of scores.

FIGURE 8: Comparison of performance for use of resources over the lifetime of the annual health check



Source: Healthcare Commission annual health check

Annual ratings for the NHS in England are imposed by an act of Parliament. There is no similar requirement in Wales or for independent healthcare. However, all independent providers are required to comply with national minimum standards, and the NHS in Wales is now assessed on an annual basis against the Healthcare Standards for Wales.

We look in more depth at progress on standards later in this report. However, it is worth noting that the introduction of core standards for the NHS, and the work done by organisations to ensure that they meet them and can demonstrate to the public that they do so, represents a major development in the 60-year history of the NHS. Importantly, it provides a platform for a more open, transparent and publicly accountable service in the years to come.

Direction of policy

It is important to point out that there are marked differences between the healthcare systems in England and Wales, and that these differences are getting bigger. The UK Government sets health policy for England, while in Wales this is the responsibility of the Welsh Assembly Government. Both governments set national objectives and targets with the aim of improving health and healthcare.

In very broad terms, the Welsh Assembly Government has, since it was established in 1999, focused much more on primary care and prevention of illness than on secondary care and waiting times. In England, 'patient choice' has become a major plank of national policy. Policies in England such as practice-based commissioning and the world-class commissioning initiative are intended to build up the ability of the NHS, through primary care trusts and GPs, to commission services more effectively and develop local expertise in identifying people's needs. In Wales, consultation is underway on ending the internal NHS market and the split at a local level between commissioners and providers of healthcare.

A new direction for England?

In our previous *State of Healthcare* reports, we have talked about the major changes in the NHS in recent years. These include the reorganisation of PCTs and ambulance trusts, and the introduction into the healthcare system of foundation trusts and independent sector treatment centres.

We have also seen the NHS in England coming to terms with policies such as payment by results, patient choice, practice-based commissioning and the drive to move care out of hospitals and into the community. In the summer of 2008, we published a report, *Is the treatment working? Progress with the NHS system reform programme* with the Audit Commission.[45] We concluded that the programme of reform is having a positive effect on the NHS:

- Patients are getting benefits from the greater diversity of providers of NHS care.
- The possibility of patient choice seems to be changing attitudes among providers (even if the numbers exercising choice are limited).
- Financial reforms have strengthened and clarified financial management.

However, we also found that some changes have been slow to come:

- There has been limited progress in moving care out of hospitals and into primary care and the community.
- Choice is not offered everywhere, and there is limited opportunity for patients to make choices based on quality of care.
- Foundation trust status appears to be doing little so far to deliver innovative models of care for patients. Our annual health check, however, shows that NHS foundation trusts are performing well.
- Most GPs are not yet engaged in commissioning.
- Introducing new workforce contracts has increased costs, without delivering a corresponding increase in productivity.

In the summer of 2008, the Government announced its plans for the NHS in England over the next 10 years, following a review by the health minister and surgeon, Lord Darzi. The review is wide-ranging, with proposals to increase the focus of the NHS on quality and the local autonomy of NHS organisations, with a particular focus on information.

This next stage of reform can be considered a success only when patients and users of healthcare services experience genuine improvements in them. We can find out if this is happening only by gathering high quality information about these services and the experiences of the people using them.

Better measures of clinical outcomes are clearly important. Patient reported outcome measures must also be part of efforts to increase the scope and quality of information about healthcare.

It is also vital that those who need healthcare have a clear understanding of what it is that the various services should be offering to them. In this report, we try to set out, across different areas of healthcare, what is currently offered and how well it matches up to what people have a right to expect.


assurance
reassurance

Meeting standards

In 2007/08, NHS trusts in England were required, for the third year, to publicly declare their compliance with the national Standards for Better Health. In Wales, trusts made their second annual self-assessment against the Healthcare Standards for Wales. Independent healthcare providers continued to be assessed according to the National Minimum Standards.

Although they cover similar ground, these three sets of standards are expressed and assessed differently, and so direct comparison is difficult. They are general standards, dealing with the provision of care by organisations, rather than professional standards concerning the competence and behaviour of clinicians. They have in common a requirement that each healthcare organisation examines its own performance and submits itself to external scrutiny. Standards are the foundation of a more open and transparent health system and give the public, as patients and consumers, a clear view of what they should expect from their services.

Main points at a glance

- The NHS in England has made year-on-year improvements in meeting the national standards set by Government.
- Relatively high levels of compliance with core standards are good news ahead of the new system of registration for the NHS in England in 2010.
- However, more than a third of trusts still only receive a score lower than "fully met", and more work is needed, particularly in the domains of 'safety' and 'governance'.
- We have adopted a new approach to inspecting independent providers of healthcare, which allows us to focus our attention on those establishments where we have the greatest concerns. Our work suggests that there has been some improvement overall.

The NHS in England

NHS trusts in England are assessed against 24 core standards. The Healthcare Commission carries out this assessment, though our annual health check, based on a combination of trusts' own declarations, a rigorous information-based checking process, and on-the-ground inspections.

In our 2007/08 assessment, 64% of trusts "fully met" the standards, and national compliance (that is, the proportion of assessments of standards where trusts were compliant) reached 95%, the highest level in the three-year history of the assessment. Table 2 shows the scores given to each type of trust and figure 9 shows the year-on-year improvements made by trusts.

Looking at the standards by domain, we can see improvement over time, most notably for standards in the domains of 'clinical and cost effectiveness', 'patient focus' and 'public health'. However, in some domains, the standards have consistently low rates of compliance, particularly those in the domains of 'safety' and 'governance' (see figure 10). In the safety domain, poor compliance particularly reflects difficulties with some of the standards relating to the hygiene code (see the section

TABLE 2: Scores against core standards in England, 2007/08

Organisation type	Fully met	Almost met	Partly met	Not met
Acute and specialist trusts	118 (70%) ↑	40 (24%) ↓	8 (5%) ↓	3 (2%) ↓
Ambulance trusts	6 (55%) ↑	3 (27%) ↑	1 (9%) ↑	1 (9%) ↓
Learning disability and other trusts	1 (33%) ↔	0 (0%) ↓	1 (33%) ↔	1 (33%) ↑
Mental health trusts	45 (80%) ↑	10 (18%) ↓	0 (0%) ↓	1 (2%) ↔
Primary care trusts	81 (53%) ↑	49 (32%) ↓	15 (10%) ↓	7 (5%) ↓
Overall	251 (64%) ↑	102 (26%) ↓	25 (6%) ↓	13 (3%) ↓

Source: Healthcare Commission. Note: Arrows indicate increase or decrease compared with 2006/07

of this report "Tackling healthcare associated infections"). In the governance domain, standards with lower rates of compliance include those on discrimination, management of records and mandatory training.

Where our information, which may include evidence from a visit to the trust, tells us that an aspect of a trust's declaration is inaccurate, we are able to 'qualify' the declaration. In 2007/08, we qualified 117 of the 396 standards we inspected, an overall qualification rate of 30%. This compares with 23% in 2006/07 and 21% in 2005/06. We inspected 79 trusts against one or more standards, selected either randomly or on the basis of risk. Forty-five of these (57%) had their overall score for the core standards component of the annual health check changed as a result. This compares to around 40% in each of the previous two years. The reasons for this shift are complex, but one factor is that more of our inspections for 2007/08 were selected on the basis of risk, rather than at random. Also, in each year of the assessment, we have become more adept at finding weaknesses, and at targeting our inspection activity to check the self-declarations of those trusts considered to be most at risk of misrepresentation.

Work we have commissioned to evaluate the impact on the NHS of the assessment against core standards suggests that the process is beneficial. Seventy per cent of trusts agreed that the process of self-declaration was a good use of staff's time, 68% that the assessment had improved the care of patients and 67% that it had improved the safety of patients.

Overall, the progress the NHS in England has made on standards is welcome. Nationally, compliance in the NHS with the core standards is 95%. But this figure still hides a great deal of variation in performance between individual trusts which, if not improved, may cause problems as the NHS moves into the new system of registration. Broadly speaking, in most areas covered by the standards, the NHS is well placed to meet the requirements of the new system of registration, which will be fully in place from April 2010. However, too many organisations still need to up their game. The standards were first published in the summer of 2004. The aspiration was that trusts would meet them all from day one. It is disappointing that, four years on, around 36% of trusts are scored at less than "fully met".

Independent healthcare in England

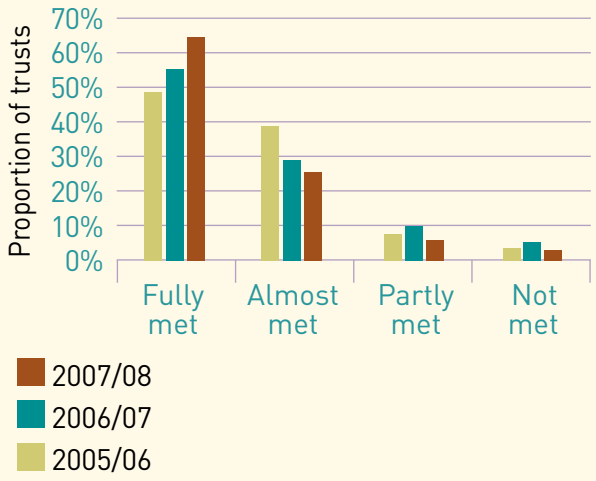
Independent healthcare providers in England have, since 2000, been subject to the Government's national minimum standards.

Each establishment has to be inspected at least once every five years, and has to make an annual statement, with evidence, on their compliance with the standards. There are two categories: the 32 core standards apply to all providers, while the service specific standards are organised by type of provider, for example, acute hospital or mental health services.

Our approach to assessing and inspecting independent providers against the standards has changed over the last two years and, in discussing performance in this sector, it is important to be clear about the nature of this change.

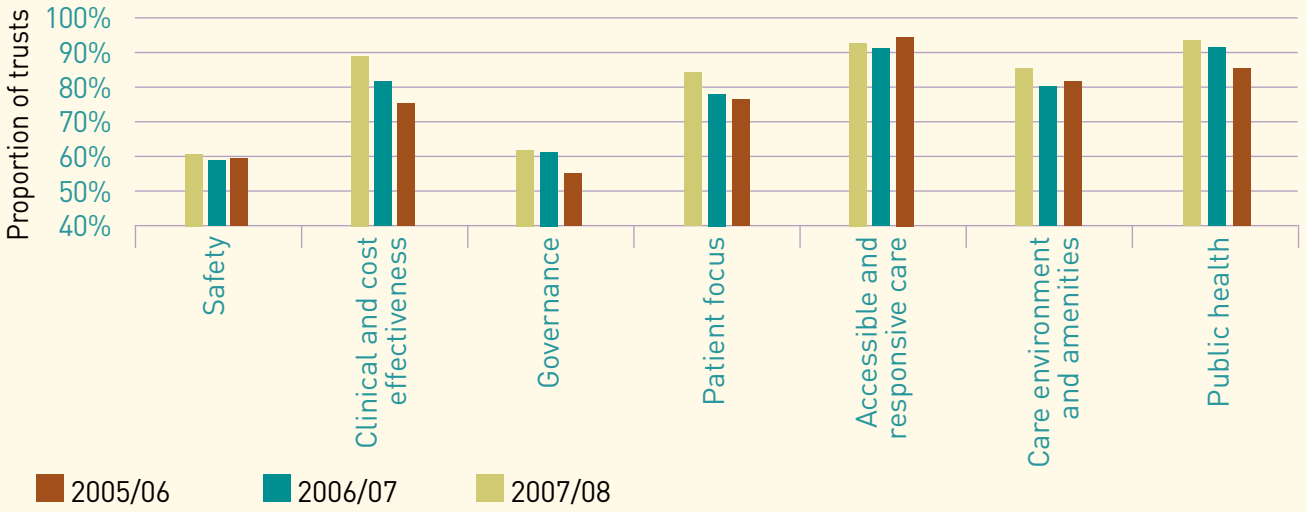
Previously we physically inspected every independent establishment, every year. From 2006/07, we adopted a new approach focusing our on-site inspections on services that give most cause for concern. This was aimed at aligning our approaches to the NHS and the private sector. We carry out a detailed risk assessment for every independent establishment and inspect where our local assessors have reason to believe that an establishment is at risk of non-compliance with one or more of the minimum standards. As a result, we have been able to reduce our rate of inspection, as shown in table 2.

FIGURE 9: Comparison of performance against NHS core standards in England, 2005/06 – 2007/08



Source: Healthcare Commission annual health check

FIGURE 10: Proportion of trusts which comply with all standards in a domain



Source: Healthcare Commission

In 2008/09, we began a programme of scheduled inspections to ensure that all establishments are inspected at least once every five years. These changes to our approach will, we hope, enable us to reduce unnecessary burden on establishments, and ensure that we can check on progress after inspections and act more quickly when we have evidence of poor services.

Table 3 shows that, in 2007/08, mental health establishments were the most likely to be inspected, which reflects our long-standing concerns about the performance of these providers. The variation in inspection rates across sectors may reflect differences in the likely risk of harm to patients, and the identified risk of non-compliance in specific sectors.

Table 4 summarises the results we have obtained for the last three years. While this appears to show substantial improvement, our introduction of risk-based assessments may have had an impact on these results. We will explore this further in our future work, aiming to ensure we have a good information available on all sectors. Table A2 in the appendix gives a picture of our findings at inspection in both 2006/07 and 2007/08, not including those providers and standards that our information suggests are not at risk of complying, and may therefore be more helpful in looking at change over time.

Table 5 provides a breakdown of the results for core standards by the major types of provider. More detailed standard-by-standard results may be found in the appendix to this report.

Across all inspections in 2007/08, the most commonly inspected standards were C4, C9, C20, C17 and C6. The least frequently inspected were C5, C32, C11 and C19 (see the appendix for full descriptions). At inspection, those standards found most often to be "not met" were:

TABLE 3: Inspection rates in independent healthcare, 2006/07 and 2007/08

Sector	Establishments inspected 2006/07	Establishments inspected 2007/08
Acute hospitals	87%	24%
Mental health hospitals	98%	61%
Private doctors	75%	6%
Hospices	48%	8%
Lasers and lights	79%	12%
Other	69%	18%
Total	78%	17%

Source: Healthcare Commission

Note: 2005/06 inspection rate was 100% for all establishments

- C8: patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clear line of accountability for the delivery of services.
- C9: patients receive care from appropriately recruited, trained and qualified staff.
- C7: appropriate policies and procedures are in place to help ensure the quality of treatment and services.

We continue to act where we have serious concerns about the safety of the services offered by independent providers. Our investigations and enforcement have risen in the independent sector. During 2007/08, we investigated 28 cases for suspected breaches of regulations and offences under the Care Standards Act 2000. In terms of enforcement action, we instigated prosecutions against two services (eventually leading to conviction). This compares with 23 investigations and

TABLE 4: Independent sectors' (all providers) compliance with core national minimum standards, 2005/06-2007/08

	Met (including 'risked out' and almost met) all 32	Met (including 'risked out' and almost met) 29 or more	Failed five or more
2007/08	92.7%	98.5%	1.1%
2006/07	66.8%	91.5%	5.7%
2005/06	50.0%	85.0%	10.0%

Source: Healthcare Commission

TABLE 5: Independent sectors' compliance with core national minimum standards, 2007/08 by sector

Type of provider	Met (including 'risked out' and almost met) all 32	Met (including 'risked out' and almost met) 29 or more	Failed five or more
Acute hospitals	89.4%	98.1%	1.9%
Mental health providers	75.8%	96.6%	1.7%
Private doctors	97.3%	99.2%	0.5%
Hospices	95.6%	99.4%	0.0%
Lasers and lights	94.8%	98.7%	1.0%

Source: Healthcare Commission
Note: Categories are overarching. Each provider organisation features only once in this table.

one prosecution in the previous year. Also, in 2007/08, we issued seven statutory improvement notices in cases where our concerns were so serious that prosecution would be an option if the provider did not take immediate action.

Healthcare Standards for Wales

In December 2007, Healthcare Inspectorate Wales (HIW) published its first review of compliance with the Healthcare Standards for Wales. While the standards themselves cover similar ground, HIW has adopted a very different model of assessment to the one used for the NHS in England. The assessment does not result in a single overall score. Instead, for each of the standards, NHS organisations report on their level of 'maturity' from a 'corporate', 'operational' and 'user experience' perspective. 2007 was very much a developmental year, as organisations got used to the new system.

The results for the 2008 assessment are expected later in December 2008, and so were unavailable for inclusion in this year's *State of Healthcare* report. The details are available from the HIW website at www.hiw.org.uk.

Providing safer care

There are always risks involved in healthcare. Even where there is world-class, clinically effective care, things can go wrong. How organisations respond when patients are harmed and how they anticipate and prevent harm – particularly in areas that are prone to such problems – is of great importance to the health of individuals and a fundamental feature of organisational culture.

Main points at a glance

- Our work shows that the safety of care provided to patients has noticeably moved up the agenda for providers of healthcare and there are some examples of good practice.
- Only around half of trusts in England comply with all of the Government's core standards relating to safety.
- There is a growing body of evidence about what works to improve safety. Our work shows the importance of leadership and of making safe care the core of the organisation's activity. Wider agreement is needed on what 'good' safety looks like.
- Our assessments show that effective systems are not always in place to understand safe care and risk, report and act on individual incidents, and analyse and act on wider lessons. The new registration requirements for health and social care should include such systems.
- Organisations still need to do more to encourage a culture of openness in identifying and reporting untoward events.
- More systematic reporting is needed, particularly from GPs.
- Better comparative information about safe care needs to be generated at national, organisation and service level, to give confidence that good practice is being followed and risks are being addressed.
- A national database of serious untoward incidents should be compiled with clear responsibilities as to who should take what action in relation to them.

How safe is care?

It is estimated that one in 10 patients admitted to hospitals in developed countries will suffer harm as the result of something going wrong – either where errors are made, or where some things are not done that should be done. A third of these people will suffer severe illness or die.[46] Around half of these occurrences of unsafe care could be avoided if lessons from previous incidents were learned. Safe care means following good practice.

In primary care, research estimates that medical errors occur up to 80 times per 100,000 consultations (up to 600 errors a day), mainly in diagnosis and treatment. Up to 20% of these lead to harm.[47] While not every lapse in care is due to negligence, figures from the

NHS Litigation Authority show that the cost of clinical negligence in England was £579 million in 2006/07.

Incidents affecting safe care

One picture of safe care in England and Wales, and the causes of harm, is available from the National Reporting and Learning System (NRLS), operated by the National Patient Safety Agency. This collects information on incidents affecting the safety of patients in the NHS, from organisations' own reports.

Between April 2007 and March 2008, 959,590 incidents (including 'near misses') were submitted to the NRLS: 893,421 were from England and 49,273 were from Wales. The vast majority of these caused low levels of harm to patients, or no harm at all. However, of the incidents reported to have occurred during 2007/08, there were 7,660 reported cases of severe harm and 3,471 deaths.

As shown in figure 11, the largest category of incident during 2007/08 (294,500 incidents, 34%) were accidents to patients – largely slips, trips and falls. Many falls are relatively minor, but falls can lead to more serious injury, more time in hospital, and even death. There are things that can be done to reduce the likelihood of a fall, such as providing better footwear or reviewing medication. The next most common incidents related to treatment and procedures (82,000, 10%), such as marking the wrong part of the body for an operation, and to medication (76,800, 9%).

While the number of incidents reported to the NRLS is increasing, the information gathered by no means represents the full picture. Firstly, research shows that reporting systems capture only a proportion of incidents and can tend to underestimate the levels of harm that have been caused.[48] To determine the full scale of harm, other methods would need to be used, such as case reviews. Particular types of incident are under-reported, and some groups of staff are not as likely to report incidents as others.

For example, data on infection for England, reported by the Health Protection Agency, shows a combined total of around 60,000 cases of *C. difficile* and MRSA bloodstream infections during 2007/08. (This figure excludes a range of other types of infection). However, only 13,400 incidents of infection were reported to the NPSA in the same period. This is because infection cases, in particular, are often monitored in separate local reporting systems.

Secondly, not every organisation sends in reports. Seven per cent of acute trusts, 14% of mental health trusts and 13% of primary care trusts in England did not report any incidents between April and June 2008. And just 0.3% of incidents reported to have occurred in England and Wales during 2007/08 were from general practice, despite the fact that the greatest number of contacts with patients is with GPs, and that the largest number of complaints that the Healthcare Commission reviews relate to primary care (38.4% for the year to July 2007).

To improve the safety of care, organisations need to use a range of reporting and detection methods, analyses and investigative tools. For example, more trusts are now using the 'Global Trigger Tool', which involves looking through patient case notes regularly to identify incidents.

Meeting standards on safe care

Trusts can improve the safety of care and avoid incidents, by having strong systems in place to ensure safer practices are implemented by staff. The performance of trusts on standards tells us the extent to which this happens.

Of the core standards set for NHS organisations in England, 12 are related to safe care, covering areas such as whether the organisation learns

from incidents, and how safely it manages medicines. Performance on these standards is mixed. Between 77% and 97% of organisations met each individual standard for 2007/08, and performance on three of the standards was worse than for 2006/07 (see figure 12). For some, for example the standard on decontamination, this is because assessments are now clearer and tougher than before.

We are concerned that performance has not consistently improved across the three years of the annual health check. In 2007/08, 49% of trusts met all standards on safe care, compared with 51% in 2006/07 and 46% in 2005/06.

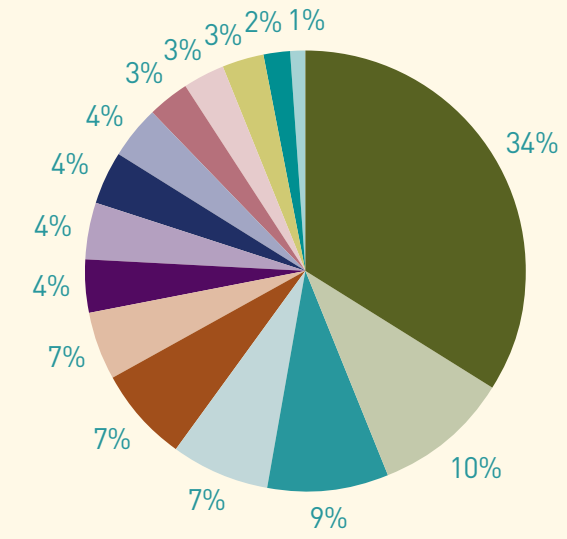
This suggests that, generally, the systems in place to ensure safer care are not yet strong enough or universally adopted. Our in-depth work in a number of areas of safe care, including infection control, supports this view (and is described in more detail in the following section).

How trusts address different areas of safe care

Through our reviews, inspections, surveys and work on complaints, we have examined a number of areas of safe care in recent years. Our key findings include:

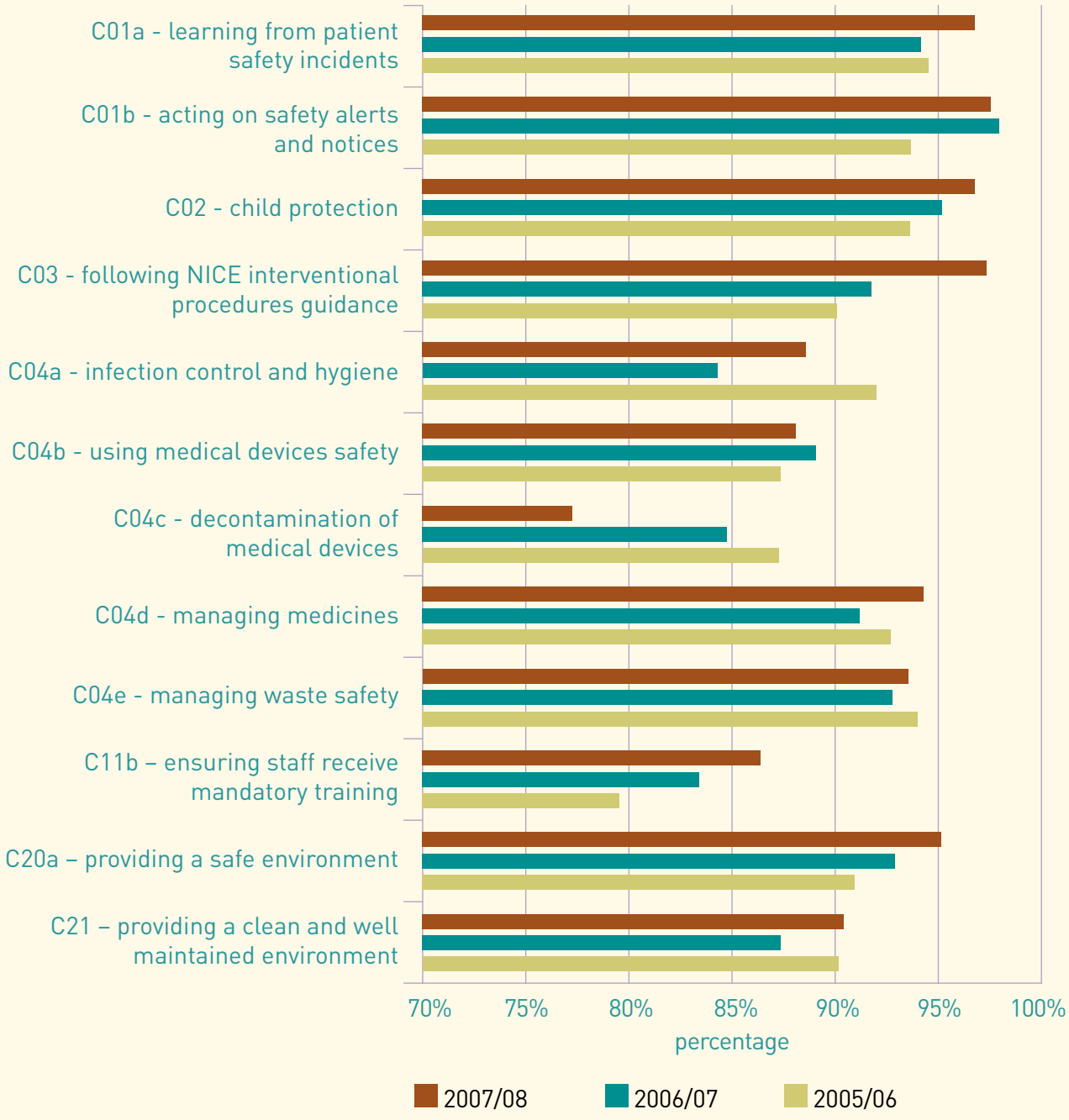
- There have been advances in infection prevention and control. Nationally, the target on MRSA has been met. However, almost all the trusts we have visited do not comply with all elements of the hygiene code (though we have found few material breaches of the code), and a number have not met their individual MRSA targets.
- Providers have taken steps to improve the management of controlled drugs, following the Shipman Inquiry.[49] However, the risks associated with medication during the handover of patients between clinicians and in certain settings (such as mental health care) are not well addressed. For example,

FIGURE 11: Percentage of incidents in England and Wales reported to the NRLS, by type, 2007/08



Source: NPSA National Reporting and Learning System. Incidents reported to have occurred during 2007/08

FIGURE 12: NHS trust compliance with standards relating to safety 2005/06-2007/08



Source: Healthcare Commission

in our 2006/07 review of the management of medicines, only 30% of PCTs said that GPs thought they received adequate information on patients' medicines on discharge from a hospital.[50] We are doing more work on this matter, and will publish the results in 2009.

- Our surveys of NHS staff show that levels of stress, work-related illness and injury are high, with 33% reporting that they are stressed and 17% that they have suffered work-related illness or injury.[51] Over the past three years, we have seen little change in the proportion of staff who report being physically attacked or abused at work, despite campaigns to tackle these matters. Only around half of staff felt that their trust took effective action after incidents of violence, harassment, bullying or abuse.
- Twenty-three per cent of the complaints about GPs that we reviewed concerned a failure or delay in diagnosing a condition.[52]
- Nationally, 11% of all inpatients in mental health services were assaulted in 2006, according to their care records.[53] Our 2008 review of these services found one in six trusts to be significantly above this average.[54]
- Poor understanding of procedures and responsibilities for the protection of vulnerable adults was a serious underlying problem in the two investigations into services for people with learning disabilities that we conducted. The multi-agency Safeguarding children report for 2008 highlighted the lack of priority given to procedures for safeguarding children by some NHS trusts.
- As noted above, sometimes a patient can be harmed by inaction. Through our reviews and audits, we have found evidence of the physical health needs of those with learning disabilities or mental health problems being overlooked.

Clearly, in some of these areas, performance and outcomes are improving. However, positive action has not been universal, rapid or always robust. Stronger systems are needed so that there can be assurance that safer care is provided.

Why is care not getting safer, more quickly?

There are a number of reasons to believe that the safety of patients is now a higher priority for healthcare organisations. These include the increased reporting of incidents and boards themselves saying that they are paying more attention to safe care, influenced by both national priorities and the aftermath of our high-profile investigations. However, a culture that encourages openness in admitting when things go wrong, addressing the root causes, reporting incidents and acting on the lessons from them has not yet become widespread.

As discussed above, some organisations need to make substantial improvements to their reporting. Our experience of what happens when incidents involving the use of radiation are reported to us illustrates this. By law, providers must report any incident when a patient is exposed to a dose of ionising radiation "much greater than intended". Over the past two years, we have received around 600 reports. To put this in context, around 25 million diagnostic imaging examinations involving ionising radiation are carried out each year.

Most of the exposures reported are at low doses and carry little additional risk to patients. However, the rates of reporting made by individual organisations vary considerably, and many organisations have not reported any incidents.

Our investigations into serious failure of services have often found, as an underlying factor, that staff felt unable to report problems, leading to these problems going unaddressed.

A higher level of reporting, paradoxically, indicates a stronger culture of safety. It increases the potential for learning and the prevention of further harm. It is important that even incidents that lead to no harm are reported, so that risks, hazards and good practice can be identified before harm occurs. The culture of reporting in England and Wales is such that, for the moment, any increase in reported incidents is to be welcomed. However, reporting on its own is worthless unless incidents are analysed so that improvements can be made.

Based on our assessments, we believe that organisations often fail to carry out systematic analysis following incidents, to identify contributory factors and the action required. Errors often have common root causes that can be addressed across organizations, something we have found in some of our annual health check visits to trusts. Our work on complaints has also found that trusts could do much to improve the way they use lessons from complaints to improve services.

This view is supported by our survey of NHS staff. While three-quarters of staff felt that they were encouraged to report incidents, and only a small proportion (12%) felt that reporting errors would lead to blaming those involved, only around half felt that action was taken to prevent similar errors happening in the future. Staff were much less likely (31%) to say they were informed about changes resulting from incidents that occurred in their trust.

Better leadership at all levels in organisations, proper training of staff and clear lines of accountability are all needed, to ensure that safer practice is provided. Our investigations have found common factors: poor leadership, ineffective management, inadequate teamwork (either between management and clinicians or between clinicians themselves), poor information, and a lack of clarity about who was responsible for what across the trust, from ward to board.

It is crucial that boards of trusts routinely receive key information on a range of factors that affect the safety of care – such as rates of infection, errors in medication and compliance with good practice. We have been surprised to find that many boards involved in our investigations did not have systems in place to ensure this. These boards were unable to spot problems and fix them before they led to further harm. We have too often found that they concentrated on other activities, such as the delivery of targets or mergers, at the expense of safety. Successful boards can manage all the competing claims that they have to deal with.

Our recent research work on governance has found that boards are paying more attention to safe care, largely driven by concern for such matters as infection control. However, the priority given and approach taken varies and, in most cases, detailed scrutiny of the safety of care takes place at committee level, with only key facts and exceptions reported to the board.

Most boards receive reports on serious untoward incidents, healthcare-associated infections and complaints, but immediate targets or finances still tend to dominate their priorities. Some boards consider information on the views of patients and staff about safety, but most feel they could do more to consider the experience of patients in relation to safety.

Research found that some boards are better than others in converting increased focus into systematic change throughout the organisation. Acute trusts (and in particular foundation trusts) tended to be more advanced in terms of reporting, due to better information systems and, perhaps, because targets applied to the sector gave rise to a culture of collecting and acting on information.

Reporting on actions is less developed in PCTs, perhaps due to the disruption that came from the changes in PCT boundaries and development in their roles, as well as poor infrastructure. There has been limited development of systematic processes for PCTs to monitor the safety of providers.

Our early evidence from further research shows that, in many cases, decision-making and acting on safety is devolved to local services or departments. In many situations this would be fine, allowing local solutions to problems to be developed, providing that good information was available to check that sufficient improvements had been made. However, monitoring and audit of improvements in safety is often poor.

What more needs to be done?

Firstly, boards need to become more involved. They need to broaden their approach, looking regularly at how their organisation is improving in a range of key areas of safe care, not just single issues. They should also work to understand and monitor their local safety culture using, for example, the results of staff surveys.

There are various ways boards can be supported in this. The Government is introducing 'quality accounts', in which organisations will report on the quality of their services. Setting out clearly what boards should include on safety in their accounts should drive improvement in the way boards address safe care. Lord Darzi's review also proposed the reporting of 'never events' – the most serious (and largely preventable) incidents.

The new Care Quality Commission will develop the criteria by which organisations are assessed, and should embed key aspects of safe care in its review and assessments across health and social care. A range of bodies offer programmes for improving leadership in safety: these should be targeted at organisations struggling to meet safety standards.

Secondly, reporting must improve. A culture of openness and fairness needs to be promoted by leaders nationally and locally, and reporting routes must be simplified. At the moment, trusts have to report incidents to a variety of organisations, which is confusing and may drive down the level of reporting and so the potential for lessons to be learned nationally. The NPSA's work in developing a new reporting route for incidents is therefore vital.

More should be done to involve patients in the safety of their care: communicating more about potential risks; encouraging patients to challenge staff and ask questions; being open and honest with patients and their carers when things have gone wrong; and learning from the experiences of patients.

Finally, a particular effort needs to be made to increase the focus on safe care, both in primary care and in the PCTs that commission care from GPs. This is particularly important, given that the vast majority of contacts that patients have are with GPs and their staff, and in view of the significant risks associated with prescribing medicines or making a wrong diagnosis. As a first step, those working in primary care should be encouraged to monitor the extent to which they follow good practice, report incidents, and try more regularly to learn from them.

The safety of care is improving, as its fundamental impact on the quality of services and outcomes for patients is increasingly recognised. But the NHS has some way to go to ensure it properly learns lessons when things go wrong, anticipates and prevents harm where possible, and has systems that ensure safe practice is followed every time, for every patient.

Tackling healthcare-associated infections

Healthcare-associated infections (HCAIs) have been a dominant theme in public discussions about healthcare during the last five years. Two infections in particular – those caused by MRSA and *C. difficile* – are of significant concern to the public, because of the perceived risk of acquiring them while in hospital and the misconception that they can't be treated.

Main points at a glance

- The NHS has made a major impact on reducing MRSA infections, and the national target for reducing infections has been met. But almost half of trusts did not meet their individual targets for reducing or minimising MRSA infections during 2007/08.
- *C. difficile* is still a major problem for the NHS, but there are encouraging signs of recent improvement in dealing with it.
- Trusts are clearly tackling infection prevention and control vigorously. However, few trusts fully comply with the hygiene code, but we have found few breaches of the code that posed an immediate risk to patients. Trusts do need to ensure they have comprehensive systems in place to maintain the decrease in infection rates.
- Healthcare providers need to ensure that they improve their systems to tackle all infections, and not just focus on MRSA and *C. difficile*. This should be underpinned by agreement at a national level on what infections should be measured and how.

The Healthcare Commission has played a key role in highlighting some of the issues surrounding HCAIs, and the problems the NHS has faced in limiting their impact, especially through our two investigations into serious outbreaks of *Clostridium difficile* (*C. difficile*) in NHS hospitals in Buckinghamshire and Kent.[55] However, HCAIs are not limited to these two infections, and we have also looked closely at the efforts healthcare organisations are making to tackle HCAIs generally, and to improve hygiene and cleanliness across the board.

MRSA

Staphylococcus aureus is a common germ that is found on the skin and in the nostrils of about a third of all healthy people. It can cause harm if it enters the body, particularly infecting wounds or the bloodstream. MRSA is a variety of *Staphylococcus aureus* that has developed resistance to meticillin (a type of penicillin) and some other antibiotics that are used to treat infections, although there are still antibiotics available to treat MRSA.

Good hygiene practice can help to prevent MRSA infections, and the use of alcohol hand gel can help to prevent it being passed from person to person in hospital. Good practice is also important in reassuring patients and the public. Our analyses of our national surveys of NHS staff and patients have found significant positive associations between the availability of

hand washing materials, as reported by staff, and patients' responses to questions about cleanliness of wards and bathrooms and about doctors and nursing staff washing their hands between touching patients.[56]

Since 2001, it has been mandatory for all NHS organisations in England to report MRSA bloodstream infections to the Health Protection Agency (HPA). In Wales, NHS organisations report to the National Public Health Service (NPHS).

Independent providers of healthcare in England have also begun reporting centrally on HCAIs, with access to the HPA's web-enabled reporting system for MRSA and *C. difficile* available to them from the beginning of 2008. However, MRSA infections, and HCAIs more generally, are much less of a problem in the independent sector than in the NHS. Numbers of patients are smaller and almost all admissions to hospital are planned (people admitted on a planned basis tend to be healthier and therefore less vulnerable to infection). Along with good hygiene and infection control, these factors are helpful to providers in ensuring high standards of hygiene and cleanliness, and keeping rates of infection low.

The most recent figures for MRSA bloodstream infections, for 2007/08, show a sharp decline in the infection rate in England. Rates in Wales have always been lower than in England, and while they have been declining in recent years, albeit more steadily, the rate for 2007/08 is higher than for 2006/07. Figure 13 shows the trends for the two countries.

Rates of death involving MRSA have been rising in recent years, as shown in figure 14, partly because of greater recognition of MRSA as an underlying cause of deaths and improved recording on death certificates.

1,593

Mentions of MRSA on death certificates in 2007 – the first year the number has declined

However, in 2007, there were 1,593 mentions of MRSA on death certificates compared with 1,652 in 2006 – the first time the number has declined. In 29% of these, MRSA was noted as an underlying cause of death. There is little difference in the death rates for England and Wales. The rate is considerably higher for men than it is for women.

C. difficile

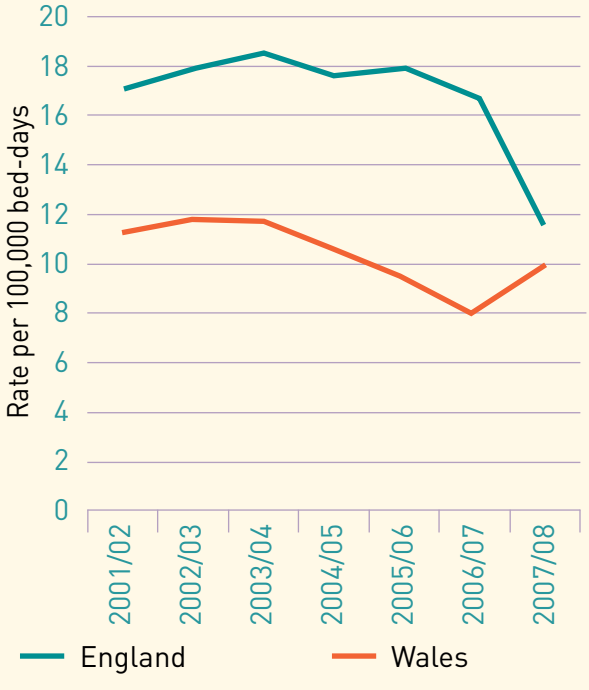
C. difficile associated disease is an infection caused by bacteria. The infection often occurs after someone has taken antibiotics to treat another illness. It can lead to diarrhoea and severe inflammation of the bowel. Those taking broad-spectrum antibiotics, and older people with other, underlying diseases, are at most risk – more than 80% of *C. difficile* infections occur in people who are 65 and over. *C. difficile* spreads via spores shed in faeces. Washing hands with soap and water, effective use of isolation, and ensuring that bed linen, toilet facilities and the general environment are kept clean, are important steps in stopping the spread of the infection and minimising the risk to other patients.

NHS organisations in England have been required to report on *C. difficile* since January 2004. Initially this was just where it affected people over 65 but, since April 2007, reporting requirements cover all people over two years

old. In Wales, NHS organisations have been required to report to the NPHS since January 2005.

The absolute number of infections in England fell in 2007, the first annual decrease since data collection began in 2004. For people over 65, there were 50,392 cases in 2007, compared with 55,635 the previous year. The rate of infection has also fallen, as shown in figure 15. Data for the first quarter of 2008/09 showed a fall in cases on the previous quarter of 18%, and a fall of 38% against the same quarter of 2007.[57] This gives real cause for optimism that progress is being made in reducing *C. difficile* infections, although we need to see this sustained over a longer period before we can say that the NHS has turned a corner on *C. difficile.*

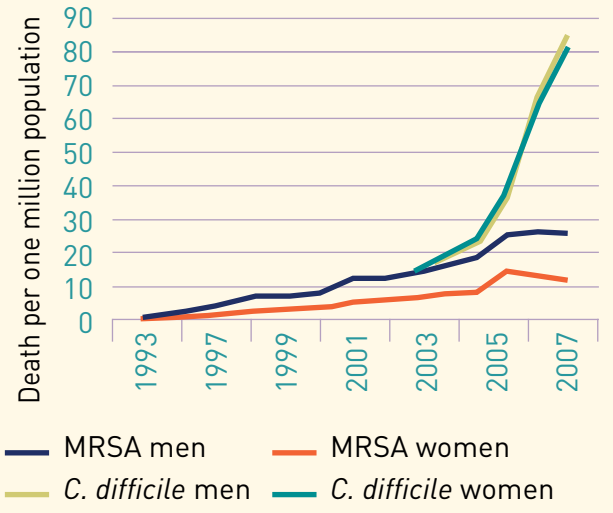
FIGURE 13: MRSA bloodstream infection rates, 2001/02-2007/08



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

In Wales, there were 3,072 cases identified in hospital inpatients aged 65 and over between July 2007 and June 2008, representing an increase of almost 10% on the previous 12 months. The infection rate in Welsh NHS hospitals increased to 18 per 1,000 admissions, from 16 per 1,000. The rates for England and Wales cannot be compared, as the methods used to calculate them are different. For the first 12 months of reporting in England for people aged two to 64, there were 8,385 reported cases in acute hospitals, a rate of 0.6 per 1,000 bed-days.

FIGURE 14: Deaths involving MRSA and *C. difficile* in England and Wales, 1993-2007



Source: Office for National Statistics.

Note: Routine coding of deaths involving *C. difficile* began in 2001

The monitoring of deaths caused by *C.difficile* has only been possible since 2001. As with MRSA, there has been a sharp increase in mentions on death certificates, again attributable in some part to increased awareness and much better recording.

Other healthcare-associated infections

In focusing on MRSA and *C. difficile*, trusts should not lose sight of the risks posed by other infections. One of the key lessons of our work investigating outbreaks of *C. difficile* was that a trust that adopts too narrow a focus on one type of infection may miss an emerging threat posed by others. The statutory hygiene code (see below) requires that trusts have effective systems to prevent or minimise all infections, understood and followed throughout organisations 'from board to ward'. Trusts need to monitor carefully other types of infection and act quickly where problems arise. Nationally, we need to ensure that we collect statistics for all the infections we want to prevent and control.

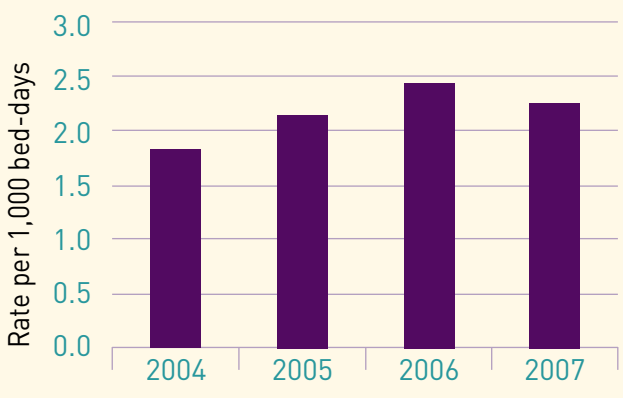
Mandatory surveillance is in place in NHS trusts for glycopeptide-resistant enterococcal (GRE) bloodstream infections and a voluntary surveillance scheme for surgical site infections (SSIs). GRE infections in England have been steady for the last two years at around 900 reports a year.

Participation in SSI surveillance has increased in recent years. In 2007 in England, 224 hospitals collected data on 83,444 surgical procedures across 10 categories of surgery. Almost 900 SSIs were identified that year, of which MRSA accounted for 64%. The majority of SSIs reported affected superficial tissue, but approximately a third were more serious, deep infections.[58] There is evidence of a continued downward trend in rates of SSI in most categories of surgical procedure. For example, the risk of SSI has decreased significantly in hip and knee replacement surgery and hip arthroplasty. Work is underway to extend surveillance of SSIs to include the period after discharge from hospital. In Wales, rates for SSIs are also falling.

Although not strictly HCAIs, norovirus infections are a greater cause for concern. They are the most common cause of gastroenteritis in the UK. Also known as the 'winter vomiting disease', noroviruses are highly infectious. They can pose a problem because hospitals are places in which many people are gathered together (norovirus infections can also affect schools and cruise ships) and because infections can be brought in by visitors. Incidence is high and studies suggest that, on average, hospital wards are affected at least once a year.

To control outbreaks of norovirus, affected wards should be closed to new admissions and staff with the illness excluded for 48 hours. This is highly disruptive and, in an epidemic year, can cost NHS inpatient services more than £100 million.[59] While there is currently no national surveillance scheme for norovirus outbreaks in hospitals, provisional data for 2006 show that there were 4,446 laboratory reports of cases in England and Wales, but this figure under-represents the true burden of illness.[60]

FIGURE 15: *C. difficile* infection rate in patients aged 65 and over in England, 2004-2007



Source: Health Protection Agency

Tackling healthcare-associated infections

A range of initiatives have been introduced to tackle HCAIs and to monitor the success of local efforts.

Targets

In 2004, the Government set a national target to halve the number of MRSA infections in acute NHS hospitals in England by March 2008. This target was met, with data for the first quarter of 2008/09 showing 836 infections (compared with a quarterly average for 2003/04 of 1,925).

To deliver this target, trusts were given their own individual, and more stretching, targets. Each acute and specialist trust with more than 12 MRSA bloodstream infections in 2003/04 (the baseline year) aimed to either reduce by 60% the number of infections by 2007/08, or have no more than 12 infections in that year. Trusts with 12 or fewer infections in 2003/04 were expected to maintain or reduce these levels. Fifty-two per cent of trusts achieved their individual targets for 2007/08.

In 2007/08, acute trusts were assessed against an indicator that required them to agree with their PCTs local targets for the reduction of *C. difficile* infections, and to ensure that the data submitted to the mandatory surveillance programme was timely and of good quality. Ninety-seven per cent of acute trusts achieved the indicator. From 2008/09, trusts will be assessed against local targets for reducing the incidence of infections, within the context of a national target for a 30% reduction by 2010/11.

The hygiene code and related standards

NHS trusts in England are now required by law to comply with the *Code of practice for the prevention and control of healthcare associated infections*, known more simply as the hygiene code. The Healthcare Commission carries out inspections against the requirements of the code. Where we have significant concerns, we have the power to issue 'improvement notices' – legal notices requiring specific improvements within a stated timescale. We then follow these up with a further inspection. As this report went to press, we had carried out 98 inspections as part of our programme for 2008/09 and 120 inspections in 2007/08.

Based on our findings from the 51 inspections we carried out in the first half of the calendar year 2008, few trusts fully comply with the code.[61] Just five met all of the duties and sub-

TABLE 6: Compliance with core standards relating to the hygiene code, 2007/08

NHS trust type	Standard C4a	Standard C4c	Standard C21	All applicable standards
Acute	90% (81%)	85% (93%)	92% (91%)	74% (73%)
Ambulance	82% (83%)	n/a (100%)	100% (83%)	82% (75%)
Mental health (including learning disability and community trusts)	92% (93%)	n/a	90% (90%)	81% (83%)
PCT	86% (84%)	68% (70%)	88% (83%)	58% (59%)
All trusts	88% (84%)	77% (85%)	90% (88%)	69% (69%)

Source: Healthcare Commission. Results for 2006/07 are in brackets.

> Based on our findings from the 51 inspections we carried out in the first half of the calendar year 2008, few trusts fully comply with the code.

duties we inspected them against. However, we found only a small number of 'material' breaches of the code (that is, a serious problem with a trust's arrangements for preventing and controlling infections, which we consider represents a risk to patients, visitors and staff). Out of the total number of breaches in this sample of 51 trusts, only 3% were material breaches.

We found a high level of compliance across many of the sub-duties concerned with appropriate management systems for infection prevention and control (duty 2). We did not identify a material breach of this duty in any of these 51 trusts. We did find breaches of the sub-duty that relates to training and supervision (2d) – 11 trusts did not meet this.

Compliance with the sub-duties related to cleanliness and the environment (duty 4) was more mixed. A high number of trusts (between 47 and 50 out of 51) met those that relate to having lead managers for cleaning and decontamination (4b), a supply of linen and laundry that meets guidance (4g), and a uniform and workwear policy (4h).

However, 27 trusts did not meet the sub-duty that relates to premises being suitable, clean and well maintained (4c). For one of the 27 trusts, the breach of this sub-duty was considered to pose a possible risk to the safety of patients, and was categorised as a material breach. Thirty-one trusts did not meet the sub-duty that relates to standards of cleaning being specified in cleaning arrangements and schedules of cleaning frequencies being publicly available (4d). These two (4c and 4d) were the two sub-duties most likely to be breached by trusts. In addition, there was a strong correlation between them – of the 31 trusts that did not follow all the guidance on cleaning arrangements, 18 also did not have consistently suitable, clean and well-maintained premises.

While we may have found particular areas of a hospital to be unclean on the day of inspection, this does not imply that the trust's premises are unclean overall – it is possible that the problem is not wide-spread. It does, however, indicate that the trust's approach to cleaning may not be consistent, thorough or frequent enough, which in turn may suggest a weakness in the trust's systems or policies. As we noted above, the vast majority of breaches that inspectors found in sub-duties relating to cleaning were not material breaches, meaning that we did not have serious concerns that there was an immediate risk to the safety of patients.

The sub-duty that relates to facilities for hand washing and antibacterial hand rubs (4e) was not complied with by 11 trusts. The same number of trusts did not comply with the sub-duty that relates to the decontamination of instruments and other equipment (4f). For example, in a number of trusts we observed a failure to ensure that clean and dirty items did not come into contact with each other. A material breach was most likely to be found for the sub-duty on decontamination (4f) – a material breach of this sub-duty was found in three trusts.

The duty that relates to the provision of suitable isolation facilities (duty 8) was breached by six out of 48 trusts. Reasons ranged from a lack of an assessment to identify the overall need for isolation facilities, to not having enough isolation facilities.

Out of the first 51 published inspections, improvement notices were issued to three trusts, which were for the three trusts where we identified material breaches. The first, issued in January 2008, was for failing sub-duties 4c and 4f, which relate to the physical environment and decontamination. The second, in February 2008, was for failing sub-duty 4f, and the third, in June 2008, was due to a failure to comply with sub-duty 4f and duty 3, in relation to facilities for mattress decontamination. In each case, further inspection found that the trusts had taken appropriate action

From April 2009, as part of the new system of registration for the NHS, trusts must comply with a new statutory regulation, supported by the criteria set out in the hygiene code. Trusts that fail to comply will risk having conditions imposed on their registration. The new Care Quality Commission will also be able to take a range of other enforcement actions.

Three of the core standards for the NHS in England are related to the hygiene code. These are concerned with infection control and hygiene (C4a), decontamination of medical devices (C4c), and well-designed, well-maintained and clean environments (C21).

For 2007/08, 69% of trusts and PCTs were assessed as compliant with all applicable standards related to the hygiene code, the same figure as in 2006/07.

While trusts are taking infection control very seriously, they need to ensure that they are fully compliant with the hygiene standards and code. Comprehensive systems are important if we are to continue to reduce infection rates.

Unannounced spot-checks in Wales

Healthcare Inspectorate Wales has continued to carry out unannounced inspections of hospital cleanliness. The most recent phase of these spot-checks took place in the summer of 2008. In visits to three NHS trusts, findings included:

- Some issues of cleanliness, especially on high-level surfaces.
- Staff generally knew when domestic staff should be on the ward, but were unaware of the location of cleaning schedules.
- Linen was stored appropriately, generally in designated linen rooms.
- Waste was generally correctly handled and disposed of, although improved labelling was recommended.
- All wards complied with national standards for safe handling and disposal of sharps.
- Equipment on wards was clean and instruments were appropriately and safely stored, although there was concern about the storage of patient wash-bowls.
- Good hand hygiene was well promoted in all cases. However, there was an over-reliance on the use of gloves.
- Kitchens were generally in poor condition and needed upgrading.

The trusts were required to complete an improvement plan to address the key areas of concern and to submit them to HIW within two weeks of the reports being published.

6 pictures of healthcare

A picture of health and healthcare in the community

Primary care trusts (PCTs) play a key role in preventing illness, promoting good health and helping people with health problems to enjoy the best possible quality of health and wellbeing. They control 80% of the total NHS budget and are responsible for ensuring that people get the care and services they need.

Main points at a glance

- A greater focus on commissioning is evident from both Government and PCTs. We welcome the work that is underway, but all would recognise that there is some way still to go. This is very important for local people, because in our in-depth reviews we have often found that where services are poor, this is because commissioning is poor. Our reviews have also identified many high-performing organisations, showing that progress is possible.
- It is clear that people trust and value their GPs, but also want more flexible access to them. We welcome both the Government's proposed introduction of regulation for GP's practices, and their efforts to resolve access issues in primary care.
- We have seen progress in some areas of public health including smoking, teenage pregnancy and access to sexual health clinics. However, progress has been more limited in other areas, such as obesity, alcohol misuse and sexually transmitted infections such as chlamydia. The greatest progress has been made where there are clear objectives and targets.
- Our annual health check has highlighted some improvement in the ability of PCTs to understand and meet the needs of people with long-term conditions. But too many organisations have not delivered all that they planned in this area.
- There is a lack of robust information about how well community services are performing.

The role of PCTs

PCTs are part of the NHS in England, typically serving the same geographic 'patch' as unitary or county councils. They are major providers of healthcare, particularly in community settings, they are responsible for 'commissioning' healthcare services for their local people and they oversee primary healthcare – local health services such as general practice and dentistry. The vast majority of NHS activity takes place in primary care, so how PCTs perform is crucial to the performance of the NHS as a whole.

Commissioning

Put simply, commissioning is the term given to the process of identifying people's health and healthcare needs and ensuring that there are services in place to meet them. Purchasing and contracting are important parts of this process, but good commissioners also have a sound strategic overview and understanding of the needs of local people, what is offered locally, and what needs to be done to enhance the provision of local healthcare.

PCTs are responsible for around 80% of the NHS budget, and they use much of this to commission services in secondary care, in acute hospitals, for example, or specialist mental health services. In 2006/07, PCTs spent £47 billion on hospital and community health services, of which £5.6 billion was spent on community services for physical health (excluding community maternity services). For the same period, PCT spending on primary medical care services was £7.8 billion.[62]

Across all hospital, community and family health services in England, more than £41 billion was spent in 2006/07 on programmes linked to the Government's objectives for improving people's health and outcomes for people with long-term conditions.[63]

300 million

Number of consultations each year in general practice in England

Protecting and improving health

Improving health, improving access to care and reducing inequalities in health are major objectives for PCTs (and underpin their decisions on commissioning). PCTs also play the key role in protecting the health of their local people, particularly through immunisation programmes (such as those for measles, mumps, rubella and polio for children and flu for older people) as well as having a planned, prepared and, where possible, practised response to incidents and emergency situations, working closely with their colleagues in local government.

Community services and care outside hospital

As providers, PCTs offer services such as district and community nursing services and health visiting. They also give intensive support to people with long-term conditions.

While the work of community healthcare has always been vital, in recent years there has been a pronounced shift in national health policy away from hospital care. Increasingly, diagnostic services, rehabilitation programmes and routine check-ups are delivered closer to, or even in, the patient's home.

Primary care

Most frequently, people come into contact with primary care services through their GP or general practice nurses. There are almost

300 million consultations each year in general practice. Most GPs are independent contractors, commissioned to provide services for their local PCT in line with the national GP contract.

Local health services in Wales

In Wales, local health boards have to date fulfilled a similar (but not identical) role to that of PCTs. They oversee primary care and work with local authorities in planning and purchasing services, while NHS trusts provide both hospital and community services.

However, the Welsh Assembly Government has proposed to end the division between purchasers and providers in Wales. Single local health organisations will become responsible for delivering all healthcare services within a geographical area. Health policy in Wales has, since devolution, had a strong focus on prevention and primary care, with the abolition of prescription charges, in particular, a flagship policy.

Major challenges to health in the community

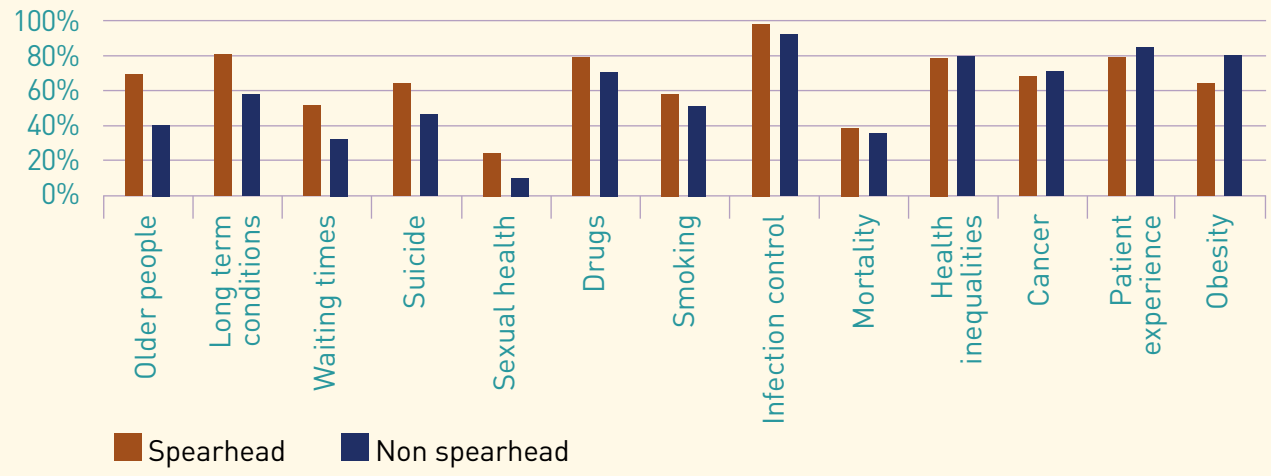
Problems associated with unhealthy lifestyles, health inequalities and the increased prevalence of long-term conditions are the major challenges facing PCTs in England and local health services in Wales.

Inequalities in health

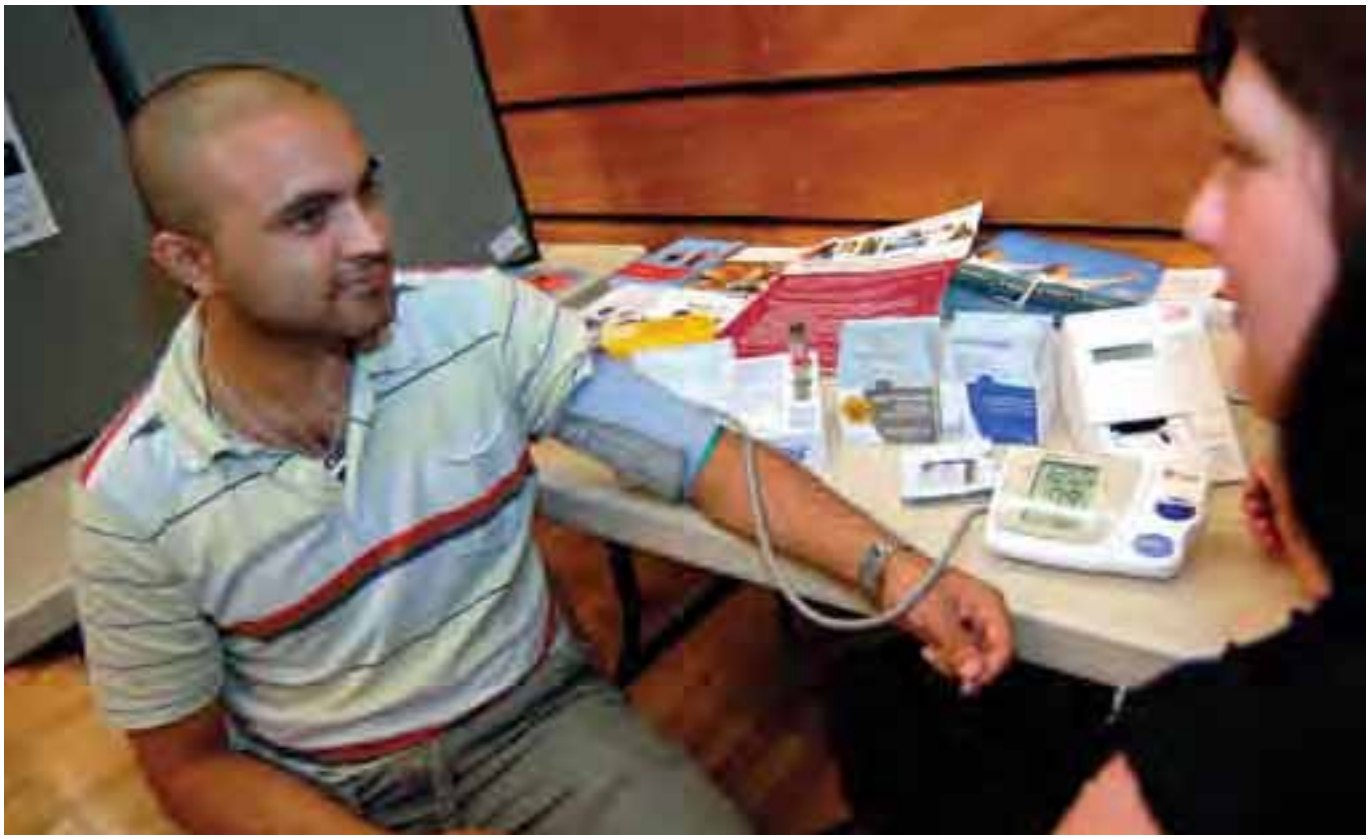
As outlined earlier in this report, there is a strong association between deprivation and poor health. There continues to be a gap in life expectancy between people from 'manual' and 'non-manual' groups, and in different areas and groups, and inequalities persist in people's 'healthy life expectancy'.

The PCTs serving the fifth of areas with the worst health and deprivation, known as 'spearhead' areas, have been given additional support, but also some stretching targets, to help reduce these gaps. Figure 16 shows how well spearhead PCTs are doing on the 13 new

FIGURE 16: Performance against the 13 new national targets (proportion of PCTs achieving), 2007/08



Source: Healthcare Commission annual health check



national targets compared with non-spearhead PCTs.

The big killers

The most common causes of death remain cancer and circulatory disease. Rates of premature death from both conditions have fallen in recent years. PCTs have an important role to play in preventing disease, but also in ensuring that people at risk of serious illness are identified, with quick access to diagnostic services and, if necessary, treatment.

Smoking

Smoking is the UK's single greatest cause of preventable illness and early death from a wide range of illnesses, including cancer, respiratory disease and heart disease. Around a quarter of the population smokes, but the proportion is declining steadily.[64] As smoking is the single largest causes of preventable illness, reducing it continues to be a priority in both England and Wales.

Local health services play a key role in reducing smoking, by promoting healthy lifestyles and offering practical support to people who are trying to quit. In England, PCTs are assessed on two objectives. The first is the number of smokers who have been helped to quit for at least four weeks. The second requires PCTs to collate, through GP practices, information on the smoking status of the people in their area.

Obesity

Obesity is a major risk factor for cancer, heart disease, osteoarthritis and type 2 diabetes. In England in 2006, just under a third of children were overweight or obese. Thirty-eight per cent of adults were overweight and 24% were obese,

compared with European Union averages of 34% and 13% respectively.[65] The Government has set national targets in England for monitoring and reducing obesity.

Drinking

Excessive consumption of alcohol contributes to liver disease, cancer and heart disease. In recent years, there has been a dramatic rise in admissions to hospital that are primarily related to alcohol misuse – over 57,000 admissions in 2006/07, an increase of more than 50% since 1995/96. In 2007, there were more than 112,000 items prescribed in the community for drugs to treat alcohol dependency: an increase of 20% since 2003.[66] The cross-government strategy for alcohol, *Safe. Sensible. Social*, was launched in 2007 and, as part of the 2007 spending review, reducing alcohol-related hospital admissions was introduced by Government as an objective in the public service agreement for England.[67]

Teenage pregnancy

Teenage pregnancy is associated with poorer health and economic outcomes for both parents and children. The UK has the highest rates for teenage conception in Western Europe. However, the rate in England and Wales is going down, in 2006 standing at just under 41 per 1,000 girls aged 15-17, a decrease of more than 13% since 1998. The Government has set targets for PCTs and local authorities to reduce further teenage conception rates.[68]

Sexually transmitted infection

Rates for sexually transmitted infection are rising in the UK, particularly among young people. Between 2006 and 2007, numbers of new diagnoses rose by 6% (from 375,843 to 397,990), while recurrent and other

> “There is a strong association between deprivation and poor health. There continues to be a gap in life expectancy between people from ‘manual’ and ‘non-manual’ groups, and in different areas and groups, and inequalities persist in people’s ‘healthy life expectancy’.”

presentations rose by 7% (from 244,442 to 260,544).[69] The Government has set targets for PCTs in England to improve access to genito-urinary medicine clinics and to increase screening for chlamydia among young adults, both of which are included in the annual health check ratings for PCTs. Chlamydia, if left undetected and untreated, can lead to infertility in women.

Drugs

Overall drug use (all classifications) has fallen in recent years for both adults and children in England. At the same time, there has been rapid expansion in the availability of effective treatment, with over 200,000 people currently in structured drug treatment. An estimated 3.7 million people use drugs in any year, but less than 10% of these experience a serious drug problem.

Hospital admissions with a primary diagnosis of a drug-related mental health and behavioural disorder have decreased to around 6,700 in 2006/07, while admissions with a primary diagnosis of poisoning by drugs have

risen to around 10,000. The sharp increases in drug-related deaths of the 1990s have been halted. The most recent available figure, for 2007, shows that there were 1,479 deaths in that year associated with those drugs identified in the Government's drug strategy.

Among adults aged 16 to 59, the use of class A drugs, particularly cocaine, has increased in the last 10 years, from 2.7% in 1998 to 3.4% in 2006/07 (the figure is the proportion of adults who had used drugs in the preceding 12 months), although most of the increase took place in the years up to 2004. Those aged 20 to 24 reported the highest levels of 'last year' and 'last month' use of Class A drugs in 2006/07 (10.4% and 5.5% respectively).

The Government's strategy for treating drug misuse is focused on the availability of a comprehensive range of treatment approaches covering both harm reduction and abstinence-based activity. Heroin is the main drug for which people receive treatment (more than 60% of all treatments), while three-quarters of clients aged under 18 are treated for cannabis use.[70]

Long-term conditions

Long-term conditions are those conditions that cannot currently be cured, but can be controlled and managed through the use of medication and other therapies. More than 15 million people in England have a long-term condition.[71] The five conditions most commonly identified on GP disease registers are shown in table 7.

The probability of having a long-term condition increases with age. Seventeen per cent of people under 40 say that they have a long-term condition, compared with 60% of those aged 65 and over.[72] Due to England's ageing population, the prevalence of long-term conditions is forecast to rise: 18 million people are expected to have one or more long-term conditions by 2025.

TABLE 7: Prevalence of main long-term conditions among patients registered with a GP in England, 2007/08

Condition	Number on GP disease registers	% of those registered
Hypertension	6.9 million	12.8%
Asthma	3.1 million	5.7%
Diabetes	2.1 million	3.9%
Coronary heart disease	1.9 million	3.5%
Chronic kidney disease	1.6 million	2.9%

Source: Quality and Outcomes Framework 2007/08

Note: Registers for diabetes and chronic kidney disease do not include younger people, but prevalence rates for these diseases are based on whole-practice list sizes (all ages). Estimates for age specific prevalence are 4.8% for diabetes and 3.7% for chronic kidney disease

People with long-term conditions are intensive users of the health service. They amount to a third of the population, but account for more than half of all GP appointments, 65% of all outpatient appointments and 72% of all inpatient bed days.[73] National efforts to improve care for these people have focused on delivering care closer to home, with the introduction in England of a target to increase the support offered through community matrons.

The prevalence of diabetes has risen in recent years, to 5.6% in men and 4.2% in women in 2006, compared with 2% in both men and women in 1991[74], and it is forecast to increase further. Diabetes in children is also increasing, with a rising proportion of children with type 2 diabetes, an increase that is probably linked to higher levels of obesity.[75]

Our work on commissioning

When the Healthcare Commission was created in 2004, PCTs were still relatively new. The very different functions of commissioning and providing care by PCTs were not defined separately in *Standards for Better Health*. Since then, the Department of Health has put a lot of effort into working with PCTs to improve commissioning.

Much of our work since 2004, particularly our in-depth reviews of services for people with heart failure, diabetes and mental health problems, has raised concerns about the quality of commissioning. We would, however, recognise that Government has made significant efforts to develop the ability of the NHS to commission services, not least through its "world class commissioning" initiative. The introduction of practice-based commissioning is intended to both build expertise in commissioning and put clinicians in the driving seat on local decisions about commissioning.

In our report with the Audit Commission, *Is the treatment working?*, we found that PCTs were responding to some of the new incentives to improve commissioning. While there was evidence of some local impact, the effect on a national scale was less obvious. Given that PCTs were last reorganised as recently as 2006, they need more time to make progress.

The annual health check for 2008/09, to be carried out by the Care Quality Commission and published next year, will, for the first time, include separate scores for PCTs as commissioners and providers.

Our work on health improvement

Our work looking at health improvement has included our national reviews and studies on tobacco control, obesity, sexual health, unintentional injury in children and drug treatment. For 2006/07, we also assessed the progress of PCTs against a developmental standard for public health, which required PCTs to identify significant public health problems and health inequalities, and act on them. Of the PCTs that reported, 34% said their progress was "excellent" or "good", 58% described it as "fair", while 8% called their progress "limited".

Our most recent report in this area, published jointly with the Audit Commission, is *Are we choosing health?*[76] This looked at the impact of policies on the delivery of health improvement programmes and services over the last 10 years.

We concluded that policies had generally had a positive impact on health improvement programmes and services, particularly those that combined a number of factors. These were: strong central targets; detailed guidance on actions required; investment in programmes and staff at national, local and regional levels, including training and development; research on effectiveness; better data; and strong management of performance. Examples included initiatives to reduce teenage pregnancies, increase access to sexual health clinics, and reduce smoking.

18 million

Number of people expected to have one or more long-term conditions by 2025

Other initiatives, where approaches have not been so consistent, have been less successful. Areas such as obesity, alcohol misuse, unintentional injury and mental health promotion all require much more work.

Our work on care outside hospital

Looking at care outside hospital, our work has included national reviews of services for people with heart failure and diabetes.

In our annual health check, we assess performance against the national targets for improving people's health and delivering community services for people with long-term conditions. These provide valuable information on progress in meeting key priorities, but there is a lack of the kind of information that could allow us to come to a broader view on how community services are performing. Future work in this area would benefit from clear evidence, drawn from routine collections of data on activity and outcomes, and a national consensus on what the right measures of performance and outcomes should be.

Our work on primary care

The Healthcare Commission has focused on the role of PCTs as commissioners of GP services. In particular, the issue of patients getting timely access to their GP has received a lot of attention recently, especially following our publication of the 2007/08 annual health check. Both our own surveys and those carried out by the Department of Health show that most people are seen quickly and are happy with the hours offered by their surgeries, but that there is some way still to go before, in line with national targets, everyone can get an appointment with their GP within 48 hours. (This issue is discussed in more detail in the "How does it feel?" section of this report.) Our surveys also tell us that people have high levels of trust and confidence in their GPs.

As we described in *State of Healthcare 2007*, we have carried out some work looking at variation in the quality of services provided by GP's practices. This work examined the relationship between the performance of GPs and rates of admission to hospital. In the year since, we have carried out further work looking at this variation, which may highlight 'non-standardised' practice within PCTs and potentially the needs of some patients not being met. However, our analysis also tells us about the rate of improvement for key markers of patient outcomes.

We have looked in particular at two examples of indicators from the Quality and Outcomes Framework (QOF) (the data used to determine payments under the national GP contract). The first is the percentage of patients with coronary heart disease whose last recorded blood pressure was 150/90. The second is the proportion of patients with coronary heart disease whose last total cholesterol was 5mmo/l or less.

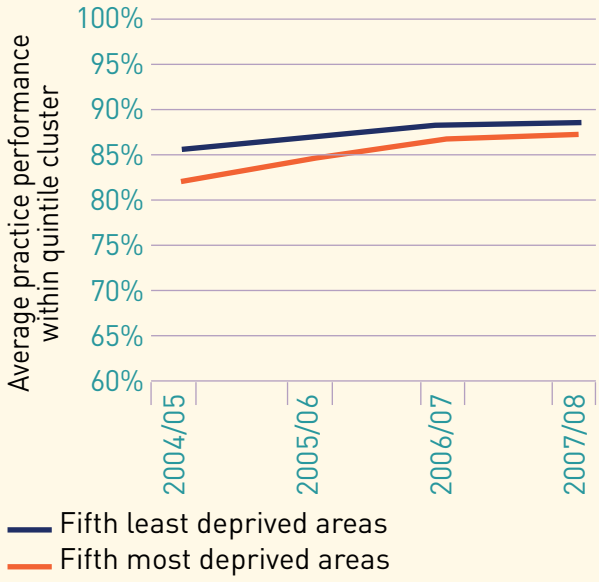
Over the period 2004/05 to 2007/08, there has been a steady narrowing of the gap between the performance of the practices serving the fifth least deprived areas and the fifth most deprived. This is accompanied by marked improvement in performance across the four years. This is good news, and it shows that the NHS is making some progress in tackling inequalities in health, even if it is too early to see this progress reflected in the measures of inequality in premature death and life expectancy.

However, despite the fact that overall performance has increased over the period, and the 'inequalities gap' on these measures has reduced, the trend over the two most recent years indicates a levelling off in performance and, in the case of the cholesterol measure, a slowing of the reduction in inequality (see figures 17 and 18).

Progress on national targets

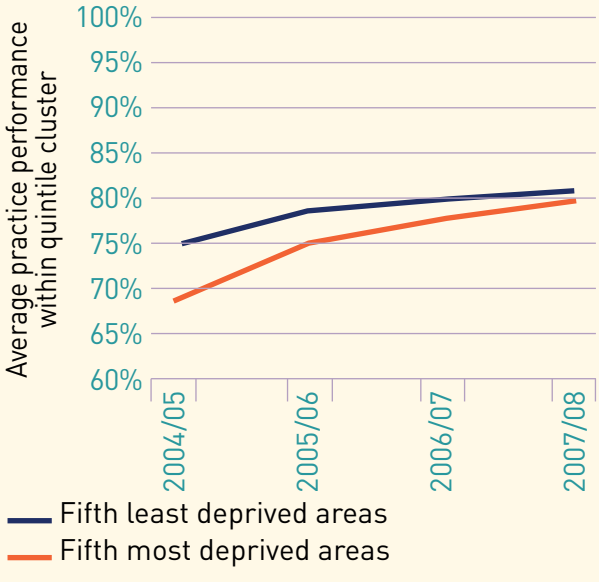
Over the next two pages, we have set out some of our key recent findings on how well PCTs are responding to some of the challenges they're facing. These findings focus on major national priorities and targets.

FIGURE 17: Proportion of patients with coronary heart disease whose last recorded blood pressure was 150/90



Source: Healthcare Commission analysis of QOF data

FIGURE 18: Proportion of patients with coronary heart disease whose last total cholesterol was 5 mmo/l or less



Source: Healthcare Commission analysis of QOF data

How are PCTs measuring up?

Progress on selected targets

Smoking

PCTs are assessed on two objectives. The first is the number of smokers who have been helped to quit for at least four weeks. The second requires PCTs to collate, through GP practices, information on the smoking status of the people in their area.

In 2007/08, 64% of all PCTs achieved the "four-week smoking quitters" measure, with over 350,000 people helped to quit. Eighty-five per cent of PCTs achieved the "smoking status among the population aged 16 and over" measure, with the smoking status recorded for two-thirds of people on GP registers.

Sexual health

While there has been some good progress on reducing the incidence of teenage pregnancy, the picture for sexual health more generally is mixed.

In England in 2007/08, 93% of those who contacted genito-urinary medicine clinics were offered an appointment to be seen within 48 hours, and 90% of PCTs achieved their targets on this.

However, only around 5% of people aged 15-24 were screened for chlamydia, just under a third of the planned level of screening. Less than a fifth of PCTs managed to deliver against their plan.

Treating people who misuse drugs

More misusers of drugs users than ever before are getting the treatment they need, and are engaged with services for longer. In 2007/08, 87% of those who entered community-based treatment programmes for drug misuse carried on their treatment up to or beyond the key 12-week milestone, against a national plan of 83%. PCTs planned for just under 238,000 users to enter treatment during 2007/08, and over 202,000 did so. Taking these two indicators together, 74% of PCTs achieved their overall target for helping people who misuse drugs.

Our latest review of substance misuse services, carried out with the National Treatment Agency, covered 149 local drug partnerships. We found considerable improvement in the commissioning and performance management of drug treatment services, resulting in more service users receiving better treatment.

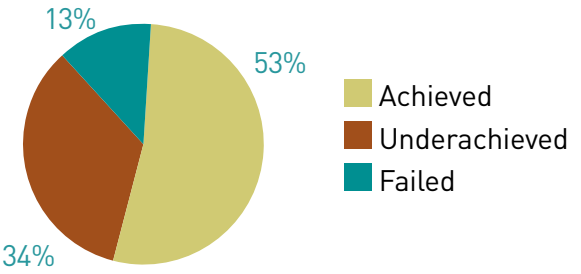
However, there were significant deficits, particularly in the provision of vaccination for hepatitis B and testing and treatment for hepatitis C. As 90% of all hepatitis C diagnoses are associated with injecting drug use, this is a key area of concern. Thirty-four per cent of local drug partnerships had an overall score of "excellent", 45% were "good" and 21% were "fair". No partnerships had an overall score of "weak".

Obesity

To provide an accurate picture of progress in tackling childhood obesity, PCTs are required to ensure the collection of information on the height and weight of children in primary education.

Most are achieving this, but a substantial minority are not, with more than one in 10 falling far short of the objective.

FIGURE 19: PCT achievement of obesity monitoring target, 2007/08



Source: Healthcare Commission annual health check

Waiting times for diagnosis and treatment of cancer

Waiting times for diagnosis and treatment of cancer have fallen dramatically, and are a real success story for the NHS. In England in 2007/08, 99.5% of people with suspected cancer were seen by a specialist within two weeks, 99.6% of people diagnosed with cancer began treatment within one month, and 97% began treatment within two months of initial referral from their GP.

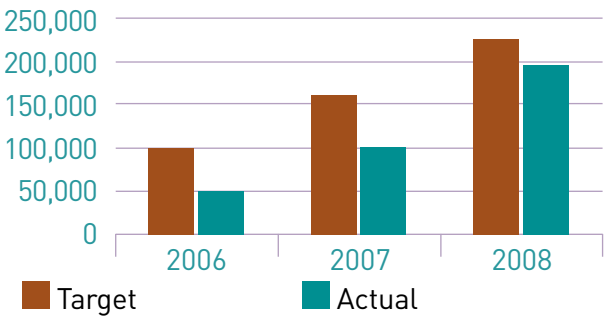
Disease registers in GP practices

PCTs are assessed against two indicators that focus on GP monitoring of the health of patients on disease registers. The first requires GP practices to monitor the health of patients with diabetes, the second requires practices to monitor the health of people at increased risk of cardiovascular disease. In 2007/08, 60% of PCTs achieved the first indicator, and 55% the second.

Supporting people with long-term conditions

In England, PCTs have been tasked with recruiting community matrons to provide support to people with complex long-term conditions who are very high intensity users of services. While not all of those needing support got it during 2007/08, the difference between PCTs' plans and delivery was not as great as in previous years. Against a plan of 226,830, 193,677 people were seen, and 69% of PCTs achieved the target.

FIGURE 20: Number of very high intensity users seen, 2006-2008



Source: Healthcare Commission annual health check

A picture of urgent care and care in hospital

For most people, treatment in an emergency or in an acute hospital is a rare occurrence, but one that most of us will experience at some point in our lives. Patients have a right to receive timely and high quality treatment for both urgent and non-urgent acute conditions.

Main points at a glance

- The level of activity in A&E departments is increasing.
- The ability of the NHS to respond quickly to urgent need has improved.
- Both NHS acute hospital trusts and ambulance trusts have shown year-on-year improvements in our assessments of the quality of their services.
- However, more work is needed on measuring outcomes for patients.
- Our review of urgent and emergency care has highlighted a lack of integration between the services provided by a wide range of organisations.

In previous years, through our programme of detailed reviews, we have focused on emergency, urgent and non-urgent care in hospital. In 2007/08, we carried out an in-depth review of urgent and emergency care outside hospital, looking at how the wide range of organisations providing such care work together.

Activity

In England in 2007/08, there were around 13.7 million patient admissions to acute NHS hospitals. Of these, 4.5 million were admitted in an emergency (see table 9 on page 63).[77] There were 19.1 million visits to A&E departments and 'urgent care centres' (our term for walk-in centres and other facilities that treat minor injuries and illness without the need to make an appointment), compared with 14 million visits in 2002/03.[78,79]

There were 7.2 million 999 calls for an emergency ambulance and ambulance services responded to 1.8 million life-threatening ('category A') incidents. Patients made 4.3 million emergency and urgent journeys to hospitals.[80]

There were 8.6 million calls made to out-of-hours GP services and 6.8 million medical assessments were completed (2.9 million by telephone, 0.9 million on home visits and 3.0 million where the patient attended a primary care centre). Of the near 300 million consultations that took place in general practice, many would have been urgent in nature.[81]

In Wales, there were 969,887 new A&E attendances and 302,664 emergency calls in 2007/08, compared with 888,705 new attendances and 203,098 calls in 2002/03.[82]

In the independent sector, there were 310 acute hospitals in 2007/08, compared with 279 in 2006/07.

Workforce

Within the NHS in England in 2007, there were 205,601 nurses working in acute, elderly and general settings, up from 159,934 in 1997. In hospital and community health services, there were 33,674 consultants and 46,783 registrars, senior house officers and other doctors in training. There were 143,389 care and nursing assistants (which includes nursing auxiliaries/assistants, nurse learners, support workers and healthcare assistants) and 68,687 allied health professionals (for example, therapists and dieticians).[83]

In NHS ambulance services in England, at September 2007 there were 17,028 qualified ambulance service staff, of which 8,241 were ambulance paramedics and 7,543 were ambulance technicians. There were 11,443 staff working in supporting roles.[84]

Funding

In 2006/07, gross expenditure in England on general and acute services was £27.5 billion, 59% of the total hospital and community health services gross expenditure. A&E expenditure was £1.7 billion, 4% of the total expenditure.[85]

Targets and standards for urgent and emergency care

The term 'urgent and emergency care' is used to describe the care provided by a number of important services, and ranges from life-saving treatment for people who suffer strokes, heart attacks or other serious medical conditions, to providing treatment and support to people with an urgent need for care and reassurance.

Both the Department of Health in England and the Welsh Assembly Government have set national targets for ambulance trusts responding to emergency calls. These are based on long-established clinical standards, which categorise calls based on their urgency and the threat posed to the life of the patient.

Category A calls are emergency calls where the situation is life-threatening; category B calls are defined as serious but not immediately life-threatening. The national targets in England require that 75% of category A calls should result in a response at the scene within eight minutes, and 95% of category A calls should result in an emergency ambulance capable of transporting the patient to arrive at the scene within 19 minutes.

Ninety-five per cent of category B calls should be responded to by an ambulance within 19 minutes.

In Wales, the targets differ and have recently been revised. For 2008/09, ambulance services in Wales are required to achieve a monthly minimum performance of 60% of first response to Category A calls arriving within eight minutes in each local health board area, and attain and maintain a month-on-month all-Wales average performance of at least:

- 65% of first responses to Category A arriving within eight minutes.
- 70% of first responses to Category A arriving within nine minutes.
- 75% of first responses to Category A arriving within 10 minutes.

Time-based targets are also in force in A&E departments. In England, 98% of patients should spend no more than four hours in A&E from their arrival to admission, transfer or discharge. In Wales, the target is 95% within four hours and 100% within eight hours.

National requirements for out-of hours GP services state that a patient's assessment should start within 20 minutes of their initial contact where a patient's needs were initially judged to be urgent, and within 60 minutes otherwise.[86] NHS Direct also has targets to commence assessment within 20 minutes for urgent (priority 1) calls and within 60 minutes for non-urgent (priority 2) calls.[87]

The targets for response by an ambulance to urgent calls, and for waiting times within A&E, are both included in our annual health check of the NHS in England. During 2007/08, we carried

out a national review of urgent and emergency care services in England, *Not just a matter of time*, looking at out-of-hours GP services, A&E services and urgent care centres, emergency ambulance services and the work of NHS Direct.

Care in hospital

In previous years, we have looked closely at the work of acute hospitals in England – carrying out reviews of areas such as ward staffing, day surgery, A&E services, the management of admitted patients, and diagnostic services – and the care they provide for children.

Until April 2008, we also managed the programme of national clinical audits, looking in-depth at the quality of care offered in the NHS in England and Wales. These look at both the treatment provided for particular conditions, such as diabetes and different types of cancer, and at specific procedures, such as coronary angioplasty. The audits are designed to improve the health and experiences of patients by systematically reviewing the delivery of healthcare. They aim to ensure that all patients receive the most effective, up-to-date and appropriate treatment, delivered by clinicians with the right skills and experience.

The results of the audits allow local bodies to identify and make local improvements for patients; give patients a chance to question the quality of their care and exercise choice; help the Healthcare Commission to corroborate local bodies' self assessments against national standards; and help the Department of Health and NHS Wales to assess progress against national initiatives

Q. How quickly can people get advice and treatment in an emergency or for an urgent physical health problem?

A. In England in 2007/08, 77% of category A calls were responded to within eight minutes. This is above the national target of 75%, and is the highest ever rate, reflecting trusts' preparation for a change to a more stringent response time measurement that begins in 2008/09. Set against a 10% increase in category A calls between 2005/06 and 2007/08, this is a real achievement for the NHS. Almost all of the 12 trusts providing ambulance services in England achieved the target level of performance above 75%. The NHS has found the category B target more difficult to meet. Just a third of trusts achieved the 95% target in 2007/08.[88] In Wales, response times are slower for both category A and B calls. In 2007/08, the target of 60% of category A calls to be responded to within eight minutes was met throughout most of the year, although performance dipped below the target level during the winter months.[89]

Acute and ambulance trusts in England are also assessed on their ability to provide quick treatment to people suffering a heart attack. A national target requires an annual increase in the proportion of people who receive thrombolysis within 60 minutes of calling for professional help during a heart attack. In 2007/08, 85% of acute trusts and 80% of ambulance trusts achieved their target in relation to this.[90]

In A&E, the number of people dealt with inside four hours has increased from 91.0% in 2003/04 to 97.9% in 2007/08.[91] In our annual health check for 2007/08, 85% of acute hospitals with A&E departments achieved the four-hour waiting target, with the least well performing trust seeing 91.9% of patients within four hours.

In *Not just a matter of time*, we found that in 65% of areas, out-of-hours GP services "fully met" or "partially met" the requirement that they start telephone assessments within 20 minutes of a patient's initial contact if a patient's needs were urgent, and within 60 minutes otherwise. In some areas, less than 80% of assessments were started within these timescales. Only 44% of out-of-hours GP services had arrangements to divert calls made to GP surgeries during the out-of-hours period. This means that patients who needed urgent care outside normal working hours may have had difficulty getting through to the correct service.

We also found that NHS Direct exceeded their target for starting telephone-based assessments within 20 minutes for the most urgent or 'priority 1' calls and 60 minutes for priority 2 calls in 95% of cases. They achieved this for 98% of priority 1 calls and 99% of priority 2 calls.

Q. How well do organisations work together to meet the urgent physical health needs of their local people?

A. GPs, NHS Direct, A&E departments and ambulance services should work together to deliver co-ordinated care. There need to be links between services so that information about patients is shared effectively and the journeys of patients through care are smooth and well organised.

In *Not just a matter of time*, we found problems with sharing information between different parts of the system. Only 20% of A&E departments were able to receive electronic data from ambulance services, and just 30% of urgent care centres reported that all GPs in their area were able to receive electronic information about their patients. In 75% of areas, out-of-hours GP services had access to care plans for vulnerable people and those with long-term conditions. However, systems to share these care plans with ambulance services and A&E departments were only in place in around 12% of areas.

We found that almost all PCTs were part of a network of healthcare bodies responsible for planning and delivering urgent and emergency care, but only a third of these networks appeared to be active and well developed.

We did find that 96% of PCTs had in place, or under development, a strategy for urgent and emergency care and had discussed it with their main local urgent and emergency care services. However, not all had discussed these plans with other services involved with meeting people's urgent care needs.

Q. How good are the organisations that provide urgent and acute physical healthcare?

A. As part of our annual health check, all NHS trusts in England received a rating which for the quality of their services. Table 8 below shows the most recent scores for acute and specialist and ambulance trusts.

In our review of urgent and emergency care, we assessed organisations jointly as partners in providing urgent and emergency care to their local area. We scored 33% of areas "best performing", 27% "better performing", 22% "fair performing" and 18% as "least well performing".

TABLE 8: Trusts' scores for quality of services, 2007/08

Organisation type	Excellent	Good	Fair	Weak
Acute and specialist trusts	51 (30%) ↑	79 (47%) ↑	32 (19%) ↓	7 (4%) ↓
Ambulance trusts	2 (18%) ↑	5 (45%) ↑	1 (9%) ↓	3 (27%) ↑

Source: Healthcare Commission

Q. What do we know about the quality and effectiveness of the care provided to people with acute physical health problems?

A. National standards for the NHS in England include five relating to clinical and cost effectiveness. In 2007/08, 95% of acute trusts and 63% of ambulance trusts complied with all five. Ninety-six per cent of acute trusts and 100% of ambulance trusts complied with standard C5a, which requires them to ensure they conform to NICE technology appraisals and take account of other nationally agreed guidance.[92]

Currently, the Healthcare Commission oversees the national clinical audit programme for England and Wales. The audits have identified that patients can get widely differing standards of care, depending on the area they live in and the hospital they go to, and that compliance with NICE guidance can be uneven.

However, the audits have identified some significant improvements in the delivery of care. For example:

- Improvements in the diagnosis and treatment of oesophago-gastric cancer.
- Reductions in postoperative death rates in patients with bowel cancer.
- Improved provision of percutaneous coronary intervention for patients with blocked or narrowed coronary arteries, with evidence to suggest that outcomes are also improving.

Our programme of reviews and studies also aims to look at the quality of services, using a range of approaches, including looking at the availability of trained staff and the use of systems to monitor clinical outcomes. As part of our review of urgent and emergency care, we supported two 'mini audits' of the care in A&E departments and larger urgent care centres. These were carried out in partnership with the College of Emergency Medicine (CEM). They looked at the provision of care to children who had suffered a broken limb and to older people with hip fractures, and collected similar data to that collected for our 2005 review of A&E departments. We collected data on a number of aspects of care, including the time that patients wait for pain medication and X-rays compared to guidelines set by the CEM.

Although we found some small improvement in these measures, performance still varies widely between different A&E departments. In particular, the proportion of children with a limb fracture that received pain relief within 60 minutes of arriving at A&E varied between different departments from under 20% to 100%. The proportion of older people with a hip fracture receiving an X-ray within 60 minutes of arrival varied from 0% to 80%.

TABLE 9: Admissions to acute NHS hospitals

Clinical area/ selected specialities	England 2007/08 Emergency	England 2007/08 Elective	Wales 2007/08 Emergency	Wales 2007/08 Waiting list*
Medical				
General medicine	1,308,899	542,041	102,435	14,156
Paediatrics	521,782	114,213	49,368	70
Gynaecology	186,261	413,112	15,361	15,069
Nephrology	48,812	738,491	5,658	321
Geriatric medicine	293,516	13,889	12,999	70
All medical specialities total	2,895,436	3,324,940	232,744	50,972
Surgical				
General surgery	510,294	854,591	43,183	49,920
Accident and emergency	498,679	2,045	2,942	14
Trauma and orthopaedics	296,007	652,417	25,554	35,632
Urology	76,770	582,634	5,459	24,491
All surgical specialities total	1,586,829	3,498,553	92,954	167,493
Radiology				
Clinical oncology	23,842	368,801	2,090	27
All radiology specialities total	24,248	380,613	2,095	1,325
Other specialities total	4,827	54,726	8	376
Grand total	4,513,053	7,273,939	335,533	220,276

Source: England: Healthcare Commission analysis of HES data (provisional). Wales: analysis of PEDW data[93] Note: HES is acute trusts only. PEDW data is all activity carried out within NHS. The grand total includes admissions under mental health specialties and admissions with blank/invalid specialty codes. *Excludes admission methods 12 & 13

TABLE 10: Urgent and emergency calls for ambulance trusts, % calls meeting standards, 2004/05-2007/08

	Category A (8 mins)		Category A (ambulance)		Category B*	
	England	Wales	England	Wales	England	Wales
2004/05	76.2%	57.7%	96.0%	89.3%	87.8%	86.4%
2005/06	75.3%**	57.0%	95.9%	86.4%	87.3%	82.7%
2006/07	74.6%	56.0%	97.0%	84.6%	90.5%	78.1%
2007/08	77.1%[94]	62.5%[95]	97.1%	89.4%	91.5%	81.2%

Source: Information Centre/Welsh Assembly Government * Classification in England changed mid-2004/05. Apr-Sept was category B/C and Oct-Mar was category B. % for 2004/05 above is Oct-Mar figure.** Unadjusted figure. In 2005/06, several trusts misreported data. The adjusted estimate is around 74%.

The picture for mothers

The safety and quality of maternity services has always been a key issue for the Healthcare Commission. We have carried out three major investigations into failing services, followed by a national in-depth review of maternity services in England.

Main points at a glance

- The number of births in England and Wales has risen by 16% since 2001, putting additional pressure on maternity services. Providers and commissioners face real challenges in meeting the needs of a growing, mobile and diverse population.
- Most women are satisfied with their maternity care, but we have found wide variations in the quality of services offered by the NHS in England and women do not always get the level of care to which they are entitled.
- In the least well performing organisations, we have found a pattern of lower levels of staff, poorer access to training for staff, poor relationships between professional groups and problems in collating and using information about maternity services.
- Essential data about maternity services is not always routinely collected, making it difficult for local heath services and national bodies to assess the quality of care provided, and to make the right changes to improve services. We welcome and support efforts by the Department of Health to make the national minimum dataset for maternity services a reality.
- During 2008, the Government has announced additional funding for the improvement of maternity services, and new standards for maternity services have been issued by the relevant Royal Colleges. Both of these developments are to be welcomed.

Demand

There were 690,000 live births in England and Wales in 2007 compared with 669,600 in 2006, an increase of 3%. The number has risen by 16% since 2001 and is still going up steeply: 2007 saw the sixth consecutive annual increase.[96,97]

Rates of fertility are also rising. The 'total fertility rate' for 2007 in England and Wales was on average 1.92 children per woman, an increase from 1.86 the previous year.[98] This figure has not been this high since 1973, when it was 2.0 children per woman.[99]

The increase in the number of pregnancies is putting significant pressures on maternity services, as are the changing patterns of pregnancy.

These include:

- Older mothers.
- More women who are obese, and so are less physically fit during pregnancy and are at a higher risk of complications during pregnancy and childbirth.
- More fertility treatment, leading to higher rates of multiple births.
- More women who, having survived serious childhood diseases, need extra care during pregnancy and childbirth.
- Increasing social and ethnic diversity, leading to a wide range of healthcare needs and sometimes communication difficulties and other social and clinical challenges.[100]

Funding

Almost £3 billion was spent on both maternity and reproductive health in England in 2006/07, 3.5% of the total NHS budget.[101] The amount spent solely on maternity services in 2007/08 was £1.78 billion.[102] In January 2008, the Department of Health announced £330 million, over three years from 2008/09, for improvements in maternity care in England. This was shortly followed by the announcement of measures to recruit 1,000 more midwives by 2009 in England, rising to around 4,000 by 2012.[103]

In August 2008, the Government announced a further £2 million to help more women in England to breastfeed. At present, the UK's breastfeeding rate is among the lowest in Europe. The extra funding is intended, in particular, to help mothers in deprived areas and support hospitals in disadvantaged areas to achieve Unicef Baby-Friendly Status, a set of best practice standards for maternity units and community services on improving practice to promote, protect and support breastfeeding.[104]

Workforce

The most recent published staffing figures show that, in England in 2007, there were 19,298 whole-time equivalent registered midwives and 9,056 health visitors in the NHS.[105] Registered midwives have increased by 6.5% and health visitors have fallen by 8.6% compared to 2002. In 2007, there were 1,506 consultants and 2,197 registrars working in obstetrics and gynaecology in England.[106] In 2007, there were 1,246.9 whole-time equivalent registered midwives and 669.4 health visitors in Wales.[107] Registered midwives and health visitors have increased by 11.3% and 2% respectively compared to 2002.

16%

Rise in the annual number of live births in England and Wales since 2001

Provision

There were 9,409 maternity beds across 177 NHS providers in England in 2007/08.[108] In Wales, there were just over 526 beds available each day for maternity in 2007/08.[109] In the independent sector in England, there are five organisations providing maternity services.

National policy

In April 2007, the Department of Health published *Maternity matters: choice, access and continuity of care in a safe service*. This guidance builds on the maternity standard in the 2004 National Service Framework for Children, Young People and Maternity Services and introduces a new national guarantee of choice for women.

By the end of 2009, women will have: a choice of how to get access to maternity care, going either straight to a midwife or to a GP; a choice of antenatal care, being able to choose between midwifery care or care by a team of maternity health professionals; a choice of place of birth, including the option of a home birth; and a choice of postnatal care, either at home or in a community setting.

Quality and safety of care

Since we were established in 2004, the quality and safety of maternity services has been an issue of great importance to the Healthcare Commission.

It is important to stress that giving birth in England in 2008 is likely to be safe for the majority of women. Maternal deaths (that is, deaths that occur during pregnancy or within 42 days of giving birth) that are directly attributable to problems in pregnancy or at birth have remained relatively stable since the mid-1980s.[110] They are rare in the UK – a review of deaths between 2003 and 2005 showed a maternal death rate of seven per 100,000 maternities directly attributable to pregnancy and 14 cases per 100,000 if including those as a result of indirect causes.[111]

In England, Wales and Northern Ireland, mortality trends for 2000 to 2006 show that, since 2000, the rates of stillbirth and perinatal death (that is, death within 28 days of birth) have remained largely unchanged, while the rates of neonatal death (that is, death with seven days of birth) have declined significantly.[112]

However, since 2004 we have frequently been alerted to concerns about specific maternity units. One in 10 referrals for an investigation to the Healthcare Commission has been maternity-related. We have carried out major investigations into high maternal death rates at three separate trusts. We found worrying similarities in these units, and identified five factors that suggest that a maternity unit may be in difficulties:

- Weak risk management, with poor reporting of incidents and handling of complaints.
- Poor working relationships and poor working in multidisciplinary teams.

“It is important to stress that giving birth in England in 2008 is likely to be safe for the majority of women. Maternal deaths have remained relatively stable since the mid-1980s. They are rare in the UK”

- Inadequate training and supervision of clinical staff.
- Poor facilities and services isolated geographically or clinically.
- Shortages of staff, coupled with poor management of temporary employees.

Following these investigations, we called on NHS trusts and PCTs to look at the performance of their local maternity services in relation to these factors. Our findings also prompted Healthcare Inspectorate Wales (HIW) to undertake a national review of maternity services in Wales. This found that, overall, maternity services were being delivered in a safe and effective way. The review highlighted concerns over information. Although trusts were collecting data about maternity services, only a few were sharing information or using the information, for example to plan services. The HIW therefore recommended that the Welsh Assembly Government develop a coherent and integrated national data set for maternity services.[113]

In February 2008, the King's Fund published its report *Safe Births: Everybody's Business*, the findings of its independent inquiry into

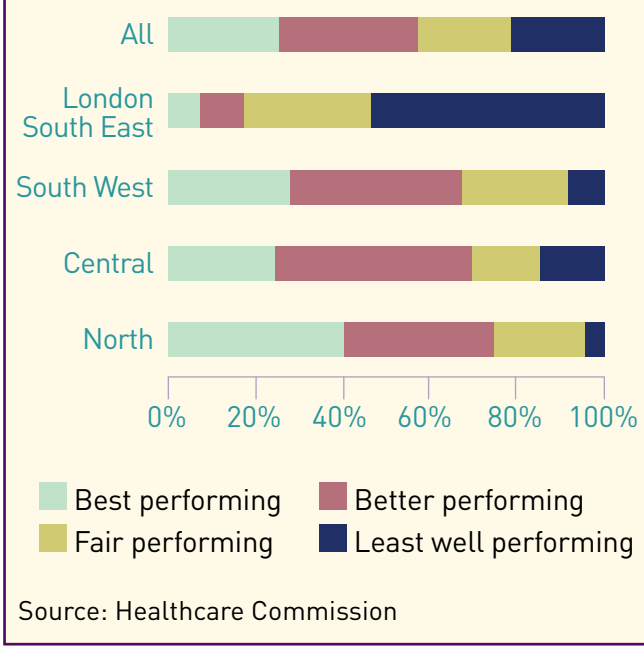
the safety of maternity services in England.[114] Key findings included:

- Some trusts' boards were not giving high enough priority to the safety of patients or to maternity services.
- Standards to improve the safety of maternity care were set by too many national bodies and thus putting administrative burden on staff. It was also unclear how these bodies were linked.
- There were tensions between midwives and obstetricians, potentially leading to poor team-working.
- Maternity teams were not always clear about leadership. Communication between clinicians, for example during emergencies or changes between shifts, was not always effective.
- Midwives were not always providing one-to-one care in labour and were sometimes diverted to tasks more appropriately done by other staff.

Our investigations convinced us that a full national review of maternity services in England was also needed. Firstly, we conducted a survey of women's experiences of maternity care in the NHS – the largest survey of users of maternity services ever undertaken – alongside a voluntary web-based survey of staff working in maternity services. Over 26,000 women and almost 5,000 staff responded to these surveys. Our subsequent review focused on the whole of the pathway of maternity care, from the start of the pregnancy through labour and birth to postnatal care, and relied heavily on the views of women using the service, gathered in the survey.

As an outcome of the review, we gave 148 NHS trusts a score for their maternity services, from "best performing" to "least well performing". Figure 21 shows the overall spread of scores by region. We found that the scores varied greatly in different parts of the country.

FIGURE 21: Review of maternity services 2007 – overall scores by region



Source: Healthcare Commission

In particular, trusts in London and the South East scored less well than trusts in other regions. During the past five years, London has seen a 21% rise in the birth rate and this has presented a huge challenge for maternity services across the capital.[115] NHS London has prioritised maternity as a key area of work and, in July 2008, launched a programme to raise standards in the capital. An extra £60 million is to be invested in maternity services across London over the next three years.[116]

Following the review, we worked with trusts in the "least well performing" category to draw up action plans to tackle the identified areas of poor performance. These plans suggest that trusts are addressing the problems identified and are making efforts to put things right.

Our survey revealed variations in care and perceptions of care, by age, ethnicity, disability, family composition, educational status and region. These included:

- Some groups known to be at risk of poorer maternal and infant outcomes (women from black and minority ethnic (BME) groups, single mothers and those from socially disadvantaged backgrounds) access services late, have poorer outcomes, and report poorer experiences of some aspects of their maternity care.
- However, women from BME groups were more likely to say they were treated with respect and dignity, and had been given adequate information, during their pregnancy and afterwards. And they were more likely to breastfeed.
- Women who said they had a disability gave fairly consistent negative feedback on their experiences of maternity care.
- Single mothers and women who left school early were less likely to breastfeed, as were women in the north of England.

These findings suggest that maternity services need to be more responsive to the particular needs of these groups of women, providing greater support and tailored care as required.

Women are entitled to maternity services that meet minimum standards. Our review of maternity services has been crucial in establishing a baseline for assessing the quality of the services that women get.

During antenatal care, women should:

- Be able to see a midwife as their first point of contact and have a named midwife throughout pregnancy.
- Be offered high quality antenatal screening.
- Receive the recommended level of antenatal appointments and be offered antenatal classes.
- Have a choice of where to give birth.

During labour and after the birth, women should be given:

- A choice of methods of pain relief and one-to-one care once they are in established labour.
- Support for breastfeeding and practical help in looking after the baby.
- Routine postnatal check-ups and advice on contraception.

As discussed above, our review and national survey of maternity care found wide variations between providers in the quality of care given to women. Over the next two pages, we summarise our key findings, setting out the level of services women are entitled to, and the level they get in reality. We also look at the factors underpinning safe, high quality care. Unless otherwise indicated, the findings are from our review of maternity care.[117]

75%

Proportion of women who said their care during labour was "excellent" or "very good"

Since we published our findings, a new set of standards for maternity services have been produced jointly by four of the Royal Colleges. These comprise 30 individual standards covering the different stages of motherhood. For the first time in one document, there are standards from preconception to the transition into parenthood. These standards will be enormously important in providing clarity for trusts, commissioners and the public on what a safe, quality maternity service should look like, and providing a basis for future regulatory work.

Future priorities

Looking to the future, our work has identified some key actions to improve both maternity care and our understanding of it.

- A centralised national collection of data about maternity care is needed. This would help to reduce the burden of multiple requests for information from regulators, and would help to ensure that the data held is of good enough quality to be of use.
- There is a need for policies on maternity services to be aligned between organisations, to ensure that women are given consistent, supportive and realistic advice at all points during their care.
- The boards of NHS trusts need to review levels of staffing against the needs of the population.
- The boards of NHS trusts need to ensure that women's views are used to design and shape maternity services.
- There is a need for better commissioning by PCTs, with improved performance management against agreed standards.
- There should be a follow-up national review within the next two years to check for improvement.
- More work should be done, possibly by the new Care Quality Commission and its partners, to explore specific areas of maternity care, such as diabetes care, home birth, obesity management and integrated antenatal care, and related topics including neonatal care and stillbirths. We currently have a very limited picture of each of these areas.

The pathway of maternity care

What should women expect and what do they get?

Antenatal care

Overall, 68% of women rated their care received during pregnancy as "excellent" or "very good". We found that many trusts were not meeting the recommendations from NICE.

A first-time mother with a straightforward pregnancy should have 10 antenatal appointments scheduled. Other women with an uncomplicated pregnancy should have seven appointments.[118] We found that 14% of trusts planned fewer than 10 appointments for first-time mothers. Overall, 25% of women reported receiving fewer than the recommended number of appointments.[118]

Women should be routinely offered an early ultrasound scan and a fetal anomaly scan to check the physical development of the baby.[118] Ninety-two per cent of women said that they had received an early scan, though the figure was 86% in some trusts. Nearly all women (99%) received the fetal anomaly scan.

Pregnant women should be offered opportunities to attend antenatal classes.[118] Thirty-seven per cent of women reported not being offered any antenatal classes at all.

The 'booking' appointment should ideally take place by 12 weeks into the pregnancy (according to the NICE guidance at the time, although new guidance says that 10 weeks is ideal).[118] Seventy-eight per cent of women could make a booking appointment by 12 weeks. Late bookings happened more often in London and other large towns and cities, and among women from some minority ethnic groups, in particular Black African and Bangladeshi groups.

For women who choose to have Down's syndrome screening, the 'combined test' or (for women who book later in pregnancy) the 'serum screening test' should be arranged.[118] All trusts offered screening in Down's syndrome, and 18% offered the most effective tests following the latest NICE guidance. The guidance has just become operational and we expect this percentage to increase rapidly.

Managers of perinatal mental health services should ensure that there are clearly specified care pathways, so that all healthcare professionals know how to access assessment and treatment.[119] Forty per cent of trusts had access to a specialist perinatal service headed by a specialist psychiatrist and 18% offered access to a community psychiatric nurse-led service. Forty-two per cent had no access to specialist services.

Staffing and training

Variation in levels of staffing suggests that some units may be understaffed. We found levels of midwife staffing ranging from 23 to over 40 per 1,000 births per year. The number of midwives for every supervisor ranged from seven to 28. This ratio should not normally exceed 1:15.[120] In a third of trusts, we found an insufficient presence of consultants on labour wards. We also found that, in some trusts, all midwives and doctors had attended appropriate courses, but in others it was 40% or less. Midwives, more than any other professional group, tell us that they feel pressured at work.[121] We also found that 28% of doctors and 58% of midwives did not feel that the two groups shared the same goals and only around a third (31% of doctors and 37% of midwives) thought handovers between shifts were comprehensive.[121]

Care during labour and childbirth

Overall, 75% of women rated their care during labour and birth as "excellent" or "very good".

There needs to be continuity of midwifery care throughout labour.[122] We found that only around 20% of women had the same midwife throughout labour, with variation across trusts of between 9% and 34% (median 20%). However, in long labours, more than one midwife would be expected.

A woman in established labour should not be left alone, except for short periods or at the woman's request.[123] One in five women reported that they were left alone in labour to the extent that it worried them.

Women should be able to choose different methods of pain relief during labour.[124] Two-thirds of women told us they definitely received the pain relief they wanted but, in a quarter of trusts, as many as 25% of women felt that they did not get sufficient pain relief. Only 11% of women used a birthing pool.

Women should be offered the choice of planning a birth at home, in a mid-wife led unit or in an obstetric unit.[123] Choice is somewhat limited by a lack of availability of midwife led units. Sixty-five per cent of trusts had only obstetric units.

Postnatal care

Women reported postnatal care to be the least satisfactory aspect of the maternity care pathway. Overall, only 59% of women rated their care after birth as "excellent" or "very good".

Midwifery-led services should provide for the mother and baby for at least a month after birth or discharge.[125] We found that the average age of the baby at last contact with the midwife ranges across trusts from 10 days to 42 days, and is typically 14 days. 21% of women said they would have liked to see the midwife more after the birth of the baby. Across trusts, this ranged from 4% to 51%.

Initiation of breastfeeding should be encouraged as soon as possible after the birth, ideally within one hour.[126] Trusts reported an average of 69% of mothers initiated breastfeeding but this varied widely between 32% and 92%.[127]

Women should be offered information on how to feed the baby.[126] Women said that midwives or other carers had not given them consistent advice (23%), practical help (22%) or active support or encouragement (22%) with regards to feeding their baby (breast or bottle).[128]

Good use of information

Some trusts lacked systems that could provide essential information about their maternity service. Only 60% had a system that complied with the requirements of Connecting For Health and 17% reported having no IT system for maternity care at all. Just 15% of trusts had information systems that covered both antenatal and postnatal care.

Good facilities

The median trust has 3.6 beds per 1,000 births per year, but some have only two beds per 1,000. Many trusts are short of baths or showers. Forty-nine per cent of women reported that toilets and bathrooms were "very clean". All obstetric units had access to general emergency facilities, but 26% of trusts do not have access to specialist interventional radiology.

The picture for children and young people

The Healthcare Commission has a special duty, given to us by Parliament, to pay attention to the rights and welfare of children and young people.

Main points at a glance

- While children are generally healthy, inequalities in health linked to deprivation persist, including death in infancy. Other key challenges include obesity and sexual health.
- While death in childhood is uncommon, there are too many cases involving avoidable factors.
- Although the overwhelming majority of NHS organisations declare that they comply with the core standard for child protection, we have some underlying concerns about the priority given, in some organisations, to issues relating to children, the levels of essential training in child protection among clinicians, and lines of accountability and responsibility for child protection. At the Government's request, we will carry out a national review of arrangements in the NHS for the safeguarding of children.
- Children and young people with complex needs, including children with disabilities or those in situations that make them vulnerable, do not always get the attention and care from healthcare services that they need.
- Our work looking at acute hospital services has shown that children receive better care in settings where they are the main focus (such as inpatient paediatric units).
- However, our work in acute hospitals also found some evidence of failure to recognise serious illness in children, due to a lack of training in paediatrics or a lack of supervision.
- Services for children with mental health needs have improved, but are still patchy.
- As for other services, there is a lack of good data with which to measure children and young people's access to services, and the outcomes they get.

Facts and figures

In 2007, there were just over 9.5 million children aged 0-14 in England and Wales, about 18% of the total population.[129]

The general health of children

Children in England and Wales are, generally speaking, healthy. The annual Health Survey for England tells us that 94% of children aged 15 and under are in good or very good health,[130] although work carried out by UNICEF suggests that young people in the UK may have a more negative perception of their own health than young people in other developed countries.[131] Other recent work, carried out by Ofsted, reported that 28% of children thought that they were "very healthy" and 58% "quite healthy".[132]

Seven per cent of children have a longstanding illness that limits their activity, while one in 10 children have recently had, at any given time, an experience of acute illness (though many such illnesses will require little or no treatment).[133] Long-term conditions such as diabetes are increasing among children.[134] Around one in 11 children in the UK has asthma.[135] Obesity is an increasing problem. In England in 2006, just under a third of children were overweight or obese. The proportion of children classed as obese has risen from 11% in 1995 to 16% in 2006.[136]

Inequalities in the health of children

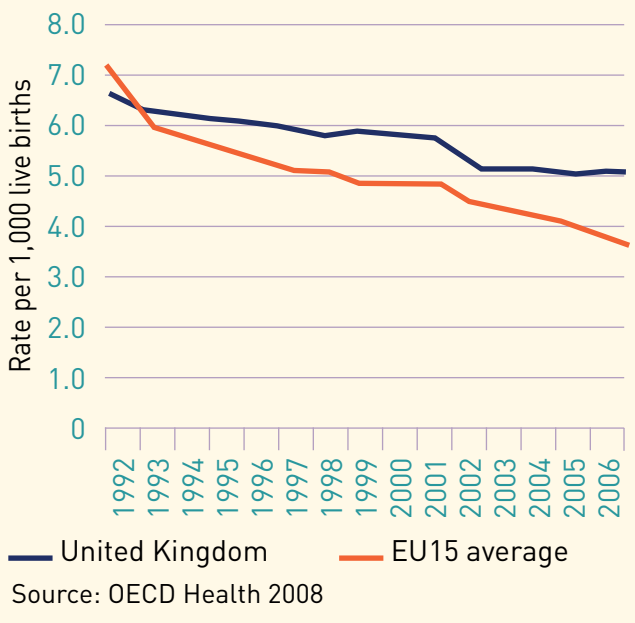
We have outlined in previous reports the effects of poverty and deprivation on children's health and their prospects for good health in later life. Put simply, children from less well-off backgrounds can expect to live shorter lives and experience worse health, both physical and mental, than those from more affluent backgrounds.

While it is true to say that absolute measures of health and life expectancy are improving, inequalities in child health are at best constant, and at worst widening. The Department of Health has set a target, by 2010 to reduce by at least 10 per cent the gap in infant mortality rates between the routine and manual group and the population as a whole (progress to be measured against the target baseline of 1997-1999). Latest data, for 2004-2006, show that the gap has widened, though the rate for routine and manual groups is now below the 1997-1999 rate for all groups.[137]

Death in childhood

Rates of death in childhood are decreasing. In 2006, there were just over 50 deaths for every 100,000 children aged 15 or under. A decade earlier, the figure was around 60 deaths.[138] Infant mortality (that is, death within the first year) has also gone down, and now stands at around five deaths per 1,000 live births. However, this is still at the higher end of the range when compared with other developed countries.[139]

FIGURE 22: Infant deaths in the UK and EU, 1992-2006



Source: OECD Health 2008

Among children aged from one to four, the rate for all causes of death is 24 per 100,000 people, with the most common cause of death being unintentional injury. Among children aged five to 14, the rate for all causes of death is 12 per 100,000 and the most common causes are injuries and cancer.[140]

In 2008, the Confidential Enquiry into Maternal and Child Health (CEMACH) published its study *Why Children Die*.[141] This was a pilot, designed to test the feasibility of national confidential enquiries in this field. It examined deaths of children, aged from 28 days to one day short of their 18th birthday, in five regions of the UK during 2006. The study found many positive examples of good care, but it also found avoidable factors in children's deaths in a variety of situations. These included:

- Failure to understand the importance of the history of the child's illness.
- Failure to examine and interpret physical signs correctly.
- Failure to recognise complications.
- Failure of clinical supervisions.
- Delays in referral or treatment.

In analysing the deaths, the study found that:

- 77% of the children had previous history of a medical condition or some sort of developmental delay, impairment or disability.
- 66% of deaths were certified in hospital, and only 2% in hospices.
- There were higher rates of suicide than previously reported. Only a quarter of children in these cases were known to have mental health problems prior to death.
- There was significant regional variation in the rates of death in 15 to 17-year olds.

The study also found differences in child death, including:

- Overall, death rates for children from families of Pakistani and Black African origin were significantly higher than the rate seen in white children.
- Higher rates of congenital malformation were seen in children from families of Pakistani origin.
- Although child homicide was rare, in a disproportionate number of cases the victim came from a non-white ethnic group.
- Death was more common among those in deprived circumstances.

Health services for children and young people

Funding

Almost £3 billion was spent on children's health services (excluding maternity services) in 2006/07 in England. For 2007/08, NHS organisations reported a total budget for children's services of £3.2 billion.[142]

Workforce

The NHS in England employs over 7,000 specialist paediatric doctors (not including trainees) and over 17,000 registered children's nurses. More than 12,000 staff are employed in managing or delivering specialist mental health services to around 176,000 children and young people.[143]

Activity

In England, around 10% of consultations in GP practices are for children aged 14 and under.[144] Around 5% of all items of prescription medication dispensed in the community are for children aged 16 and under.[145]

In 2007/08, there were 1,723,911 admissions to hospital of children aged 14 and under

(including babies born in hospital),[146] around three million attendances in A&E of children up to 16, and 4.5 million outpatient appointments. More than half a million children each year are admitted to hospital as emergency patients. A similar number go into hospital for surgery.

National policy

Two initiatives, both launched in 2004, are at the centre of national efforts in England to improve children's health and healthcare. The National Service Framework for Children, Young People and Maternity Services set out standards for care, together with a 10-year programme for improvement.

Every Child Matters: Change for Children focused more widely on the wellbeing of children, and emphasised the importance of strong partnerships between organisations such as health trusts, schools and local authorities. Both of these initiatives are detailed and demanding, and our work on children's healthcare is largely based around them.

Future development of health services for children in England will be guided by the new *Child Health Strategy*. Wales has its own national service framework for children, young people and maternity services, published in 2005, which sets out the quality of services that children, young people and families have a right to receive.

Our work

We have a statutory duty to pay attention to the rights and welfare of children and young people. Because of the multi-agency nature of children's services, much of our work is carried out in collaboration with other national inspectors and regulators. Our work includes our in-depth review of acute hospital services for children, our work with Ofsted on joint area reviews (JARs) of local children's services, and our work with HM Inspectorate of Probation inspecting the work of youth offending teams (YOTs). We carry out a range of activities to test the arrangements of health and healthcare organisations for the protection and safeguarding of children, and contribute to the annual joint inspectors' report on safeguarding.

We believe that this wide-ranging and detailed work has given us a good overview of the progress made by services for children and young people. To describe this overview, we have come up with some key questions about the healthcare provided to children and young people. We focus in particular on the services provided to children and young people with complex needs, and those in situations that can make them vulnerable.

> “Inequalities in the health of children are a major and persistent issue. The rise in the numbers of overweight and obese children is an increasing problem, with huge implications for the future health of the population. Drinking among teenagers remains too high, though it is decreasing.”

Q. How successful are services in promoting good health?

A. Good progress is being made on promoting health in infancy and early childhood. Infant deaths continue to decline. Fewer women now smoke during pregnancy and more start breastfeeding. Rates of childhood immunisation continue to improve. However, there remain very poor levels of staff cover in neonatal units[147] and a national task-force has been established to address key issues in this area.

There are fewer children and young people smoking than in the past. Rates of teenage pregnancy are decreasing, and are down 13% since 1998 (although the national target in England of a 50% reduction by 2010 appears unlikely to be met). Our studies tell us that there have been improvements in both access to and provision of mental health services for children and young people, though this can vary by area.

Inequalities in the health of children are a major and persistent issue. The rise in the numbers of overweight and obese children is an increasing problem, with huge implications for the future health of the population. Drinking among teenagers remains too high, though it is decreasing.[148]

And, although there has been progress in reducing teenage pregnancies, this varies markedly by area. The rate of abortion in under-19s continues to rise, from 30 per 1,000 women in 2002, to 33 per 1,000 in 2007.[149] A quarter of children say that they need better information and advice on alcohol, smoking and drugs, and more than a third say they need more information about sex and relationships.[150]

Q. Do services have the right systems in place to safeguard children and young people?

A. The Government has defined the term 'safeguarding children' as: "The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the

Q&A

provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully."[151]

The tragic case of Baby P has increased the public's awareness of the crucial role of healthcare organisations and other public bodies in the protection and safeguarding of children.

For 2007/08, 97% of NHS trusts and PCTs declared that they complied with the core standard for child protection (C2). As part of our assessment process for these organisations, we invited commentaries from local safeguarding children's boards (LSCBs), the bodies responsible for local security of arrangements for child protection and safeguarding. These commentaries were overwhelmingly positive.

However, we have some concerns and, at the request of the Government, we will carry out a national review of child safeguarding in the NHS. While many NHS trusts and PCTs have worked hard to raise the profile of children's services, concerns remain about the priority given to children's issues by some NHS trust and PCT boards and by independent healthcare providers.[152]

Our work with other inspectorates has also found that, in some agencies (including some NHS bodies), lines of accountability and responsibility for child protection are still not always clear.[153] Of the those independent providers we inspected during 2007/08 for compliance with the core standard relating to arrangements for the protection of children, 10.5% were "not met" (amounting to 0.4% of all providers).[154]

Following our 2005/06 review of hospital services for children, we expressed concerns about the level of staff training in child protection in acute hospitals. We have carried out further work to follow up on this review, including the question of training. Following further analyses and follow-up visits during December 2008 and January 2009, we will report publicly on our findings.[155]

Concerns about training are echoed in work carried out by Healthcare Inspectorate Wales and in research examining the Child Death review process.[156,157] Other recent work has highlighted that only 50% of GPs have formal training in paediatrics, and access to child protection training for GPs has been identified as "limited".[158,159]

Our work on safeguarding tells us that some of the most vulnerable children and young people are poorly served by public services, particularly those who are looked after by their local authority, are in secure settings, are seeking asylum or are detained because of their mental health needs.[160] We will be contributing to a programme of thematic inspections alongside HM Inspectorate of Probation and Ofsted, with one of the themes focusing on the journey some young people make from the community to custody and back again, and the health and welfare of looked-after children.

Looking to the future, the new arrangements for LSCBs to review the deaths of all children should help to improve local practice, as should the Government's new *Staying Safe Action Plan* and the new public service agreement on safeguarding.

Q. How well do services work together?

A. Most local authorities and PCTs either have, or are working towards, joint posts with pooled budgets. Staff in health, education and social care are increasingly working together to improve services, as are public health teams, looked-after children teams, professionals involved in safeguarding, and commissioners.[161]

We have seen greater involvement of healthcare organisations in the management of youth offending services. Funding and commissioning of substance misuse services for young people has improved, as has support from mental health services. PCTs are contributing between 0% and 8.7% of youth offending team budgets, although the average of around 4.7% remains low. We are finding that service level agreements and protocols between youth offending and health services are still not used enough.[162]

A recent study published by the Audit Commission concluded that the introduction of 'children's trusts' as vehicles for greater joint working, improved commissioning and pooled budgets, are in varying levels of development, but that joint working is improving largely irrespective of their establishment. Increasingly there are examples of innovative practice.[163]

However, our recent work in Haringey looking at arrangements for the protection of children, carried out with Ofsted and HM Inspectorate of Constabulary, found that systems were not adequate to enable agencies to work together effectively on behalf of children. Our forthcoming national review of child safeguarding in the NHS will look at how healthcare organisations work in partnership with others to safeguard children.

> Our recent work in Haringey looking at arrangements for the protection of children found that systems were not adequate to enable agencies to work together effectively on behalf of children.

Q. How well do organisations meet the healthcare needs of children and young people?

A. Our findings include the following:

Care in acute hospitals

Broadly, we have found that, where children and young people are the main focus (such as in specialist hospital paediatric facilities), care is of good quality, meets the wider needs of children and is age-appropriate.[164] However, essential training for staff is still inadequate in too many areas.

Our recent work on urgent and emergency care found that pain management and facilities for children were poor in some trusts.[165] Our follow-up work on children's hospital services has found that there are still too many trusts in which surgeons and anaesthetists carry out very low levels of work with children.[166]

Our work on the 2005/06 review of children's hospital services found some evidence of failure to recognise serious illness in children, because of a lack of training in paediatrics or lack of supervision. This issue was also highlighted in CEMACH's report *Why Children Die* (see above). Consultation is underway, led by the Royal College of Paediatrics and Child Health – this includes looking at options for the reconfiguration of services to improve specialism (as recommended in the Bristol Inquiry report).[167]

Services for children and young people with disabilities

Our recent work looking at specialist inpatient services for young people with learning disabilities concluded that young people were generally safe and their health needs were met. However, some were not receiving the range of experiences and services that young people need if they are to live a fulfilled adult life and feel part of the wider community.[168]

We have found that the funding and provision of services for children and young people with learning and/or physical disabilities varies throughout the country.[169] The recent review of access to speech and language services identified significant waiting times for this important service.[170]

Mental health services

Although the numbers involved are relatively low, too many children with mental health problems find themselves admitted to adult wards. Legislation is due to come into force in spring 2010 that ensures that no young person is placed inappropriately on an adult mental health ward. Recent work by the Children's Commissioner shows that many, but not all, trusts are on target.[171]

All PCTs now report that they commission the key elements of a comprehensive child and adolescent mental health service (CAMHS), but we have found that quality and waiting times are variable.[172,173] Our work also suggests that the commissioning of CAMHS rarely involves systematic evaluation of new models of care, the measurement of outcomes or assessments of need.[174]

The transition to adult services

The transition from children's to adult services remains a major concern for young people with mental health problems, diabetes, disabilities and complex needs, and life-limiting conditions.

Physical health checks for young people who offend

We have concerns that children and young people in contact with youth offending services do not always have their physical health assessed adequately, and so do not get the referrals to mainstream health services they need.[175]

Management of diabetes

Management of long-term conditions such as diabetes could be improved for children. The most recent published national diabetes audit, for 2005/06, found that 30% of children had unacceptably high HbA1c recordings of over 9.5%, and that many young people with diabetes were not getting the routine eye and foot examinations and cholesterol checks they needed.[176]

Information

For children and young people's services, as for other services, there is a lack of good data through which to measure access to services and outcomes. Lord Darzi's recent review of the NHS recommended that indicators of clinical outcomes be developed, and we hope that this will lead to a better, and broader assessment of these services in the future.

What next?

The Healthcare Commission has, during 2008, conducted a review of existing clinical and other indicators relating to children's health and healthcare, and developed a suite of benchmarked measures for which there is national, consistently available data. In 2009, these will be issued to the NHS with a view to expansion to a wider and more representative set enabling PCTs and trusts to examine their relative position against these indicators, comparing themselves against other organisations.

The new Comprehensive Area Assessment will, from April 2009, examine how well services are working together for children and families, as well as reviewing the overall health of people of all ages within a local area. Our successor, the Care Quality Commission, is expected to play a significant part in these assessments.

The picture for people with mental health needs

Many of us will, at some time, experience a mental health problem. The Healthcare Commission has looked closely at mental health services and the experiences of those who use them.

Main points at a glance

- Compared with other trusts, specialist mental health trusts have tended to perform best in our annual health check.
- Good progress has been made towards the national target for reducing suicide.
- Substantial progress has been made in expanding the range of community-based services. People using these services report high levels of satisfaction.
- We have seen progress in inpatient services, helped by national initiatives
- However, the quality and safety of the care provided in both community and inpatient services vary enormously from area to area.
- There continues to be a greater representation of inpatients from black and minority ethnic groups than in the wider population, suggesting the need for better understanding of what could be done to avoid admissions for this group.
- Major work is underway to expand access to talking therapies for people who experience depression and anxiety, but access to a range of therapies for all with mental health needs could still be improved.
- There are major gaps in the availability of information about the quality of mental health care.

Facts and figures

It is estimated that, at any one time, one in six people of working age in Great Britain has a mental health problem, ranging from common issues such as stress, anxiety or depression to conditions that tend to be more severe or enduring, such as schizophrenia or bipolar disorder.[177]

Mental ill-health and poor physical health are closely linked. People with a severe mental illness are at much greater risk from heart disease, respiratory disease, stroke, diabetes and hypertension. Just as poor physical health is associated with deprivation, there are strong links between mental ill-health and low income. Around one in three of the 1.3 million people receiving long-term incapacity benefit in the UK has a mental health problem, mostly mild to moderate depression.[178]

In the workplace, stress, depression and anxiety are the leading causes of absence due to sickness. Mental ill-health can adversely affect a person's employment prospects – of the main groups of people with disabilities, people with severe mental health problems have the lowest rate of employment.

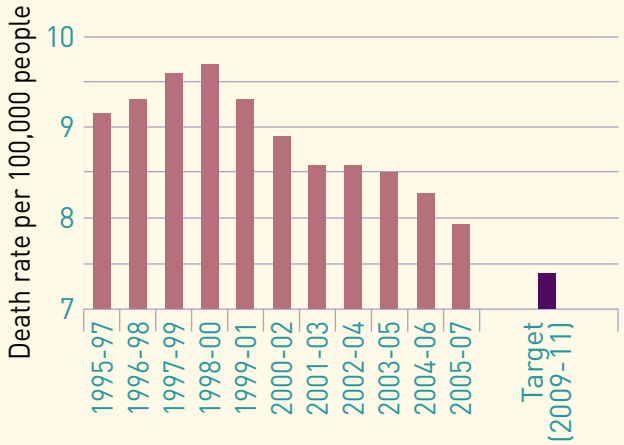
Recent evidence shows that the incidence of psychosis is higher in black and minority ethnic groups in England, particularly among people from African-Caribbean groups.[179]

Good progress has been made towards achieving the Government's main target for mental health in England, a one-fifth reduction in deaths from suicide and undetermined injury by 2010, with notable changes in the rates among young men and inpatients. Providing the current rate of decline is sustained, the target should be met.

Funding

The NHS funds the vast majority of mental health care in England and Wales. Investment in specialist mental health services for adults of working age in England in 2007/08 was estimated to be £5.5 billion[180], a year-on-year increase of 3.7% in real terms, with total gross public spending on mental health (for all age groups) estimated for 2006/07 at £8.4 billion (excluding spending to tackle substance misuse) – the highest figure for any of the Department of Health's 'programme budgeting' categories.[181]

FIGURE 23: Deaths from suicide and undetermined injury in England, 1997-2007



Source: Office for National Statistics

Reform of the service

Most mental health services for adults are divided between those for people of 'working age', that is aged 16-64, and those for older people aged 65 and above. However, services can (and often do) operate with more flexibility than this, making a distinction between 'functional' mental health problems, such as depression, anxiety and psychosis, and 'organic' mental health problems such as dementia.

The implementation of the National Service Frameworks (NSF) for Mental Health in both England (1999) and Wales (2002), the NSF for Older People (in England, 2001) and the detailed care and clinical guidelines published by the National Institute for Health and Clinical Excellence have all changed the structure and delivery of specialist mental health services.

Broadly, in services for adults of working age, the emphasis has moved further from inpatient provision to an expanded range of community services, such as 'assertive outreach', 'crisis resolution home treatment' and 'early intervention in psychosis teams', all designed to prevent or minimise the need for people to be admitted to hospital, reflecting the preferences of people using these services. Changes in older people's mental health services have perhaps received less public attention, but they have also stressed the importance of services in the community, integrated across health and social care.

In the wake of these changes, the national agenda continues to develop. It is focusing more heavily on issues such as: the physical wellbeing of people with mental health needs; the problems of stigma and social exclusion associated with mental ill-health; reducing inequalities for people with mental health problems from black and minority ethnic groups; and improving the care and outcomes for people with mental health needs in prison and people who misuse drugs and alcohol.

The need for services to meet the wider health and social care needs of service users has been highlighted in updated policy guidance on the care programme approach.[182] There has also been renewed policy attention on inpatient services due to concerns about the safety of these services and the quality of care, alongside extensive capital investment to improve the inpatient environment, particularly to extend access to single sex accommodation for women. The need to substantially improve access to psychological therapies has also been identified.

How services are delivered

Most of the people treated by the NHS for a mental health problem are treated by their GP, and are not referred on to more specialist services, although some may be offered additional treatment in the form of talking therapies such as cognitive-behavioural therapy. It is thought that a third of all consultations with GPs relate to a mental health issue.

Medically unexplained symptoms account for as many as one in five new consultations in primary care. Up to 70% of people with these symptoms will also have depression or anxiety that could be detected and treated.[183]

The vast majority of users of services who get access to more specialised mental health services do so by referral from their GP. Other means include referral from a liaison psychiatry service operating in another part of the NHS (such as A&E, acute hospitals or maternity departments), specialist learning disability services, services for older people and services for those addicted to alcohol or drugs. Referrals from outside the NHS include those from the criminal justice system.

In England, secondary mental health services are provided by mental health NHS trusts, some primary care trusts and a range of independent providers. NHS mental health services in Wales are delivered by healthcare trusts responsible for providing a full range of physical and mental health secondary care services. Some users of mental health services will access only outpatient or community services. Some will also need treatment as an inpatient. In 2006/07, over 1.1 million people were in contact with specialist NHS mental health services in England – about one person in 50.[184]

NHS community mental health teams in England have a total caseload of more than 300,000 people. For community mental health teams for older people, this figure is more than 150,000 each year.[185] In 2007/08, 106,000 episodes of home treatment were delivered. At the end of the year, 20,000 people were receiving care from assertive outreach teams and 16,000 young people were on the caseload of early intervention in psychosis services.

Each year, there are around 130,000 admissions of people to inpatient NHS mental health services, of whom approximately 48,000 will be detained under the Mental Health Act at some point. Based on a one-day snapshot taken on 31 March 2008, the 2008 *Count Me In* census indicated that there were 31,020 inpatients in NHS and independent sector mental health services, of whom 45% had been detained under the Mental Health Act on admission.[186]

Depending on need, users of mental health services may also be referred to specialist services such as those for people with eating disorders, substance misuse services, learning disability services or forensic psychiatry.

As part of their wider remit, secondary mental health services also work with other local public services such as housing, employment, education and benefits agencies to promote independent living and social inclusion.

Treatment by specialist services, in particular community services, will often overlap with care provided by a GP. However, as the need for treatment in secondary care diminishes, service users are discharged back into the care of their GP and the primary care team, who will continue to monitor their condition, review and, in some cases, administer their medication, and assess their physical health needs.

On the next two pages, we set out at a high level what we know about the quality of mental health services in England and Wales, for patients and users at different stages of their journey through care. This picture is incomplete, particularly so in primary care, and filling in these gaps will be a major challenge for the new Care Quality Commission and its partners.

It should be recognised that NHS mental health trusts in England have done well in our annual health check assessments, performing best both for quality of services and use of resources. This reflects, in particular, the progress they have made on the targets set for them by Government and their ability to deliver services that meet core standards.

Gaps in the picture

While we have developed a good understanding of the quality of care offered by NHS providers of mental health care, particularly for adults of working age, there are some important gaps that need to be addressed by services, Government and in the work of the new Care Quality Commission:

- The effectiveness of implementing the range of NICE guidelines that are relevant to mental health.
- The effectiveness of arrangements to provide defined pathways through care for users, particularly where users move through specialist services such as eating disorder and forensic services.
- Limited information to compare services in the NHS and independent sector.
- Limited information on outcomes for users of services, particularly those defined and reported by users themselves.
- In primary care, an absence of key data, including information about prescribing, characteristics of users of services, and access to a range of interventions.
- Value for money, payment by results and the quality of commissioning.

There is a clear need to develop information systems in mental health and to improve the availability and coverage of robust information about mental health services. The Government's mental health information review, which will report in late 2008, will seek to set priorities for improving mental health information.

The quality of services for people with mental health needs

Primary care

Around a third of consultations in primary care are, at least in part, related to a mental health issue. Nine out of 10 people with a mental health need have their condition managed entirely in primary care, including a quarter of people with severe mental illness. Despite this, information about the quality of the care received by people treated solely in primary care is limited.

Acute hospitals (physical health)

Standards of assessment and management of mental health needs in A&E departments have been identified as variable, with calls for improvement in the training of A&E staff and the development of multi-disciplinary teams in acute hospitals working in close liaison with crisis teams, primary care, and/or specialist services. A large minority of acute trusts do not have access to a specialist perinatal mental health service. Antenatal and postnatal support could also be improved.

Mental health and employment

We have found that people with severe mental illness are still not getting the physical health checks that they need. We are seeing better assessments of occupational or vocational needs, but little movement in rates of employment for people with a mental health problem. Only half of those wanting help to find employment receive help. The Government has announced its intention to develop a national strategy for mental health at work.

Psychological therapies

Access to psychological therapies in primary care has historically been poor. The national roll-out of the programme for improving access to psychological therapies for anxiety and depression has given a fresh impetus to this, and the development of good measures to assess progress is underway. It is important that the lessons from this are applied to improving access to a wider range of psychological therapies across both primary and secondary care.

In our work in secondary care, we have found little improvement in access to therapies for people with schizophrenia, and reduced provision of psychosocial family interventions.

Mental health in prisons

There has been good progress on developing mental health in-reach teams for prisons. By 2007, 80% of prisons had nurse-led mental health in-reach teams, consisting of a core team of psychiatric nurses with varying access to other professionals. Mental health awareness training was also made available to prison staff. Despite these developments, concerns remain that people with mental health needs are still being inappropriately criminalised, and that the structure of mental health services in prison is currently not meeting the full range of prisoner's needs.

Community services

Overall, our work on community services has found good progress on putting in place the nuts and bolts of the services set out in the NSF. The newest community services are now well established. Although nationally there have been marked improvements, there are still problems in some areas in gaining access to specialist help or help in a crisis. A substantial minority of PCTs are still not achieving targets for crisis resolution home treatment and early intervention in psychosis services. Our surveys of service users tell us that satisfaction is reasonably high, with 78% of people rating their care as "excellent", "very good" or "good". But they also highlight enduring concerns about involvement, information and choice, and access to therapies.

Older people

Our work on specialist mental health services for older people is ongoing and we will publish our national study in 2009. Key themes for the study include ageism, the comprehensiveness of services, safety, and joint working between health and social care.

In earlier work, we found that, in 2007/08, four out of five NHS mental health trusts had community mental health teams that were integrated with social care. Three-quarters of PCTs had an up-to-date picture of both the mental health needs of older people in their areas, and the services available to them. In inpatient services, based on our national audit, we have concerns about the level of violence on wards and the quality of some of the accommodation offered.

Inpatient care

In our review of NHS acute inpatient services, we found considerable variation in quality between, and sometimes within, NHS providers. There were trusts that showed that good quality acute care is achievable and being achieved. However, we found more services failing to meet minimum standards than in our review in the community. This is a real concern, given the critical and frequently complex nature of the needs of people using these services. We found particular issues with personalised care, safety, access to appropriate treatment, and the pathway of care into and out of hospital. The 2006/07 national audit of violence found that, although violence on wards had increased, the effectiveness of staff in preventing and managing incidents had also improved.

Independent providers of inpatient care are the most frequently inspected of all types of provider in our risk-based inspections in independent healthcare, reflecting our ongoing concerns in this area.

Our annual census of inpatient services has found little change in rates of admission and detention for people from black and minority ethnic groups, with greater representation of patients from BME groups than in the wider population. Better prevention and early intervention in primary care, so that people can get help before a crisis, may help to tackle this.

The picture for people with a learning disability

Historically, people with a learning disability have experienced worse health than the general population. Their health needs have been poorly understood and inadequately met. How well healthcare services can understand and meet the needs of these people, and improve their health, is a key test of their ability to care for the population as a whole.

Main points at a glance

- We have concerns about the commissioning of health services for people with learning disability. We are carrying out further work in this area and will report on this in 2009.
- Specialist healthcare services for people with learning disabilities are generally safe. However, they do not always adequately meet the wider needs of the people using them.
- There are still barriers for people with a learning disability in getting access to mainstream services, and so their physical health needs are too often poorly addressed. Within mainstream services, staff lack an awareness of how to respond to someone with a learning disability.
- We have too little information about care for people with both a learning disability and mental health needs, but we have concerns and so we have included in the annual health check for 2008/09 a measure of performance in this area.

'People with a learning disability' is a broad term, and a short way of referring to people who have a significantly reduced ability to understand new or complex information and learn new skills, and a reduced ability to cope independently, which started before adulthood with a lasting effect on development.[187]

In this report and to avoid confusion, we use the term 'learning disability', as this is the one most commonly used in healthcare.

We acknowledge that 'learning difficulty' is often preferred, particularly by users of these services, but this is also used in education where it has a different meaning.

Facts and figures

We do not know exactly how many people with learning disabilities are living in England and Wales. Recent estimates suggest that 985,000 people in England have a learning disability (2% of the general population) including 828,000 people aged 18 or over. Of these, it is thought that 177,000 are known users of learning disability services, most of whom will have severe or profound learning disabilities.[188] Department of Health estimates for adults with severe or profound learning disabilities put the figure at 145,000. There are thought to be approximately 60,000 people with a learning disability in Wales.[189]

These numbers are expected to rise considerably over the next two decades, because of increased life expectancy, and growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood.

Prevalence is higher in South Asian communities.[190] People with learning disabilities from minority ethnic communities can experience disadvantage due to both race and impairment.

People with learning disabilities tend to experience worse health, have greater need of healthcare and are more at risk of dying early compared with other people – they are 58 times more likely to die before the age of 50.[191] Specifically, they are more likely to:

- Die from things that could have been prevented. Four times as many people with learning disabilities die of preventable causes as people in the general population.
- Have epilepsy. A rate of 22% has been estimated, compared with 0.4% to 1% in the general population.
- Be at risk from a thyroid dysfunction, particularly hypothyroidism.
- Have a sensory impairment. People with learning disabilities are between 8.5 and 200 times more likely to have a problem with their sight, and around 40% are reported to have a hearing impairment.[192]
- Have dementia. For older adults with learning disabilities, the prevalence of dementia is 22%, compared with 6% in the general older adult population.
- Experience mental ill-health generally, with a prevalence of schizophrenia three times greater than other people (3% as against 1%).
- Contract gastrointestinal cancer (although people with a learning disability have a lower incidence of other types of cancer).[193]

The leading cause of death for people with learning disabilities is respiratory disease – a rate of death of 46%-52%, compared with 15%-17% for the population as a whole. Coronary heart disease is the second most common cause of death, increasing as people get older. Around half of all people with Down's syndrome are affected by congenital heart problems.

Some of the key risk factors that affect people's health generally are also more of a problem for people with learning disabilities. They are more likely to be underweight, overweight or obese. Less than 10% of adults with learning disabilities eat a balanced diet: not knowing enough about healthy eating, not eating enough fruit and vegetables, and lacking choice. Over 80% of adults with learning disabilities engage in less physical activity than the minimum levels recommended by the Department of Health.[194]

Recent information suggests that just under one in five (19%) people with learning disabilities smoke, a smaller proportion than in the population as a whole, where current rates are around 25%. The rate is higher among people with mild to moderate learning disabilities (30%) than people with severe learning disabilities (11%) and people with profound and multiple learning disabilities (4%). Rates of smoking are also higher among people living in private households.[195]

Health services

Mainstream healthcare providers such as GPs, community pharmacists, dentists and acute hospitals can meet many, if not most, of the general health needs of people with learning disabilities. National policy emphasises the importance of making these services accessible. Key steps to achieve this include training staff in awareness and communication, liaison with specialist learning disability staff, and more effective strategies for involving people with learning disabilities.

There are also specialist services for people with more complex needs. These include:

- Acute inpatient assessment and treatment
- Specialist residential and day care
- Low, medium and high secure forensic services for people likely to become a danger to themselves or others
- Services for young people
- Short breaks
- Community learning disability teams
- Specialist teams that provide intensive support in people's homes.

In 2006/07, Government spending in England on the health aspects of caring for people with learning disabilities was estimated to be £2.5 billion.[196] It is unlikely that this captures all funding for services used by people with learning disabilities.

National focus on learning disability

The publication in 2001 of the Government white paper *Valuing People* was a breakthrough in national policy. Cutting across health, education and social care, it set out a clear set of goals for improving the lives of people with learning disabilities. Key actions included ensuring that all people with learning disabilities were registered with a GP, improving support for people on health issues, providing individual health action plans, and an end to the NHS's historic role as a provider of residential accommodation.

While *Valuing People* has had an impact, insufficient progress has been made in the area relating to health.[197] During 2007/08, the Government carried out a consultation on *Valuing People Now*, to refresh its policy for people with learning disabilities. The consultation document included health as one of its top five priority areas for attention.[198]

Over the last few years, a series of reports have highlighted serious deficiencies in the healthcare provided to people with learning disabilities. These include reports from the former Disability Rights Commission, Parliament, the independent inquiry chaired by Sir Jonathan Michael, our investigations and audits, and those of Healthcare Inspectorate Wales. The Michael report, *Healthcare for All*, appears to be having a major impact, with renewed Government focus on access to mainstream services. Over the next three pages, drawing on our findings and those of other bodies, we provide an overview of the current state of healthcare for people with learning disabilities.

Healthcare for people with learning disabilities

Q. Do mainstream services meet the physical health needs of people with learning disabilities?

A. This does not seem to be happening adequately. It is an issue that has been a consistent theme of recent national reports and inquiries.

Evidence suggests that adults with learning disabilities, when seeking access to mainstream services, are discriminated against because of their disability, and that there are barriers to registering with GPs.[199,200] Too few organisations are aware of national guidance and best practice in providing care for people with learning disabilities. Services lack data and there are shortcomings in training for staff.[201]

In Wales, access to care for short-term physical illness is generally good, but there is a lack of support in acute hospitals, which puts an extra burden on carers and families. There appears to be a better understanding of people's needs within primary care.[202]

Q. Are the health needs of people understood and planned for?

There are many needs of people with learning disabilities that are not being met, and evidence that they receive less effective care than they are entitled to.[203] Both these factors suggest that the health needs of this group are not adequately understood.

Commissioning for people with a learning disability has already been identified as a major issue in Wales, and found to be poorly understood and managed at both national and local levels.[204] We are looking at the state of commissioning in England, and will report on this in 2009. However, the evidence from our recent audit of inpatient services suggests that there is limited engagement between commissioners and providers.[205] Other recent reports have found little or no evidence of informed commissioning for this group.[206]

Q. Do people with learning disabilities get the right health checks?

People with a learning disability who have diabetes have fewer measurements of their body mass index than other people with diabetes. Those with stroke get fewer blood pressure checks. Rates of screening for both cervical and breast cancer are also lower than in the general population.[207]

Health checks for people with learning disabilities tend to uncover previously unmet health and healthcare needs.[208] The Government has announced a system to reward GPs for providing annual health checks for people with learning disabilities.

Healthcare Inspectorate Wales (HIW) has found that, generally speaking, people on local authority registers for learning disability get annual health checks, although there are variations in the quality and consistency of these checks. However, this is only a limited picture, given that 47,000 of the estimated 60,000 people with a learning disability in Wales are not on these registers.[209]

Q. Are specialist health services safe?

We have carried out two major investigations into services provided for people with learning disabilities, where we found institutional abuse. This work prompted our comprehensive audit of inpatient learning disability services. In our audit, we found only a few services where the quality of care and the attention paid

to the safety of people with learning disabilities were uniformly good across all aspects of care.

We found that procedures for the safeguarding of vulnerable adults were poor, though we were reassured that procedures were robust in adolescent services. We could not be sure that the human rights of people with learning disabilities were always upheld, and we were concerned that access to advocacy services was patchy, given the value these services can have in providing outside scrutiny and highlighting poor practice.[210]

Q. What is it like for people with learning disabilities who also have mental health needs?

In England, the national service framework for mental health applies to people with learning disabilities in the same way as everyone else. We have concerns that, as is the case with physical healthcare, people with learning disabilities and mental health needs are not included in mainstream services. We have, therefore, included in the 2008/09 annual health check an indicator that looks at the mental health care provided by the NHS to people with learning disabilities.

In Wales, HIW has identified gaps in services for young people who need mental health care. They also found there to be no fully operational specific pathways of care for people with both learning disabilities and co-existing mental health problems. Training in mental health for learning disability nurses is reported to be insufficient. Professional boundaries within the NHS in Wales are leading to a fragmented service, as some medical professionals do not feel qualified to deal with both learning disabilities and mental health issues.[211]

Q. Are people listened to and fully involved in decisions about their care?

In England, we found that, on the whole, involving people in planning their own care is poorly done.[212] In particular, few trusts had arrangements in place to listen to the views of young people, their families or the staff who care for them.[213]

Q&A

In Wales, HIW found a clear lack of investment in speech and language therapy, which is key to helping people communicate better – particularly in advocacy services, which help people protect against their vulnerability.

Q. Do people with learning disabilities get good access to wider activities, including social activities?

In England, we have found that some specialist inpatient services have good levels of stimulating activities and opportunities for people to take part but, in others, choice is limited.[214]

Not all young people in specialist adolescent services are offered the range of fundamental experiences and support that they should have, such as socialising with friends or having opportunities for learning and employment outside their health setting. Outside agencies could be more involved in supporting young people and ensuring that they have access to such opportunities.[215]

In Wales, the quality and depth of activity that is needed to help people to reach their maximum potential varies considerably. HIW has identified places of 'institutionalised comfort', where people are well cared for in terms of fundamentals, but lack stimulation.[216]

What next?

- We have developed some new national indicators, including indicators on planning care, progress towards ending provision by the NHS of residential 'campus' accommodation, and the adoption of best practice in mental health services for people with a learning disability. These will be part of the 2008/09 annual health check.
- Our review of commissioning will be published during 2009.
- The establishment of the Care Quality Commission should provide new opportunities to look at the health and life outcomes experienced by people with learning disabilities, and the impact of public services on these.

985,000

Estimate of the number of people in England with a learning disability

how does it feel for patients?

How does it feel for patients?

So far in this report, we have looked at how well healthcare services meet minimum standards, how well they handle the key risks to the safety of patients and how well they provide care in different settings and to particular groups. In this section, we look at how patients and users of services experience health services, with the emphasis on what they have told us in national surveys.

Main points at a glance

- Patients and users of healthcare services are generally very positive about the care they receive from the NHS, but they also want:
  - More flexible access to their GPs
  - Better information
  - Greater involvement in decisions about their care
  - Meaningful choice
  - Respect for their dignity.
- Waiting times for acute hospital care have fallen in both England and Wales.
- We continue to have concerns about access to mental health services, particularly access to talking therapies and out-of-hours crisis care.

We have arranged the section to address three key elements of the experience of patients and users of services:

- Getting access to services.
- Having choices, and being informed and involved.
- Respect for dignity, equality and human rights.

Overall experience

Our surveys of NHS patients in England have found consistently high levels of satisfaction with services. In the most recent, 92% of acute inpatients and 78% of people using community mental health services described their care as "excellent", "very good" or "good". Around three-quarters (74%) of those who responded to our survey looking at local health services, and who had visited their GP practice or health centre in the past year, said that the main reason they went was dealt with "completely" to their satisfaction.

Getting access to services

Seeing your GP

The national targets in England for access to primary care state that all patients should be able to get an appointment with a GP within 48 hours, and an appointment with another primary care professional (such as a practice nurse) within 24 hours. Of the patients who responded to the Department of Health's 2008 GP patient survey, 87% said that they were able to get an appointment with their GP for the same day or for one of the following two days the surgery was open[217] – a finding backed up by our own survey of the experience of patients in primary care. Performance varied between PCTs, from 74% to 93%.

Our survey in 2008 of patients' experiences of their local health services in England shows

that most people are very positive about the care they receive from their GP and happy with the hours offered by their local surgery – more than three-quarters said that they were seen as soon as they thought was necessary. However, there are some underlying issues. Eight per cent of patients said that they were often put off going to their GP practice or health centre because of inconvenient opening times and 17% that they were sometimes put off. These proportions rose among patients of working age. Some patients also report difficulties in contacting their practice by telephone – 13% told us that they always had a problem getting through and 42% that this was sometimes the case.[218] There is clearly a need for more flexibility in how people can get access to these services.

In Wales, surveys report high levels of satisfaction with access, but there is recognition that access remains an area for development. A GP enhanced service has been introduced to allow extended access and the Government is working with professional colleagues to improve access in routine hours.[219]

NHS dentists

The NHS operating framework for 2008/09 states that "PCTs need to ensure robust commissioning strategies for primary dental services, based on assessments of local needs, and with the objective of ensuring year-on-year improvements in the number of patients accessing dental services". According to the latest information on NHS dental services in England, the number of people receiving dental services in the most recent two-year period has fallen since March 2006. Just under half of all adults, and 69% of children, were seen in the two years to 31 March 2008.[220]

Our local health services survey confirmed that there are significant and worrying gaps in access to NHS dental care in England. Just under a quarter of the people we surveyed are seen regularly as a non-NHS patient and just over a quarter do not visit a dentist on a regular basis. Strikingly, of those who said they did not currently visit a dentist as an NHS patient, over three-quarters said that they would like to be able to do so. Also, three-quarters of those who said that they regularly visit a dentist as a private patient said they would like to receive dental care as an NHS patient, as did 81% of those who had not seen a dentist at all in two years.

Patients' ability to access general dental services in Wales has improved following the significant investment supporting the introduction of the new dental contract. During the summer of 2008, 19 out of a total of 22 local health boards reported no access issues and had dental practices in their areas accepting new NHS patients.

The number of patients being treated by an NHS dentist in Wales within the proceeding two years has remained fairly constant. There were 1.6 million patients recorded as having been treated in the two years to 31 March 2008. This amounts to 54% of the population: 65% of children and 50% of adults.[221]

Waiting for hospital treatment

The Government has set a target, for the NHS in England, of a maximum waiting time of 18 weeks from GP referral to hospital treatment – this must take in the first outpatient appointment, diagnostic services and admission to hospital. The target has to be met by December 2008. We have assessed all PCTs and acute hospital trusts on their progress towards this target. The milestones set for March 2008 were for 85% of admitted patients and 90% of non-admitted patients to start treatment in 18 weeks or less. Sixty-five per cent of PCTs and 64% of acute trusts met these milestones.[222]

As well as moving towards an 18-week maximum wait from referral to treatment, the NHS in England still has to make sure that patients do not exceed maximum waiting times for both inpatient and outpatient treatment. In 2007/08, of the 8.2 million people who attended a first outpatient appointment after being referred by their GP, fewer than 1,000 waited more than the standard of 13 weeks. And fewer than 3,000 people (out of 4.6 million) who were admitted to hospital as elective patients following a GP referral exceeded the 26-week standard.[223]

In Wales, a target stated that, by the end of March 2008, nobody should be waiting for admission as an inpatient or day-case, or for a first outpatient appointment, for more than 22 weeks. By this date, out of a total inpatient or day-case waiting list of 50,631, just four had been waiting for longer than 22 weeks. The number of people waiting between 14 and 22 weeks was 10,832. The outpatient waiting list stood at 149,832 people – of these, no one had been waiting for more than 22 weeks, and 25,042 had been waiting for between 10 and 22 weeks.

The targets on waiting times for March 2009 have been set at a maximum wait of 14 weeks for inpatient or day-case treatment, and 10 weeks for a first outpatient appointment.[224]

Targets have also been set for maximum waiting times for diagnostic and therapy services in Wales. On 31 March 2008, just two people were still on the waiting list for the selected diagnostic services after more than 14 weeks, and just two were still on the waiting list for specified therapy services against the 24-week target.[225]

By December 2009, the maximum waiting time from primary care referral to start of definitive treatment, including time spent waiting for specified diagnostic tests and therapy services, will be 26 weeks.

Mental health services

The 18-week target in England, as currently measured, tends to exclude waiting times for mental health services. The target records those cases where people in need of mental health care are referred to a named consultant, but this misses the much more common situation where referrals are to a multidisciplinary team.

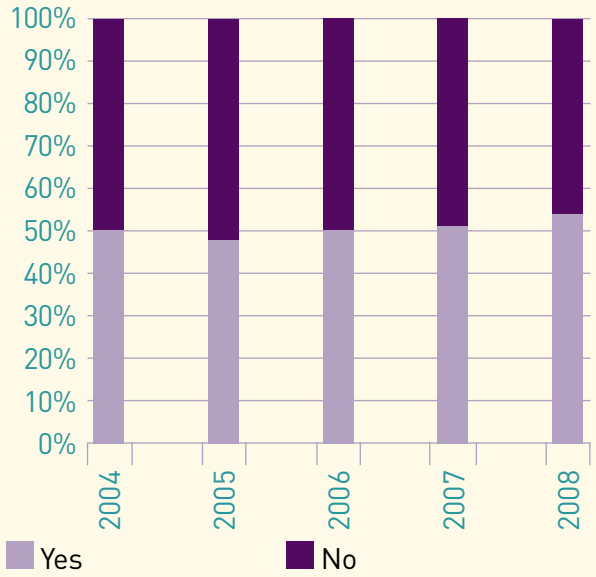
In our surveys of the experiences of people using mental health services, service users tell us that some aspects of these services are more difficult to access than they would like. In particular, access to counselling (such as talking therapy) is not as good as it could be. In 2008, 62% of those who responded to our survey told us that they had not had any counselling sessions from NHS mental health services during the previous year. Out of these, around a third said that they would like to have had such sessions. Access to crisis care is improving, but from a fairly low base. In 2008, 55% of users of services told us that they had been given the number of someone to contact out of office hours (see figure 24). But of the 37% that had used it, less than half reported that they had "definitely" received the help they needed.

While access to psychological therapies in primary care has historically been poor, the national roll-out of the programme for

28%

Proportion of patients who said that they were offered a choice of hospital for their first appointment with a specialist

FIGURE 24: Proportion of users of mental health services who said they had a phone number they could call out of hours, 2004-2008



Source: Healthcare Commission surveys of users of community mental health services

improving access to psychological therapies for anxiety and depression has given a fresh impetus to this, and the development of good measures to assess progress is underway.

It is important that the lessons from this are applied to improving access to a wider range of psychological therapies across both primary and secondary care. In our work in secondary care, we have found little improvement in access to therapies for people with schizophrenia, and reduced provision of psychosocial family interventions.

Access – hidden issues

In previous reports, we have highlighted the issue of 'hidden' waits, that is, waiting times for services where information is not routinely collected. These tend to be in areas either not included or only partially included in the measurement of the Government's 18-week target, which is designed to improve access to hospital treatment. Examples include waiting times for psychological therapies (as discussed above), physical therapies (for example, physiotherapy), and audiology.

Having choices, and being informed and involved

Choice in the NHS in England

'Patient choice' is a major plank of the programme of system reform in the NHS in England. The Government sees it as key to the delivery of services that are patient-centred, while also giving providers an incentive to improve their services and, particularly, benefiting people in the poorer sections of society.

In the summer of 2008, with the Audit Commission, we published the national report *Is the treatment working?*.[226] We looked at the introduction of choice into the NHS in England. We found that:

- Choice was not offered everywhere, and the infrastructure was still not fully in place to support patient choice that was genuinely based on the quality of care provided.
- The potential for patients going elsewhere for treatment, rather than patients actually doing so, appeared to be driving a positive change in attitude among providers.

Our annual health check of the NHS in England includes national targets on offering choices to patients. Acute trusts have to ensure that up-to-date information about their services are available on the NHS Choices website and that appointments are available for patients to book onto. Fifty-eight per cent of acute trusts achieved the target in 2007/08. PCTs are assessed on the number of people booked into a first outpatient appointment (as a proportion of all people referred) and on whether patients are offered a choice of hospital. In 2007/08, just 27% of trusts achieved the target.

Our survey of acute inpatients also shows that choice has yet to become the norm for the majority of patients. Only 28% of those admitted on a planned or elective basis said that, when they were referred by their GP, they were offered a choice of hospital for their first appointment with a specialist. Twenty-seven per cent said they were given a choice of admission dates, a figure that is unchanged across the last three surveys.

The introduction of choice has been relatively recent and so it will take time before a clear assessment of its impact can be made. What is obvious at this stage is that implementation has been slow, and that there is still too little information available to patients with which they can make meaningful choices about their care.

Getting information about your care and treatment

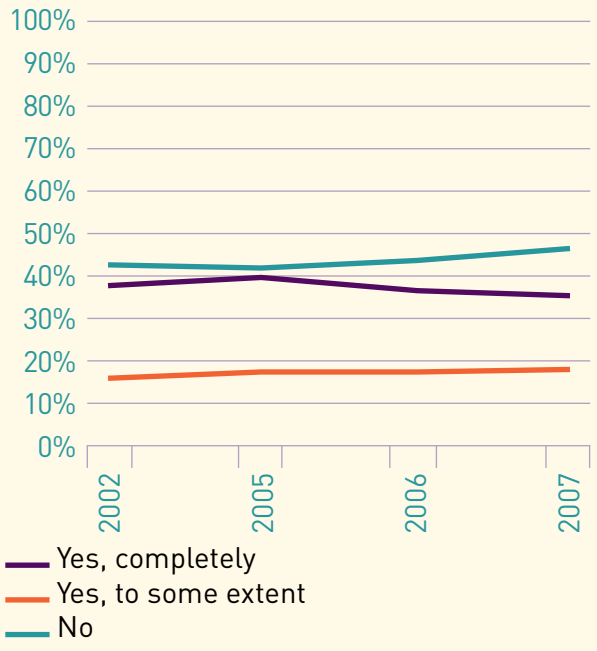
One of the core standards for NHS trusts in England says that trusts must make available to patients and users information about their care and treatment and what to expect during and after their treatment. In 2007/08, 98% of acute trusts, 91% of ambulance trusts, 92% of mental health trusts and 97% of PCTs complied with this standard.[227]

We also looked at this issue in our surveys of adult inpatients in acute hospitals, users of community mental health services and users of local health services such as general practice. The kind of information people need differs according to the type of care they are getting, so the answers across the three surveys cannot be directly compared.[228]

In acute settings, more than 80% of inpatients who had an operation or other procedure told us that they were "completely" informed about the risks and benefits, and 65% said they were "completely" informed afterwards about how the operation had gone. Just under three-quarters of inpatients who had been admitted in an emergency said that they were given the "right amount" of information about their condition or treatment while in A&E.

In mental health trusts, where many users of services require care or treatment over a relatively long period, it is particularly important that people have information about their care. Fifty-nine per cent of those people surveyed said that they had been given, or offered, a written copy of their care plan. This is a rise of 10 percentage points since 2004. Seventy-four per cent of those on the enhanced level of the care programme approach said that they had been given, or offered, a written copy of their care plan. This falls far short of the national requirement that all receiving this level of support should have a copy.

FIGURE 25: Proportion of inpatients who said they were told about the side-effects of medication, 2002 and 2005-2007



Source: Healthcare Commission surveys of patients in NHS hospitals

In local health services, just under three-quarters of people said that if they had questions to ask their GP or family doctor, they definitely got answers they could understand, and just 3% said that either they didn't get answers or they had no opportunity to ask. Seventy-seven per cent of patients told us that their doctor explained the reasons for any treatment in a way they could understand completely.

Our surveys continue to highlight some problems for patients in getting information about the side-effects of medication. In acute inpatient settings, just under half of people said that they were not told about possible side-effects when taking new medicines home (see figure 25). Of those prescribed new medicine at their GP practice or local health centre, 41% said they were given no information or not enough. In both settings, the picture has worsened slightly over the period covered by our surveys. There has been some improvement in mental health services, but just 40% report that they definitely were told about possible side-effects.

In the independent sector in England, the core national minimum standards require that "patients receive clear and accurate information about their treatment and its likely costs". In 2007/08, of the providers we inspected against this standard, we assessed 13% to be "not met" (amounting to 1% of all providers).[229]

Being involved in decisions about your care

It is increasingly important that patients and users of services are actively involved in decisions about their care and treatment. A more informed and less passive relationship with the professionals providing their care can give people a greater sense of control.

In our survey of acute inpatients, we found that just over half of those surveyed felt that they were definitely involved as much as they wanted to be in decisions about their care and treatment. A further 38% said that they were involved to some extent. These figures have shown no real change since the question was first asked in 2005. In our 2007 survey, we asked about the involvement of patients in decisions about their discharge from hospital. Fifty-three per cent said they definitely felt involved; 14% said they did not feel involved.

Our survey of users of community mental health services suggests that around a quarter of people are not involved in deciding what is in their care plan – this proportion has not changed significantly in the four surveys conducted to date. However, the proportion saying that that have no say in decisions about their medication has gone down from 20% to 17%. On a broader question of involvement, 86% of people said that they had a say in decisions about their care and treatment, with half of these saying it was definitely enough of a say.

In local health services, 95% of people told us that they had at least some involvement in decisions about their care and treatment. Eighty-nine per cent reported that they were involved in decisions about their medication.

Engagement of patients and the public in healthcare

If healthcare organisations are to be successful in delivering services that are truly centred on patients, it is critical that they work with the people they serve.

Our annual health check includes a requirement that "the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services". In 2007/08, 99% of NHS trusts assessed themselves as compliant with this standard.

While this high figure is welcome, the standard does not necessarily cover everything that a healthcare organisation can do to ensure that they have high quality and effective engagement with patients and the public. We have very little data routinely available to us with which to judge how well the NHS engages with the public.

In 2008, we launched a national study focusing on how patients and the public are engaged in commissioning, planning, delivering and improving health services. The results of this work will be published in 2009, and we aim to:

- Explore the range of approaches and methods that different types of healthcare organisations use to engage patients and the public.
- Explore the impact that engaging patients and the public has had on healthcare organisations, their service users and the services they provide.
- Comment on how effective patients and the public find these attempts to engage them.
- Identify what helps and hinders organisations to engage effectively with patients and the public.

We are paying particular attention to how organisations engage with vulnerable and marginalised groups, and how healthcare organisations are working with the new local involvement networks that replaced patient and public involvement forums in April 2008.

From November 2008, a strengthened duty has been placed on NHS organisations to involve patients, the public and their representatives in the planning and development of services, and to consult them on changes to the operation of services.

To ensure that the NHS tells people what action they have taken in response to feedback, a new duty has been introduced for PCTs to report on how people's views have shaped their commissioning decisions. This will come into force in 2009.

In the independent sector, providers must ensure that "patients' views are obtained" and that these are used to "inform the provision and treatment of care, and prospective patients". In 2007/08, of the 182 providers we inspected against this standard, we found just under 14% to be non-compliant. (amounting to 1.2% of all providers).

Complaints

Complaints made by patients or their representatives can be a valuable source of information for healthcare organisations, helping them to understand what they can do to improve their services. The ability of organisations to respond constructively to complaints, and to learn lessons from them, is a key test of a patient-centred NHS.

For the NHS in England, there are three stages a complainant can go through. Firstly, people should complain to the local organisation responsible. If this does not resolve their complaint, they can ask for an independent review. Should this still not resolve the complaint, the final stage is to go to the Parliamentary and Health Service Ombudsman.

The Healthcare Commission reviews complaints at the second stage. Around 140,000 complaints are made about the NHS in England each year. Between August 2006 and July 2007, 7,500 complaints were referred to us for review.

In our most recent report on our work, we found that the NHS was getting better at handling complaints. However, in over a quarter of the cases we reviewed, more could have been done locally. We also saw that standards of handling complaints can vary significantly between providers.

While there has been progress, the NHS needs to do more to learn from the complaints it receives. Many of the complaints we review deal with the basics of healthcare – communication between staff, the attitude

of staff, standards of care and safety, and fundamental aspects of nursing care such as nutrition, and privacy and dignity.[230]

In 2008, the National Audit Office (NAO) published *Feeding back? Learning from complaints handling in health and social care*. It found problems with access to, and confidence in, the NHS complaints system.

Just 5% of people who are dissatisfied about the NHS go on to make a formal complaint. The main reason for such a low figure was that people felt nothing would be done as a result. The NAO also concluded that the complaints system is not straightforward, and that few people were aware of, or received, support from the national advocacy service. In line with our own findings, the NAO noted a lack of systematic learning from complaints to improve services.[231]

From April 2009, a new, more streamlined process for resolving NHS complaints will be in place, with greater emphasis on local resolution and a single independent review stage to be operated by the Ombudsman.

In Wales, work is underway, as part of the 'putting things right' project, on a number of reforms to the way in which the NHS in Wales will be expected to investigate and remedy things that go wrong. The arrangements will cover issues identified from patient safety incidents, complaints and claims for clinical negligence.[232]

Respect for dignity, equality and human rights

Why dignity matters

Dignity matters, because it is what patients and users of services want. It is critical that providers of healthcare make sure that patients and users of their services maintain their dignity and privacy, and are treated with respect. 'Dignity' can be a difficult term to define – it is perhaps easier to identify those situations where dignity is compromised. Our work on complaints in the NHS in England has highlighted some typical examples:

- Being addressed in an inappropriate manner or being spoken about as if they were not there.
- Not being given proper information.
- Not seeking patients' consent or considering their wishes.
- Being left in soiled clothes or being exposed in an embarrassing manner.
- Not being given appropriate food or help with eating or drinking.
- Being placed in mixed sex accommodation.
- Being left in pain.
- A noisy environment at night causing a lack of sleep.
- Wards and toilets that are unclean and smelly.
- A lack of protection of personal property, including hearing or visual aids.
- Being subjected to abuse and violent behaviour.

Any loss of dignity can cause significant distress, and diminish the confidence that people have in their healthcare services. Organisations that have respect for dignity and privacy have taken an important step towards putting patients and users of services at the heart of their work.

In our most substantial work to date looking at dignity in care, we focused on the needs of older people in acute hospitals – as a group, the biggest users of hospital services. In the autumn of 2007, we published our national report *Caring for dignity*. Encouragingly, we found that dignity, nutrition and privacy were moving up the agenda for providers. While we found no major breaches of national standards relating to dignity, we found that NHS trusts

needed to do more to make respect for dignity an integral part of they way they deliver care.[233]

What people tell us about dignity and respect

In our 2007 survey of hospital inpatients, 78% said that they were "always" treated with respect and dignity, 19% said this happened "sometimes" and 3% said they were not treated with respect and dignity.

We have found some, albeit small, improvements in the proportion of inpatients who said that they shared a sleeping area (such as a room or bay) with someone of the opposite sex. Around one in 10 of those who had a planned admission said they shared accommodation on first being admitted, or after being moved to another ward. This was more common among patients admitted in an emergency, with 29% sharing when first admitted, and 15% after being moved. Thirty per cent of people said that they had used a bathroom or shower area that was also used by patients of the opposite sex. (Under Department of Health guidelines, bathrooms should be single sex, unless they contain specialised bathing equipment.) This experience varied between organisations, ranging from 1% to 45% of respondents.

Our surveys have repeatedly shown that a substantial proportion of people who need assistance with eating do not get enough help from staff to eat their meals. In 2007, one in five of those who needed help to eat said that they did not get it. This proportion has increased since 2002, when it was 18%. Again, wide variations between trusts demonstrate that it is possible to do better, with a range of 3% to 42%.

In each of our five annual surveys of users of community mental health services, we have asked whether people are treated with respect and dignity by psychiatrists, community psychiatric nurses and other professionals. For each group of staff, there has either been a small, but significant, increase in the proportion of patients definitely feeling that they were treated with respect and dignity or a consistently high proportion. In each instance, the figures are now in excess of 80%. This is positive news.

In local health services in 2008, 93% of patients who saw a doctor said that they were treated with respect and dignity "all of the time".

Meeting standards for dignity in care

Our 2007/08 annual health check found high levels of compliance in the NHS in England against the three standards relating to dignity in care. These require trusts to have systems in place to ensure that:

- People are treated with dignity and respect.
- Their dietary needs are met (including any assistance needed with eating).
- People are treated in environments that support privacy and confidentiality.

In each instance, the percentage of trusts assessing themselves as complying was at least 95%.

The standards look at the issue at a different level from our surveys of patients, and so present a different picture. The standards look at the systems organisations have in place, while the surveys tell us more about the actual

experience of patients. That said, organisations could do more to both explore and address the gap that appears to exist between the systems they have in place and the experience that people have.

Equality and human rights

Healthcare organisations have a responsibility, both as providers of services and as employers, to eliminate unlawful discrimination and to promote equality. As public bodies, NHS trusts have a legal duty to promote equality in relation to race, gender and disability. Reducing health inequalities and personalising services to meet individual needs are at the heart of the Government's agenda for reform. The draft NHS Constitution, proposes seven key principles, to guide the NHS. The first of these states that "the NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, religion or sexual orientation".

In order to gain a better understanding of trusts' progress in promoting race equality in healthcare and to develop recommendations for action for the Government and healthcare organisations, we have carried out a review of race equality in the NHS in England. The review aimed to determine how well NHS organisations are meeting their general and specific duties under race equality legislation and to assess how effectively they are addressing the needs of their patients and staff from black and minority ethnic and newly arrived and transient communities. We will publish our findings in 2009.

In the national standards for the NHS in England, standard C7e requires organisations to challenge discrimination, promote equality and respect human rights. Compliance with this standard has declined over the last three years, falling from 91% in 2005/06, to 86% in 2006/07 and 83% in 2007/08. This places it within the group of six standards with the lowest overall rates of compliance, and within the three standards with the biggest annual deterioration in compliance rates.

The agenda on equality and human rights is one of the major challenges facing everyone who works in healthcare. It will undoubtedly be central to the work of the new independent regulator of health and social care, the Care Quality Commission, and will be at the heart of continuing efforts to put patients, users of services and carers at the heart of care.

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 assessments in England during 2007/08.

TABLE A1: Rates of non-compliance with core national minimum standards, 2007/08

		All providers	Acute hospitals	Mental health	Private doctors	Prescribed techniques (all)	Hospices
C1	Patients receive clear and accurate information about their treatment and its likely costs	0.9%	0.3%	1.1%	0.0%	1.4%	0.0%
C2	The treatment and care provided are patient-centred	0.2%	0.3%	0.6%	0.0%	0.3%	0.0%
C3	Treatments provided to clients are in line with the relevant clinical guidelines	0.1%	0.3%	1.1%	0.0%	0.0%	0.0%
C4	Clients are assured that monitoring of the quality of treatment and care takes place	1.6%	1.9%	3.9%	0.5%	1.7%	0.6%
C5	The dying and death of patients is handled appropriately and sensitively	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
C6	Patients' views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients	1.2%	0.6%	2.2%	0.0%	1.8%	0.0%

TABLE A1: Rates of non-compliance with core national minimum standards, 2007/08

		All providers	Acute hospitals	Mental health	Private doctors	Prescribed techniques (all)	Hospices
C7	Appropriate policies and procedures are in place to help ensure the quality of treatment and services	1.2%	3.2%	1.1%	0.0%	1.0%	1.1%
C8	Clients are assured that a fit person runs the establishment	1.4%	1.3%	2.8%	0.5%	1.7%	0.6%
C9	Clients receive care from appropriately recruited, trained and qualified staff	1.7%	1.3%	7.3%	0.3%	1.5%	1.1%
C10	Clients receive treatment from appropriately recruited, trained and qualified healthcare professionals	0.3%	0.6%	0.6%	0.8%	0.0%	0.0%
C11	Clients are treated by healthcare professionals who comply with their professional code of conduct	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
C12	Patients and healthcare professionals are not infected by blood borne viruses	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
C13	Children receiving treatment are protected effectively from abuse	0.4%	1.0%	1.1%	0.5%	0.2%	0.0%
C14	Patients have access to an effective complaints process	0.5%	0.6%	1.1%	0.8%	0.3%	0.0%
C15	Patients receive appropriate information about how to make a complaint	0.3%	0.0%	0.6%	0.3%	0.5%	0.0%

TABLE A1: Rates of non-compliance with core national minimum standards, 2007/08

		All providers	Acute hospitals	Mental health	Private doctors	Prescribed techniques (all)	Hospices
C16	Personnel are freely able to express concerns about questionable or poor practice	0.2%	0.0%	1.1%	0.0%	0.3%	0.0%
C17	Patients receive treatment in premises that are safe and appropriate for that treatment	1.3%	1.6%	5.6%	0.3%	0.9%	1.1%
C18	Patients receive treatment using equipment and supplies that are safe and in good condition	0.5%	0.6%	0.0%	0.0%	0.8%	0.0%
C19	Patients receive appropriate catering services	0.0%	0.0%	0.0%	0.0%	0.0%	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	1.1%	2.6%	1.1%	0.3%	1.1%	0.0%
C21	The appropriate health and safety measures are in place	0.5%	1.0%	1.7%	0.0%	0.5%	0.0%
C22	Measures are in place to ensure the safe management and secure handling of medicines	0.76%	1.6%	2.8%	0.5%	0.1%	0.6%
C23	Medicines, dressings and medical gases are handled in a safe and secure manner	0.1%	0.3%	0.0%	0.3%	0.1%	0.0%

TABLE A1: Rates of non-compliance with core national minimum standards, 2007/08

		All providers	Acute hospitals	Mental health	Private doctors	Prescribed techniques (all)	Hospices
C24	Controlled drugs are stored, administered and destroyed appropriately	0.3%	1.0%	0.6%	0.3%	0.0%	0.6%
C25	The risk of patients, staff and visitors acquiring a healthcare associated infection is minimised	0.7%	1.0%	1.7%	0.5%	0.6%	0.0%
C26	Patients are not treated with contaminated medical devices	0.2%	1.6%	0.0%	0.0%	0.0%	0.0%
C27	Patients are resuscitated appropriately	0.5%	0.6%	3.9%	0.0%	0.1%	0.6%
C28	Contracts ensure that clients receive goods and services of the appropriate quality	0.4%	0.3%	2.2%	0.3%	0.2%	0.0%
C29	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations	0.4%	0.0%	0.0%	0.3%	0.7%	0.0%

TABLE A1: Rates of non-compliance with core national minimum standards, 2007/08

		All providers	Acute hospitals	Mental health	Private doctors	Prescribed techniques (all)	Hospices
C30	Clients are assured of appropriately completed health records	0.6%	1.0%	2.8%	0.0%	0.3%	0.6%
C31	Clients are assured that all information is managed within the regulatory body to ensure confidentiality	0.2%	0.0%	0.0%	0.3%	0.4%	0.0%
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	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%

TABLE A2: Standards inspected as "not met", as proportion of inspections carried out, 2006/07-2007/08

	Overall		Acute hospitals		Mental health		Hospices		Private doctors		Prescribed techniques (all)	
	07/08	06/07	07/08	06/07	07/08	06/07	07/08	06/07	07/08	06/07	07/08	06/07
C1	12.9%	6.3%	4.8%	3.5%	6.9%	7.5%	0.0%	2.3%	0.0%	4.3%	20.3%	8.1%
C2	4.1%	4.3%	3.7%	7.6%	3.2%	10.9%	0.0%	0.0%	0.0%	0.8%	5.9%	3.2%
C3	3.8%	4.4%	5.9%	3.1%	6.5%	14.3%	0.0%	0.0%	0.0%	0.8%	0.0%	3.7%
C4	15.8%	12.8%	14.0%	7.0%	10.0%	16.3%	12.5%	8.3%	14.3%	13.0%	22.8%	13.5%
C5	0.0%	2.9%	0.0%	0.0%	0.0%	5.0%	0.0%	0.0%		0.0%		14.3%
C6	13.7%	9.8%	7.4%	4.7%	8.0%	11.5%	0.0%	4.1%	0.0%	8.4%	21.8%	11.9%
C7	16.2%	9.1%	33.3%	11.1%	4.7%	17.1%	22.2%	3.3%	0.0%	5.2%	17.7%	7.9%
C8	27.3%	6.4%	26.7%	6.8%	38.5%	8.9%	25.0%	3.6%	22.2%	3.3%	26.1%	7.5%
C9	17.4%	12.1%	9.8%	8.8%	16.7%	17.6%	18.2%	10.1%	7.1%	6.5%	25.8%	13.3%
C10	9.5%	13.5%	6.1%	12.1%	5.9%	21.4%	25.0%	20.7%	42.9%	6.1%	0.0%	15.7%
C11	3.2%	5.2%	0.0%	2.0%	0.0%	14.3%	0.0%	0.0%	0.0%	1.0%	11.1%	8.6%
C12	2.6%	7.2%	0.0%	0.0%	7.1%	25.0%		4.8%	0.0%	0.0%	0.0%	6.7%
C13	10.5%	9.0%	15.8%	11.1%	10.0%	8.0%	0.0%	6.4%	22.2%	3.8%	5.7%	11.1%
C14	5.9%	3.5%	6.5%	0.8%	3.7%	10.6%	0.0%	2.2%	27.3%	2.2%	4.2%	2.9%
C15	5.7%	3.4%	0.0%	1.0%	2.2%	4.8%	0.0%	0.0%	20.0%	2.4%	9.4%	4.4%
C16	10.6%	3.9%	0.0%	0.0%	15.4%	7.0%	0.0%	0.0%	0.0%	2.9%	15.8%	5.1%
C17	14.3%	6.6%	14.3%	7.5%	13.0%	17.8%	25.0%	11.5%	8.3%	0.7%	15.6%	2.9%
C18	9.6%	4.2%	11.1%	3.1%	0.0%	8.3%	0.0%	2.9%	0.0%	1.7%	12.7%	4.8%
C19	0.0%	2.9%	0.0%	2.3%	0.0%	5.0%	0.0%	0.0%		0.0%	0.0%	3.6%
C20	11.6%	8.7%	17.8%	9.6%	3.2%	12.1%	0.0%	11.1%	7.7%	6.0%	17.9%	7.7%
C21	8.9%	5.7%	11.1%	6.4%	9.4%	9.5%	0.0%	2.2%	0.0%	3.1%	10.0%	5.9%

TABLE A2: Standards inspected as "not met", as proportion of inspections carried out, 2006/07-2007/08

	Overall		Acute hospitals		Mental health		Hospices		Private doctors		Prescribed techniques (all)	
	07/08	06/07	07/08	06/07	07/08	06/07	07/08	06/07	07/08	06/07	07/08	06/07
C22	13.0%	7.0%	16.7%	5.2%	11.4%	10.6%	14.3%	7.5%	15.4%	7.3%	7.1%	1.7%
C23	2.9%	6.6%	3.7%	4.1%	0.0%	9.8%	0.0%	6.8%	8.3%	5.8%	7.1%	8.5%
C24	7.3%	8.1%	8.6%	6.2%	3.2%	8.4%	14.3%	7.1%	16.7%	8.5%	0.0%	17.6%
C25	10.7%	8.1%	8.6%	10.0%	9.7%	12.7%	0.0%	8.9%	28.6%	2.8%	12.0%	7.0%
C26	10.6%	6.1%	21.7%	11.2%	0.0%	0.0%	0.0%	0.0%	0.0%	2.3%	0.0%	6.0%
C27	10.2%	11.8%	11.8%	4.6%	13.0%	24.5%	14.3%	6.1%	0.0%	8.2%	4.5%	10.3%
C28	12.3%	5.4%	8.3%	8.2%	23.5%	17.8%	0.0%	0.0%	20.0%	0.0%	7.4%	4.8%
C29	9.3%	6.6%	0.0%	9.4%	0.0%	7.4%	0.0%	2.9%	11.1%	3.8%	15.2%	7.2%
C30	7.9%	7.0%	10.7%	11.5%	10.6%	11.0%	25.0%	2.6%	0.0%	3.1%	4.8%	6.2%
C31	12.5%	5.1%	0.0%	0.0%	0.0%	11.4%		0.0%	20.0%	1.7%	19.0%	6.9%
C32	5.3%	6.6%	0.0%	5.4%	0.0%	7.1%		3.8%	0.0%	5.9%	10.0%	8.1%

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Concordat gateway number: 156

ISBN: 978-0-10-295836-2

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