



A Quality Chartbook

Patient and Public Experience in the NHS

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Foreword

Shortly after coming to power in 1997, the Blair government outlined a ten-year quality agenda for health, promising to put quality at the heart of the NHS. During the development and implementation of that agenda, we have monitored and reported on the quality of healthcare in England.

Unlike much of our previous work, which examined quality of care very broadly, this chartbook focuses on a particular facet of quality: patient and public experience. It concentrates on the responsiveness of the NHS to the needs and desires of the patient and public, and assesses the degree to which ‘patient centredness’ – an explicit policy goal – has been attained. Numerous government policies have sought to elevate the importance of the patient experience through a wide range of reforms: improving access, offering choice, improving amenities, etc. The heightened emphasis on the needs and expectations of individual patients has resonated across a broad spectrum of issues, including personal choice of providers, technological advances (such as a patient accessible medical record) and greater emphasis on patient views and feedback within regulatory and performance management frameworks.

The government sought to establish a ‘patient-led’ NHS, but what exactly does this mean? General surveys indicate that the NHS provides a service that is valued by patients: results consistently show that about three-quarters of patients rate the care they have received as excellent or very good. Such overall evaluations give a valuable picture of quality, but are often too general to be useful either in delineating where quality of care is deficient, or in shaping future policy and direction. Fortunately, there is a considerable amount of data available to help better understand and

respond to specific patient and public priorities for the NHS. A distillation of data from multiple sources shows that patients and the public prioritise:

- information and involvement in decision-making about care
- being treated as an individual
- choice where it makes a difference
- predictable and convenient access
- equitable treatment and health outcomes
- being safe and protected from harm in healthcare settings.

Using a wide variety of sources, this chartbook presents data relevant to each of these priority areas. So what does this information show? As ever, the available quality data provides a mixed picture. Relative successes include the following:

- improved access to care for inpatients, outpatients and primary care
- the vast majority of patients feeling that they are treated with respect and dignity
- cost concerns not inhibiting patients seeking medical care when needed (an accomplishment compared with other countries)
- systems being in place to deal with adverse events.

The following areas of improvement are needed:

- more predictable access to timely and technologically advanced clinical interventions
- better engagement of patients in decision-making and self-care
- decreased variation in healthcare outcomes such as life expectancy and infant mortality
- increased patient safety, in particular prevention of hospital-acquired infections.

The NHS has conscientiously conducted various polls and surveys to understand the needs and desires of the public and patients. However, there appears to be a mismatch between what the public and patients say are priorities for quality and what the government has chosen as being most important in policy initiatives. In May 2007, the Picker Institute released the findings of a survey that sought to identify which aspects of care hospital patients regard as most important in England (Boyd, 2007). The survey asked patients to score the importance of 82 different aspects of care. The results suggest that a truly 'patient-centred' NHS would place a high priority on communication, patient-professional interactions, and treating patients as individuals. Patients rated many of the key components of the current patient choice agenda – such as choice of hospitals or admission dates – among the least important aspects of care.

Clearly, the government's intention and actions to make the NHS more responsive to patients and the public has been a fundamental and much-needed change. A great deal has been done to reinforce the obvious commitment of the public to the institution of the NHS. However, it appears that there are several areas that are both meaningful to patients and where immediate policy, managerial and professional attention could realistically be focused:

- better provision of information to and communication with patients
- engagement of the patient in shared decision-making about treatment options
- geographic convenience and ease of transport to health services
- improvements in patient safety.

In the past ten years, credit is due to the NHS as it has purposefully developed policies, strategies and initiatives to support, listen to and engage with patients. There are challenges ahead in providing healthcare to an ever-more sophisticated population that has increasing awareness of and expectations for quality, perhaps as a result of political rhetoric, government promises and exposure to the publicly released data on NHS performance. The challenges ahead are significant, but those who strive for improved quality in healthcare have a great asset – the patients and public – to guide future policy and direction.

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Kim Sutherland

Section 1: Introduction

Since the Labour government has been in power, health policy documents have consistently emphasised the primacy of the patient in the reform agenda. From the outset, with the initial health White Paper *The New NHS: Modern, dependable*, (Department of Health, 1997), policy-makers have been unwavering in using the rhetoric of a patient-centred health service:

'the needs of patients will be central to the new system'

(Department of Health, 1997, para 1.4)

'There is a new national alliance behind a reformed, patient-centred NHS. These are the most fundamental and far reaching reforms the NHS has seen since 1948.'

(Department of Health, 2000, p 13)

'The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.'

(Department of Health, 2000, p 4)

'The next stage in the NHS's journey is to ensure that a drive for responsive, convenient and personalised services takes root across the whole of the NHS and for all patients.'

(Department of Health, 2004a, p 8)

Policy context

Shortly after coming to power in 1997, the Blair government outlined a ten-year quality agenda for health (Department of Health, 1998), promising to

put quality at the heart of the NHS. In a review of progress in 2003, at the ten-year agenda's mid-point, we characterised the NHS quality reforms as:

the world's most ambitious, comprehensive, systemic and intentionally funded effort to create predictable and sustainable capacity for improving the quality of a nation's healthcare system.

(Leatherman and Sutherland, 2003, p 1)

Since 1997, we have monitored and reported on the quality of care delivered by the NHS in England (Leatherman and Sutherland, 2003; Leatherman and Sutherland, 2005; www.health.org.uk/qquip). Our work has adopted a broad and inclusive definition of quality, encapsulating six key domains: effectiveness, access, safety, patient responsiveness, equity and capacity.

This chartbook presents a focused perspective on quality in England's NHS, with an emphasis on patient and public expectations, experiences and evaluations. The focus on patient and public views is, in part, a response to the increasing policy priority of developing a patient-led NHS. Various government policies have sought to elevate the importance of the patient experience in the design and implementation of a wide range of reforms: improving access, offering choice, improving amenities, etc. The heightened emphasis on the needs and expectations of individual patients has resonated across a broad spectrum of issues, including personal choice of providers, technological advances (such as a patient accessible medical record) and greater emphasis on patient views and feedback within regulatory and performance management frameworks. Box 1 below provides a summary of significant policy documents that have focused on the development of a patient-centred NHS in recent years.

Box 1: Significant policy reforms and commitments focusing on a patient-centred NHS	
Policy document	Reforms and commitments
<i>Building on the Best: Choice, responsiveness and equity in the NHS</i> (Department of Health, 2003)	<ul style="list-style-type: none"> • Provide patients with a greater say in how they are treated: the NHS will listen to how people want to be treated and will give them the opportunity to record their own information in their records. Everyone will have their own HealthSpace, linked to their electronic health record, allowing individuals to make their preferences known to the clinical team. From 2004, patients will be able to record their own information securely on the internet. • Increase choice of access to a wider range of services in primary care: not only traditional primary care services but also innovative new providers, particularly in deprived areas where primary care has traditionally been weak. It will also mean extending the ways in which people can get advice, and new arrangements to help people access care away from home. • Increase choice of where, when and how to get medicines. • Enable people to book appointments at a time that suits them, from a choice of hospitals. From August 2004, those waiting longer than six months for surgery will be offered faster treatment at an alternative hospital. By December 2005, patients requiring surgery will be offered a choice of four to five providers at the point of referral. • Widen choice of treatment and care, starting with increased choice in maternity services and greater choice over care at the end of life. • Ensure people have the right information, at the right time, with support to use it.
<i>The NHS Improvement Plan: Putting people at the heart of public services</i> (Department of Health, 2004a)	<ul style="list-style-type: none"> • By the end of 2005, patients will have the right to choose from at least four or five providers. • In 2008, patients will have the right to choose from any provider meeting NHS standards within the national maximum price that the NHS will pay. • Each patient will have access to their own personal HealthSpace on the internet to see their care records and note their individual preferences.

Box 1: Significant policy reforms and commitments focusing on a patient-centred NHS (continued)

Policy document	Reforms and commitments
<i>Choose and Book: Patient's choice of hospital and booked appointment – policy framework</i> (Department of Health, 2004b)	<ul style="list-style-type: none"> • By December 2005, all patients who need a referral to hospital (or a suitable alternative provider) for elective care, can expect: <ul style="list-style-type: none"> • to be offered a choice of four to five hospitals or suitable alternative providers • to book the appointment with preferred hospital/suitable alternative provider • information to be available locally to inform their choice • to be supported to make their choice by their GP or primary care professionals and by a range of practice, primary care trust (PCT) and community and voluntary sector-based services. • PCTs to provide targeted packages of support designed to ensure patients (including hard-to-reach patients and communities) can benefit from choice • aftercare and rehabilitation to be provided locally post-hospital. • PCTs will be responsible for ensuring that choices are available and necessary systems are in place to support choice and to enable booked appointments to be made.
<i>Creating a Patient-led NHS: Delivering the NHS Improvement Plan</i> (Department of Health, 2005)	<ul style="list-style-type: none"> • More choice and information to help patients make choices. • Stronger standards and safeguards for patients. • Improvements in the ability of NHS organisations to understand the needs of patients.
<i>Our Health, Our Care, Our Say: A new direction for community services</i> (Department of Health, 2006a)	<ul style="list-style-type: none"> • Offer patients choice of GP surgery. • Incentivise GP practices to offer convenient appointment times. • Introduce a NHS 'Life Check' to help patients assess their lifestyle risks and to make healthier choices. • Introduce an 'information prescription' for people with long-term health and social care needs.

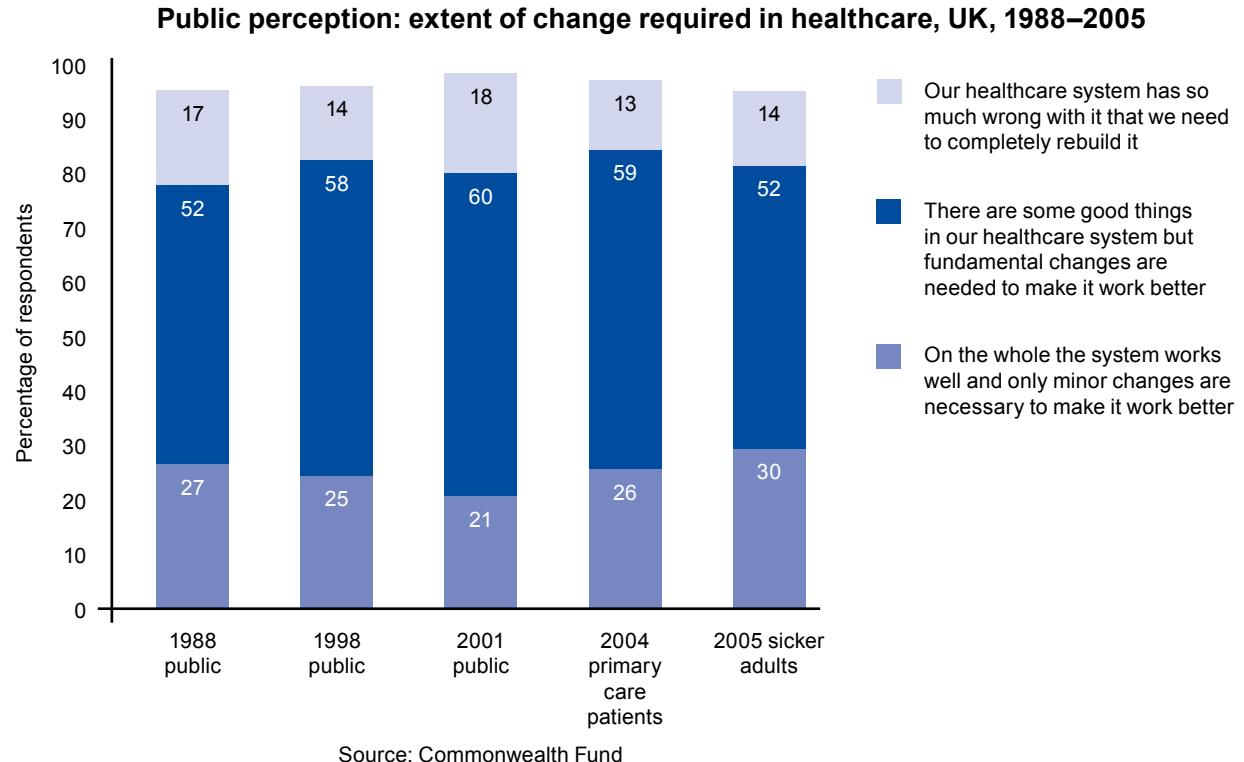
General perceptions

The last decade has seen a significant increase in the use of patient and public surveys as a way of informing managers and policy-makers about the perceived quality of patient care. Taken together, these surveys provide a multifaceted view of how the public views the healthcare system and how individual patients experience it. This section presents data from two main survey instruments: the Commonwealth Fund International surveys and the Healthcare Commission patient surveys.

The metadata for all charts and full source details are available at:
www.health.org.uk/qquip

Extent of change required in healthcare system

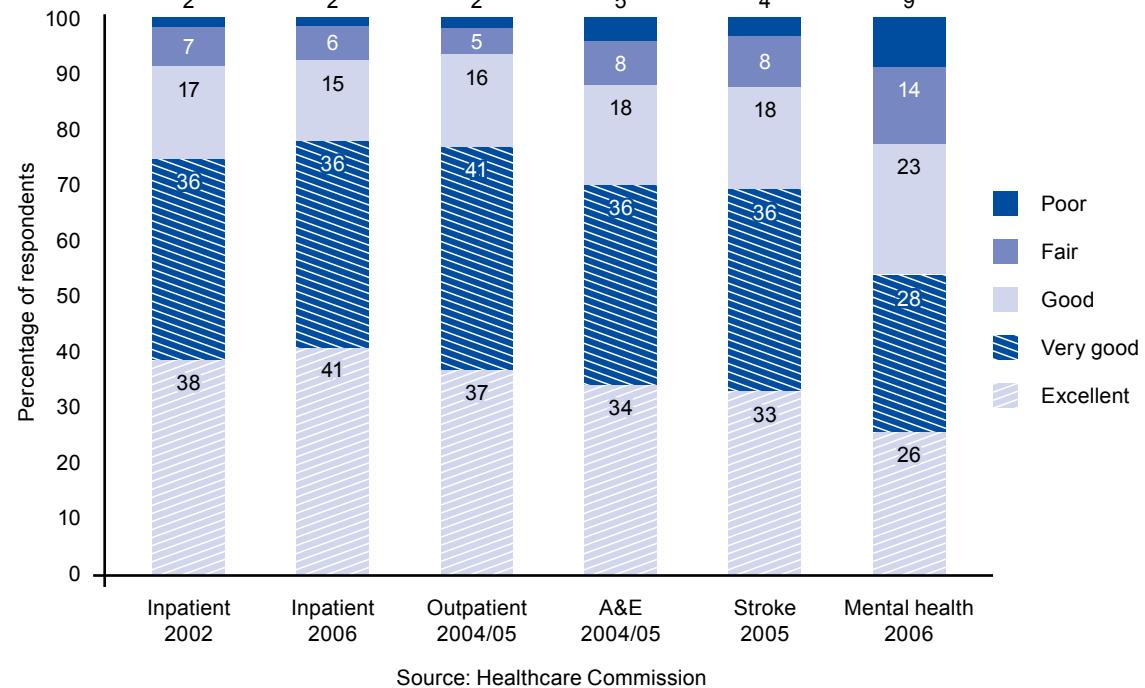
The Commonwealth Fund International Health Policy Survey was first conducted in 1988. Since 1998, it has been carried out annually and focuses on different provider, population and patient groups. The chart illustrates the way in which UK respondents, over time, have answered the question: 'Which of these statements comes closest to expressing your overall view of the healthcare system in this country?' Notably, the response asserting that only minor change was required in the UK achieved its highest score in the 2005 survey, which focused on sicker adults.



Patient ratings of care

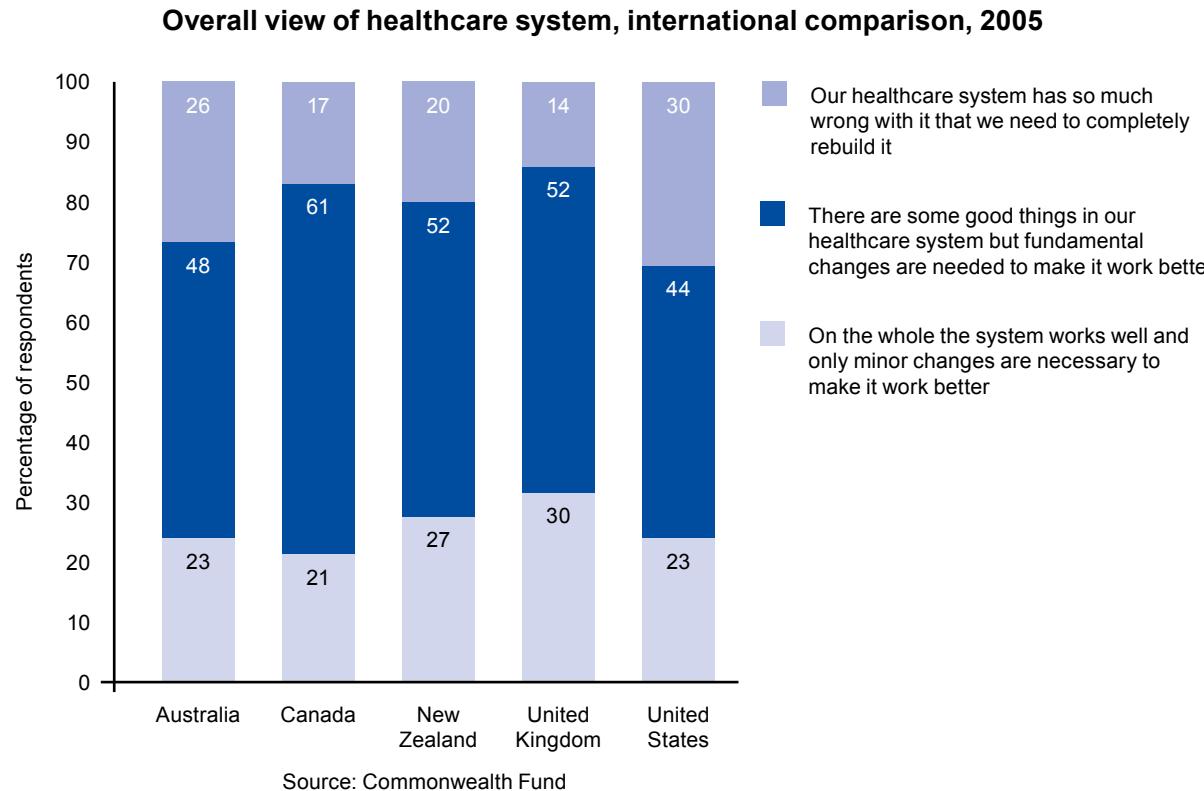
The Healthcare Commission conducts large-scale patient surveys in England across different patient groups in the NHS. The chart illustrates the responses to the question: 'Overall, how would you rate the care you received?' The data was drawn from six separate surveys: adult inpatients in 2002 and 2006 (allowing for comparison over time); outpatients in 2004/05; emergency department patients in 2004/05; stroke patients in 2005; and adult mental health patients in 2006. For inpatients and outpatients, the overall rating was high, with around three-quarters of respondents indicating that care was excellent or very good. Mental health patients were less satisfied with the care they received, with 54 per cent rating it excellent or very good.

Patient ratings of care, England, 2002, 2004, 2005 and 2006



Extent of change required in healthcare systems: international comparison

The 2005 Commonwealth Fund International Health Policy Survey, which focused on sicker adults, asked respondents: 'Which of these statements comes closest to expressing your overall view of the healthcare system in this country?' UK respondents were the most satisfied with their healthcare system. As seen in this chart, 14 per cent of UK respondents indicated that their healthcare system required a complete rebuild; by contrast, more than twice as many (30 per cent) of US respondents indicated this level of dissatisfaction. UK respondents also had the highest proportion of respondents (30 per cent) indicating that only minor change was required.



Public and patient perceptions: from general perceptions to specific issues

In terms of general perceptions, the available survey data indicates that the NHS provides a service that is valued by patients: almost three-quarters of patients rated the care they had received as excellent or very good. While such general assessments of care are of interest and provide a broad picture of quality, they are unable to provide data that is specific enough to inform the direction of healthcare reform or to evaluate the impact of policies and interventions that have been implemented to improve the NHS.

In the following sections, we summarise available evidence on what patients want from healthcare services, and present data to judge the performance of the NHS against those expectations and priorities.

Section 2: What do patients and the public want?

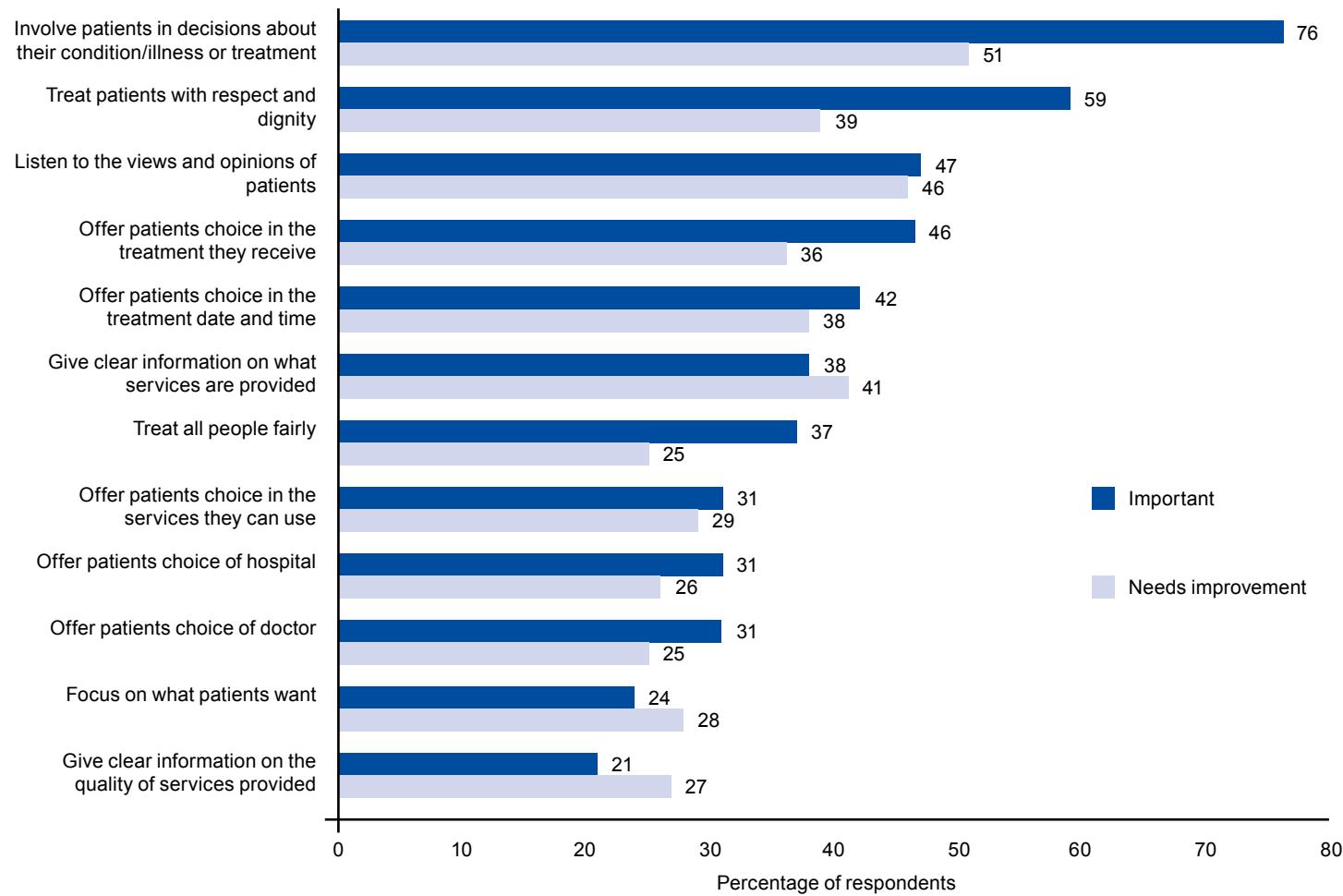
What exactly does it mean to be a ‘patient-centred’ NHS? Who defines what makes a patient-centred service? The UK population has two distinct roles in the NHS: first as a collective of citizens who fund the health service through taxation, and second as individuals who are patients, carers or recipients of services. These different roles may encapsulate differing expectations and perceptions of the healthcare system in general and of particular priority areas or service attributes. The following sections outline key evidence on the public and patients’ views on priorities and critical attributes for the NHS.

The public

Surveys and studies to find out the expectations and priorities of the public for the NHS have become increasingly popular in recent years. We draw on three sources that combine to provide a picture of how the public rates what is important.

The national choice consultation, undertaken by the Department of Health in 2003, reported that 76 per cent of respondents thought the most important aspect of NHS care was involving patients in decisions about their illness and treatment; half of respondents indicated that this element of NHS care needed improvement (see chart on p15).

Important aspects of the NHS and the need for improvement, public survey, England 2003



Source: National Choice Consultation, 2003

In 2005, Coulter reviewed the available evidence on what patients and the public want from the NHS. She concluded that citizens prioritised the following as the most important attributes:

- affordable treatment and care, free at the point of use
- safety and quality
- health protection and disease prevention
- accessible local services and national centres of excellence
- universal coverage; geographical and social equity
- responsiveness, flexibility and choice
- participation in service developments
- transparency, accountability and opportunity to influence policy decisions.

Along a similar vein, a British Medical Association (BMA) survey in 2005 asked members of the public to rate ten options for increased government NHS funding (using a scale of 0 to 10, where 0 was 'wholly unimportant' and 10 was 'very important'. The list of options provided to respondents and how they rated them is shown on the right:

Priority option	Mean score
Cleaner hospitals	9.23/10
Improved Accident & Emergency (A&E)	8.52/10
Shorter waits for outpatient appointments	8.42/10
Research into new treatments	8.35/10
More funds for prevention	8.07/10
Better out of hours care	7.89/10
Expanded family doctor (GP) services	7.83/10
More time with doctor	7.26/10
Better hospital food	6.51/10
Choice of where to have an operation	6.43/10

Source: BMA, 2005

Patients' views

In recent years, many large patient surveys have been undertaken. These surveys provide insights into quality of care, through the eyes of those who use NHS services. The surveys provide both snapshot and longitudinal information about patients' priorities, expectations and preferences.

Inpatient care

In May 2007, the Picker Institute published the results of a survey that sought to identify which aspects of care are regarded as most important to hospital patients in England (Boyd, 2007). The survey asked patients to score the importance of 82 different aspects of care. The ten elements of care rated most important, and the ten rated least important, are shown in Box 2 below. This data is significant, particularly when considered alongside current policy priorities. The results suggest that a truly 'patient-centred' NHS would place a high priority on communication, patient–professional interactions, and treating patients as individuals. However, respondents rated many of the key components of the current patient choice agenda, such as choice of hospitals or admission dates, as among the least important aspects of care.

For a full list of aspects of care ranked by importance that were included in the survey, see the Appendix.

Box 2: Most and least important aspects of care, as ranked by patients in England**The ten most important aspects of care**

1. The doctors know enough about my medical history and treatment.
2. The doctors can answer questions about my condition and treatment in a way that I can understand.
3. I have confidence and trust in the hospital staff who treat me.
4. The doctors wash or clean their hands between touching patients.
5. The nurses know enough about my medical history and treatment.
6. Before my operation or procedure, I get a clear explanation of what will happen.
7. The risks and benefits of my operation or procedure are explained to me in a way that I can understand.
8. The nurses wash or clean their hands between touching patients.
9. The rooms and ward are clean.
10. The doctors and nurses are open with me about my treatment or condition.

The ten least important aspects of care

73. I am told how to make a complaint about the care I receive.
74. I have a choice of admission dates.
75. I receive printed information about the hospital before admission.
76. I have a choice about which hospital I am admitted to.
77. I receive help to eat my meals, at the time I need it.
78. The hospital provides facilities that allow me to practice my religious beliefs.
79. A translator or interpreter is provided by the hospital.
80. I have enough information about different hospitals so I can make a choice.
81. I have access to food when I am hungry (not just at mealtimes).
82. I am not bothered by noise during the day.

Source: Boyd, 2007

Primary care and general practice

A systematic review of the literature (Wensing *et al*, 1998) on patients' priorities for general practice care examined 19 studies published between 1966 and 1995 and found that the most important factor was 'humaneness', which ranked highest in 86 per cent of studies that included this aspect. This was followed by 'competence/accuracy' (64 per cent), 'patients' involvement in decisions' (63 per cent) and 'time for care' (60 per cent).

An international study (Grol *et al*, 1999) found that patients across Europe consistently reported the following aspects of care to be of high importance: enough time for consultation; rapid access to care in emergencies; confidentiality of information; communication; and preventive services. For patients in the UK, out of a list of 38 items, the five priorities for general practice care were the following:

1. A GP should be able to provide a quick service in case of emergencies.
2. During the consultation a GP should have enough time to listen, talk and explain to me.
3. A GP should guarantee the confidentiality of information about all his/her patients.
4. A GP should make me feel free to tell him or her my problems.
5. A GP should tell me all I want to know about my illness.

Williams *et al* (1995) reported similar findings. They conducted a study of 504 patients attending their GP and found that patients most frequently wanted explanation of their problem and support. Baker (1996) found patient satisfaction to be positively associated with a longer consultation and the use of a personal list system.

These results were echoed in a review by Coulter (2005) of the available evidence on patients' priorities in general practice, which concluded that patients want:

- fast access to reliable health advice
- effective treatment delivered by trusted professionals
- participation in decisions and respect for preferences
- clear, comprehensible information and support for self-care
- attention to physical and environmental needs
- emotional support, empathy and respect
- involvement of, and support for, family and carers
- continuity of care and smooth transitions.

Section 3: What is important to patients and the public?

There are a number of themes that emerge from the available evidence on patient and public priorities for the NHS. Several aspects of care are consistently identified as important. We have used these aspects of care as thematic headings to present data on quality in this chartbook. In short, patients want:

- information and involvement in decision-making about care
- to be treated as an individual
- choice where it makes a difference
- predictable and convenient access to healthcare
- equitable treatment and chances for health
- safety from harm.

The following sections present data that relate to these themes. The metadata for all charts and full source details are available at:
www.health.org.uk/qquip

What do patients want? Information, communication and involvement in decision-making about care

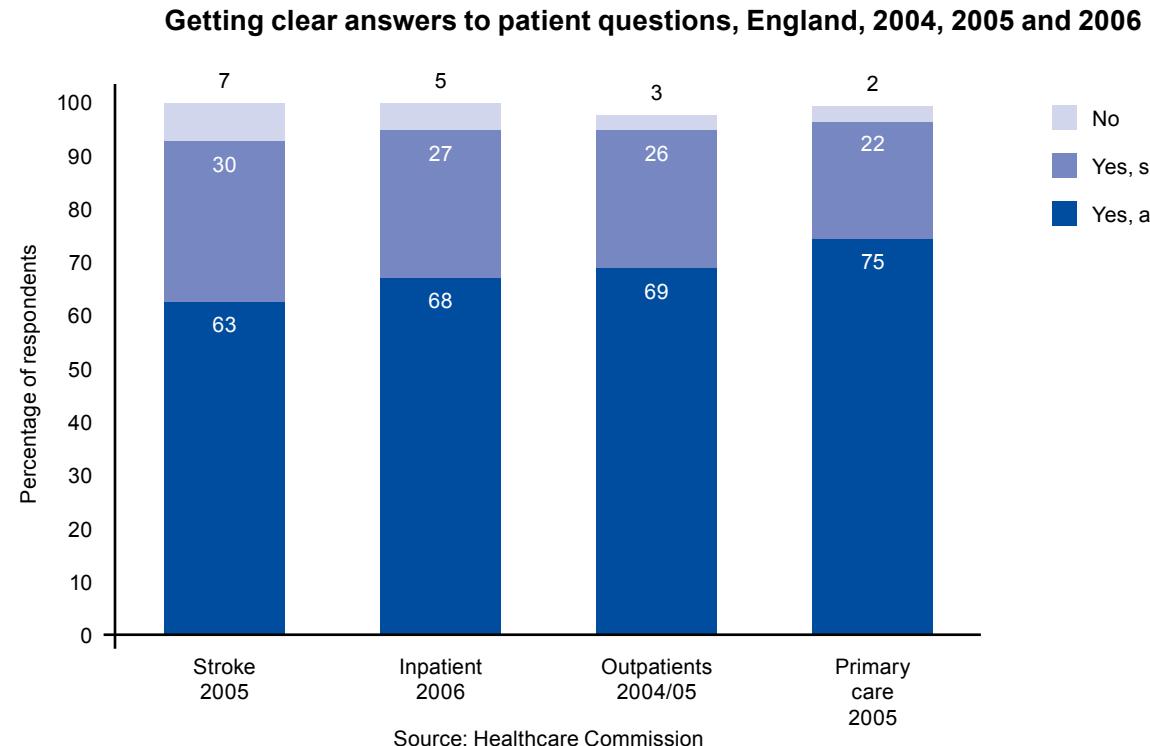
The traditional model of clinical decision-making cast patients as passive recipients of care, and assumed that doctors alone were sufficiently informed and experienced to decide what action to take. This paternalistic approach is not aligned with current patient expectations and priorities. Patients now expect to be given information about their condition and treatment options, and for clinicians to take account of their preferences. Some patients want to be actively engaged in the decision-making process. There is a growing body of evidence to suggest that engaging patients in treatment decisions and in self-managing their healthcare can lead to more appropriate and cost-effective use of health services and better health outcomes (Coulter, 2002; Coulter and Ellins, 2006).

As shown in the chart on page 15, the Department of Health's national choice consultation in 2003 found that 76 per cent of people said the main healthcare priority should be to involve people more in decisions about their illness and treatment.

The following charts in this section draw upon data from a wide range of patient surveys. We present a broad picture of patient experiences across many clinical conditions. We also provide a more focused set of data on diabetes patients to illustrate the detail of information available.

Communication: doctor answered questions/explained action in a way that was understood

The Healthcare Commission conducts large-scale patient surveys across different patient groups in the NHS in England. The chart draws data from four surveys conducted between 2004/05 and 2006 (stroke patients, inpatients, outpatients and primary care patients) and presents responses to the question: 'If you had questions to ask the doctor, did you get answers that you could understand?' The majority of respondents indicated that they always received comprehensible answers to their questions.



Communicating about treatment options: international comparison

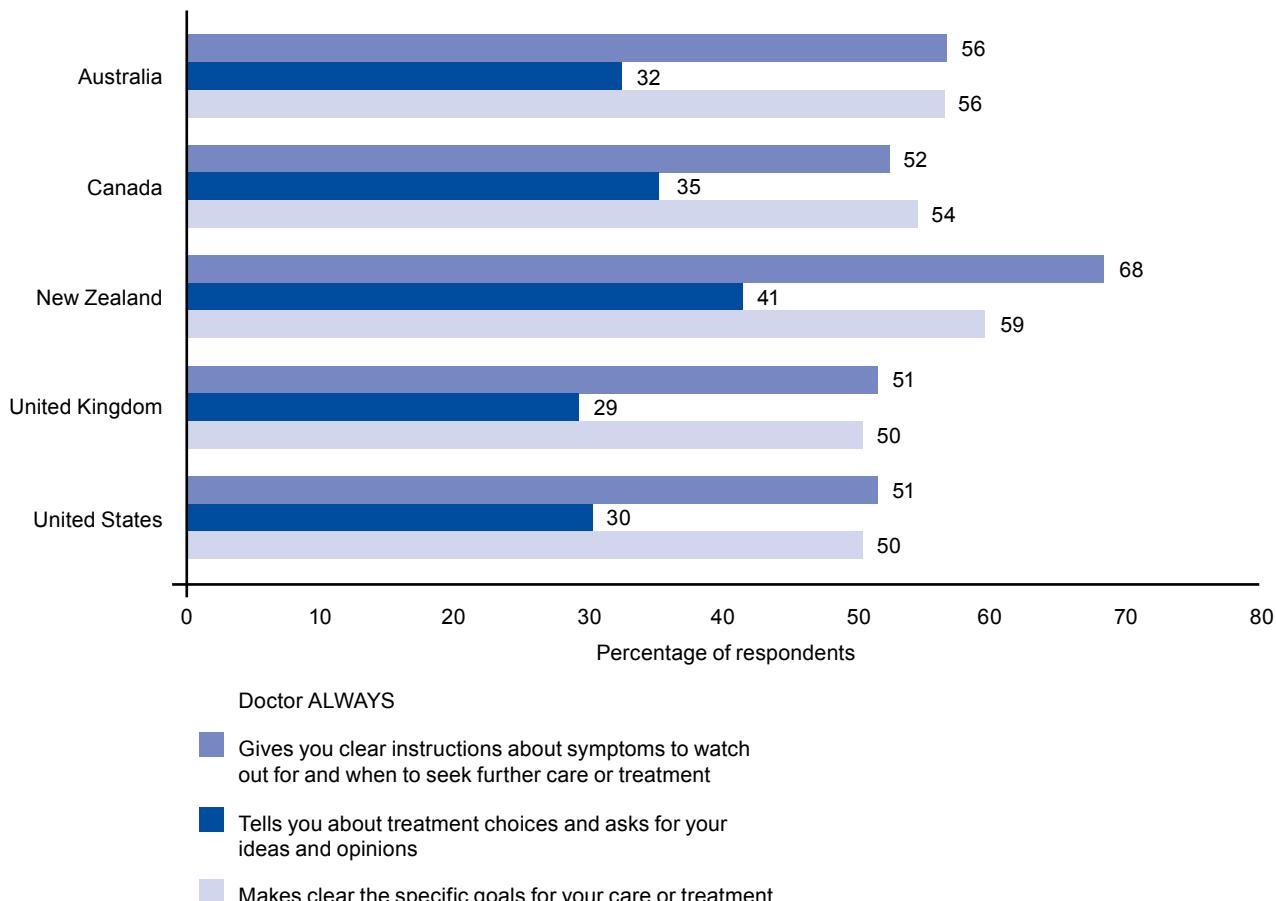
The 2005 Commonwealth Fund International Health Policy Survey focused on sicker adults and asked patients about three communication issues with their regular doctor:

'If you need care or treatment, how often does your regular doctor/GP:

- tell you about treatment choices and ask for your ideas and opinions
- make clear the specific goals for your care or treatment
- give you clear instructions about symptoms to watch for and when to seek further care or treatment?'

Fewer than a third of respondents in Australia, the UK and the US indicated that an active dialogue about treatment choices always takes place. Only about half of respondents in all countries indicated that clear goals for care and instructions for self-monitoring are always communicated (except in New Zealand, where responses suggest better doctor–patient communication).

Patient perceptions of GP communication about treatment options, international comparison, 2005



Source: Commonwealth Fund

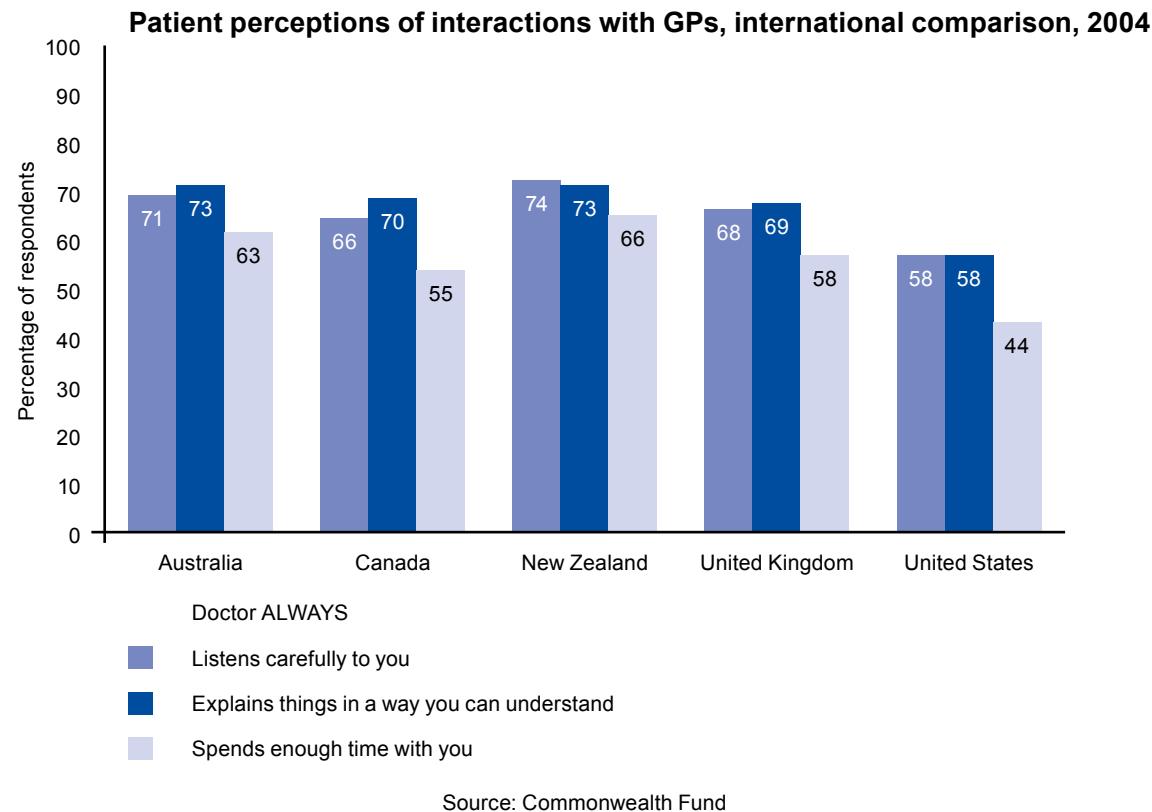
Patient interactions with general practitioners: international comparison

In the 2004 Commonwealth Fund International Health Policy Survey, three questions focused on the quality of interactions between patients and general practitioners (GPs):

'When you visit your doctor, does he or she always:

- listen carefully to you
- explain things in a way you can understand
- spend enough time with you?'

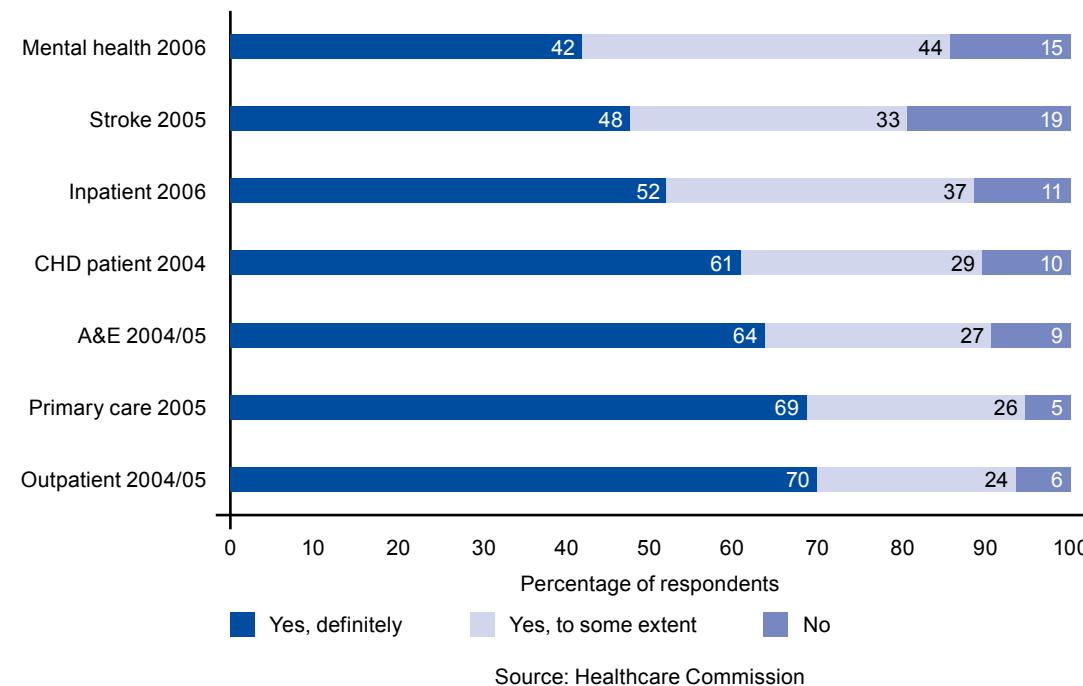
Ratings for the first two questions generally fell between 65–75 per cent; but with the US as an outlier at the lower end of this range. For the third question, ratings were much lower across all the countries surveyed, reflecting patients' concerns that time pressures interfere with doctors always spending enough time with them.



Communication and information: patient involvement in decisions about care and treatment

The Healthcare Commission's largescale surveys in England across different NHS patient groups regularly ask: 'Were you involved as much as you wanted to be in decisions about your care and treatment?' Data in the chart was drawn from seven separate surveys: mental health patients; stroke patients; inpatients; patients with coronary heart disease (CHD); patients attending A&E; primary care patients; and outpatients. Approximately 70 per cent of primary care and outpatient respondents indicated that they were definitely involved as much as they wanted to be in decisions about their care; however, only half of inpatients and 40 per cent of mental health patients indicated that they were fully involved. Stroke patients had high levels of dissatisfaction, with almost one in five respondents indicating they were not as involved in decisions as they would have liked to be.

Patients involved as much as they wanted to be in decisions about care and treatment, England, 2004, 2005 and 2006



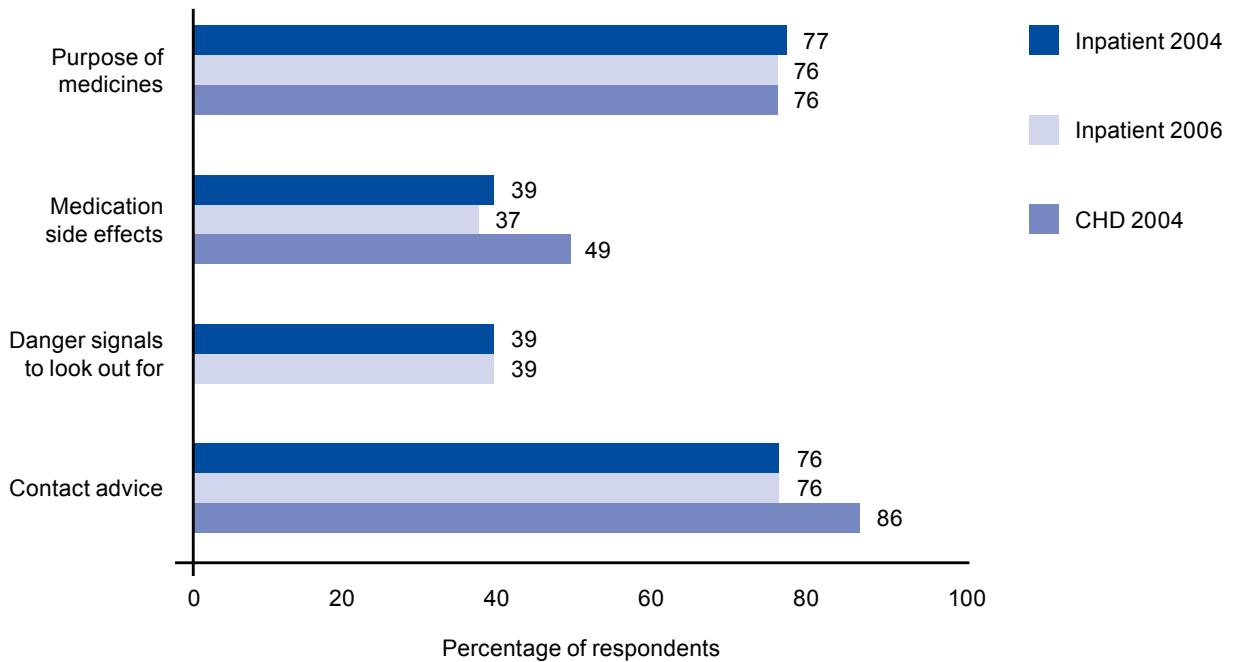
Communication and information: hospital aftercare

Healthcare Commission patient surveys ask respondents to indicate whether staff discussed a number of aftercare issues with them before their discharge from hospital:

- danger signals patients should watch for after they went home
- who to contact if patients were worried about their condition or treatment after discharge
- medication side effects to look out for
- the purpose of medicines they were taking.

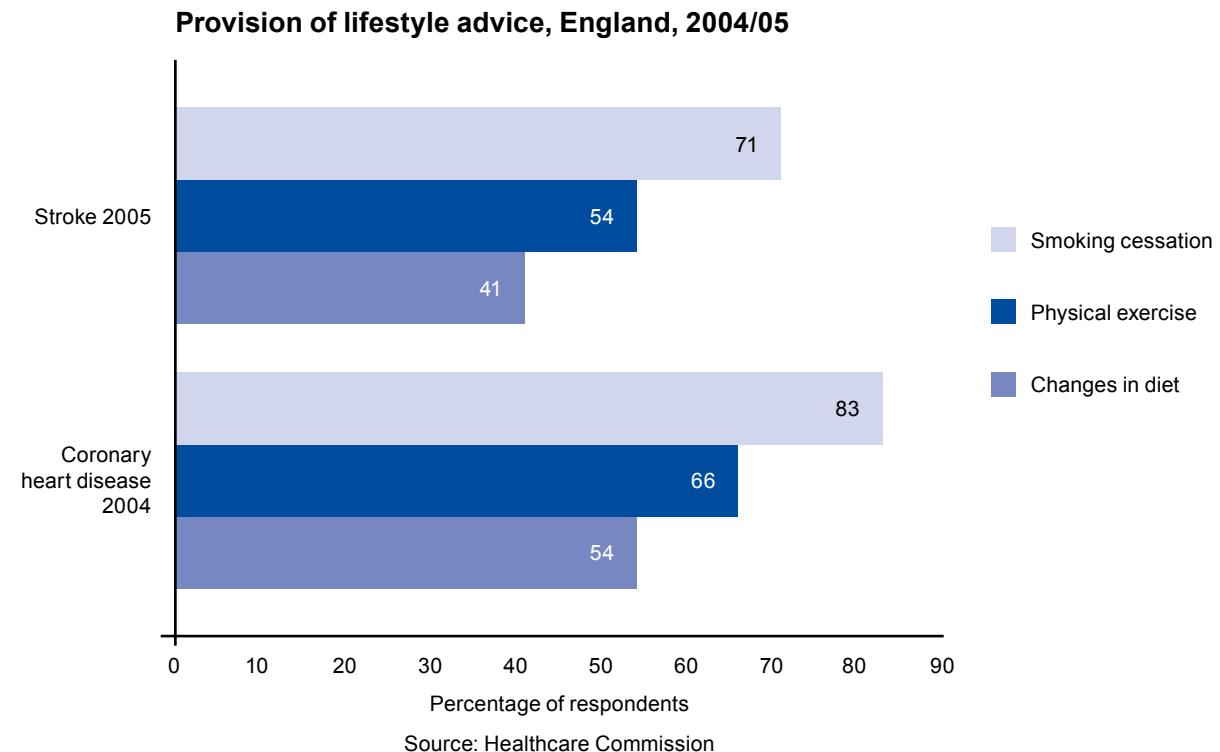
The chart illustrates the proportion of respondents who indicated that these issues were explained completely. Fewer than half of respondents indicated that danger signals and medication side effects were explained to them fully before discharge.

Aftercare: patient perspectives, England, 2004 and 2006



Circulatory disease patients: lifestyle advice on leaving hospital

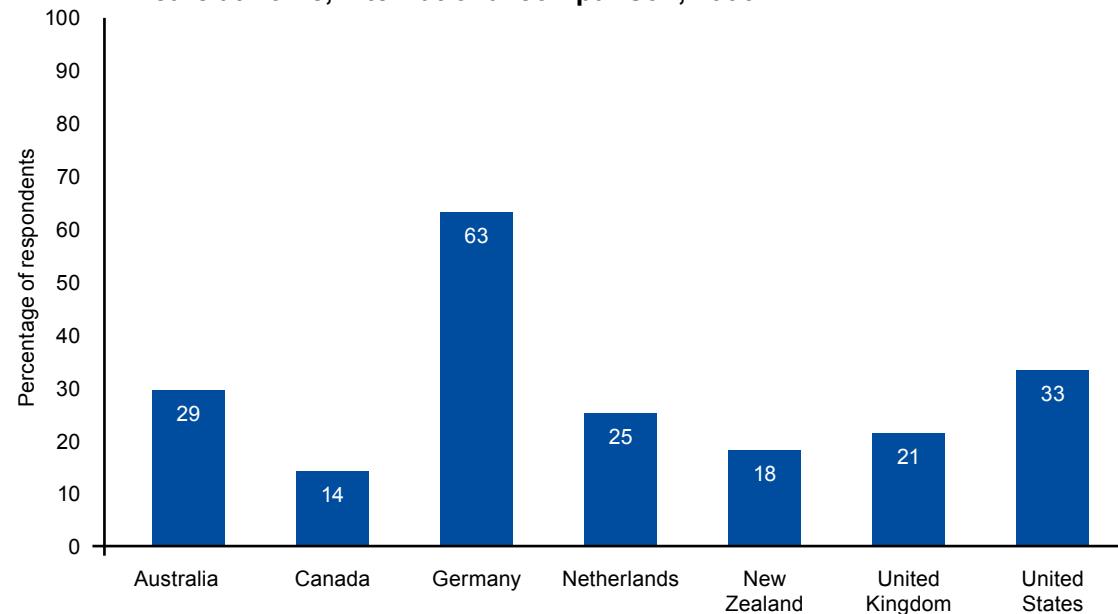
In 2004/05, the Healthcare Commission conducted large-scale surveys of hospitalised stroke and coronary heart disease (CHD) patients. The chart illustrates responses to questions on whether lifestyle advice was given to patients at discharge. In both groups of patients, smoking cessation advice was the most commonly given. At least a third of patients indicated that they were not given advice about physical exercise or changes in diet that might help their condition or prevent another hospitalisation; this proportion rose to over half of stroke patients not receiving dietary advice. In general, lifestyle advice was given to a higher proportion of CHD patients than stroke patients.



Doctor routinely gives chronic care patients a self-management plan: international comparison

The 2006 Commonwealth Fund International Health Policy Survey was conducted across seven countries and asked primary care physicians: 'Do you give your patients with chronic diseases written instructions about how to manage their own care at home (eg instructions on what to do to control symptoms, prevent flare-ups, or monitor their condition at home)?' Improving self-care is a major goal of policy and service development across various national and organisational settings, although a recent review concluded that there are significant limitations in the evidence base on self-care interventions (Coulter and Ellins, 2006). The chart illustrates that the routine provision of written care plans was generally low. With the exception of Germany, a third or fewer of all respondents in each country indicated that they routinely provide a written care plan for their patients with chronic diseases.

Doctor routinely gives patients with chronic diseases plan to manage care at home, international comparison, 2006



Box 3: Diabetes case study

Diabetes mellitus is a disease characterised by the non-production, or improper utilisation, of insulin. Insulin is a hormone, produced by the pancreas, which is needed to convert sugar, starches and other food into energy. Insulin deficiency results in the high blood sugar levels characteristic of diabetes. There are two main forms of diabetes: Type 1 results from the body's failure to produce insulin; and Type 2 diabetes results from insulin resistance (ie, suboptimal use of insulin). Type 2 diabetes is closely linked with obesity.

Estimates suggest that currently there are almost 2.35 million people with diabetes in England, a figure that is predicted to increase to more than 2.5 million by 2010. Around 90 per cent of people with diabetes have Type 2. Incidence and prevalence of diabetes is greater in areas with higher levels of deprivation. Mortality rates from diabetes are higher in people from lower socioeconomic groups. The risk of people from minority ethnic communities developing diabetes is up to six times higher than average.

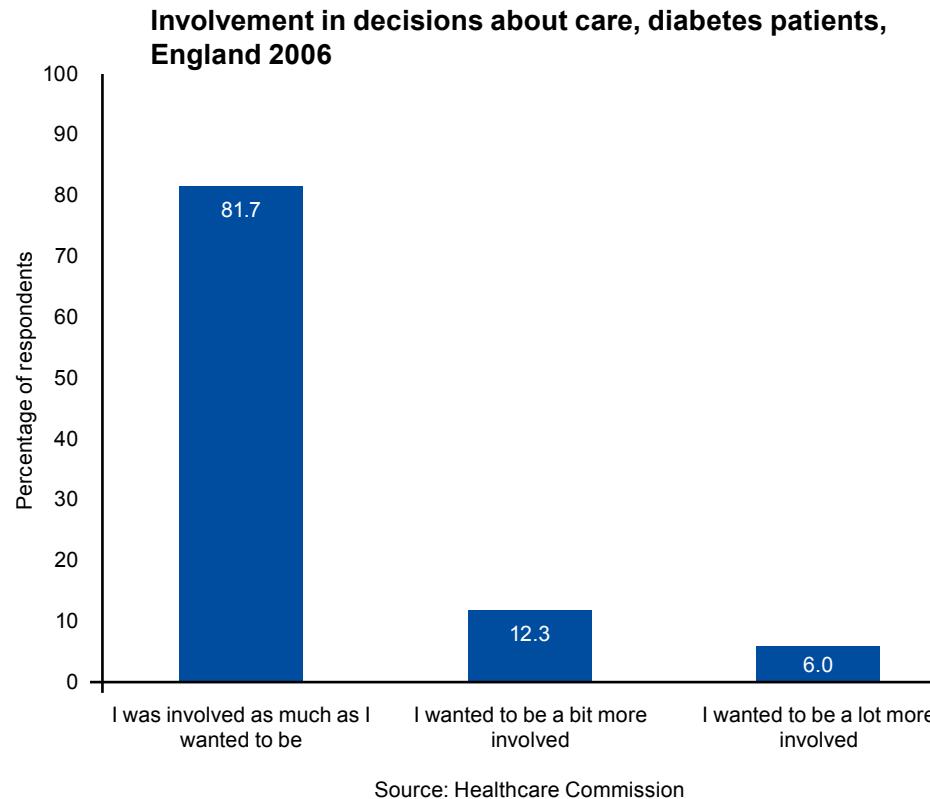
Diabetes is a chronic and progressive disease and can cause serious ill-health, disability and premature mortality. Long-term complications include heart disease, stroke, blindness, kidney disease and limb amputations. Many of the long-term effects of diabetes could be avoided with effective control of blood sugar levels and blood pressure. Life expectancy is reduced by at least 15 years in patients with Type 1 diabetes, and by up to ten years in patients with Type 2 diabetes.

Around 5 per cent of total NHS expenditure (and up to 10 per cent of hospital inpatient spend) is used for the care of people with diabetes.

For more information, see: www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Diabetes/DH_074762

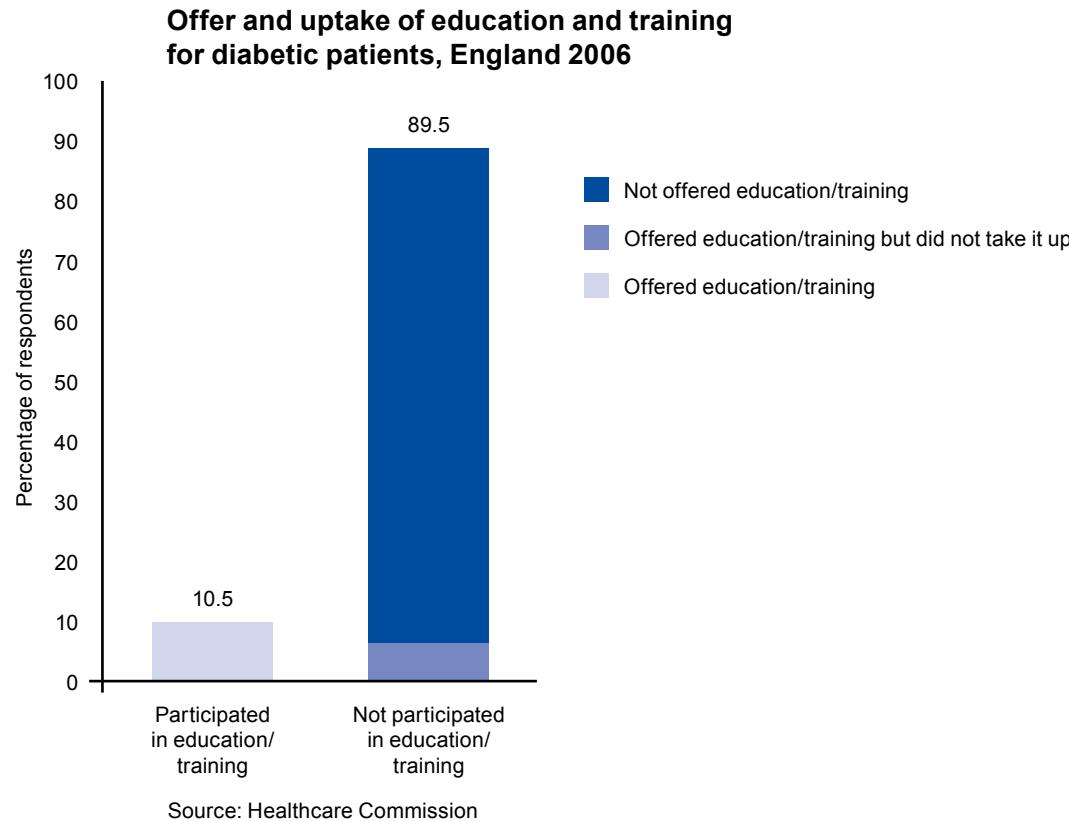
Diabetes patients: involvement in decisions about care

In 2006, the Healthcare Commission undertook a survey of diabetes patients in England and asked respondents: 'Thinking about all of the care you have received from your GP surgery, not just for diabetes, have you been involved as much as you wanted in decisions about your care and treatment?' The chart shows that the majority of diabetes patients indicated that they were involved as much as they wanted to be in decisions about their care.



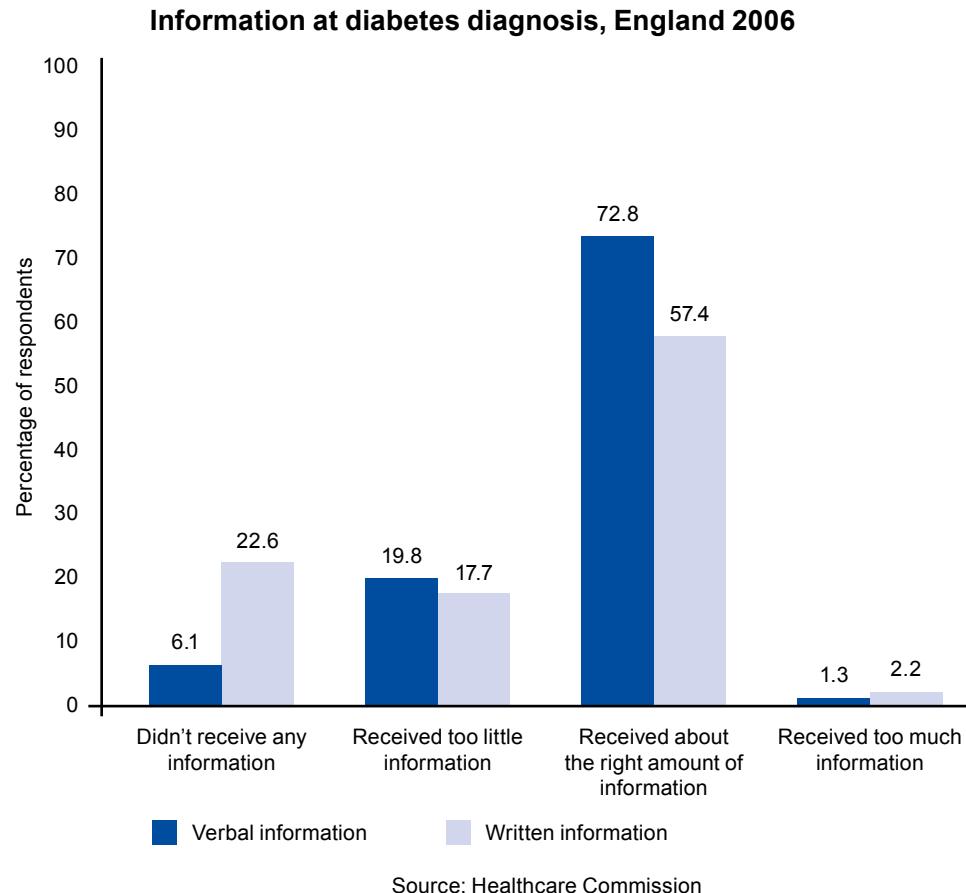
Patient education: diabetes care

The Healthcare Commission's 2006 survey of diabetic patients in England asked respondents about their access to training and education programmes. Maintaining good glycaemic control, as measured by HbA1c levels, is important in preventing the development of many of the serious sequelae of diabetes. The National Diabetes Audit (2004/05) found that 48 per cent of diabetes patients had HbA1c levels above the recommended threshold of 7.5 per cent. Improved self-care is seen as a key intervention to help improve HbA1c levels. The chart shows that only 10 per cent of diabetic patients indicated that they had participated in education and training programmes. Of those that had not participated in such programmes, the vast majority (83 per cent of total respondents) had not been offered the opportunity to do so.



Diabetes patients: information at diagnosis

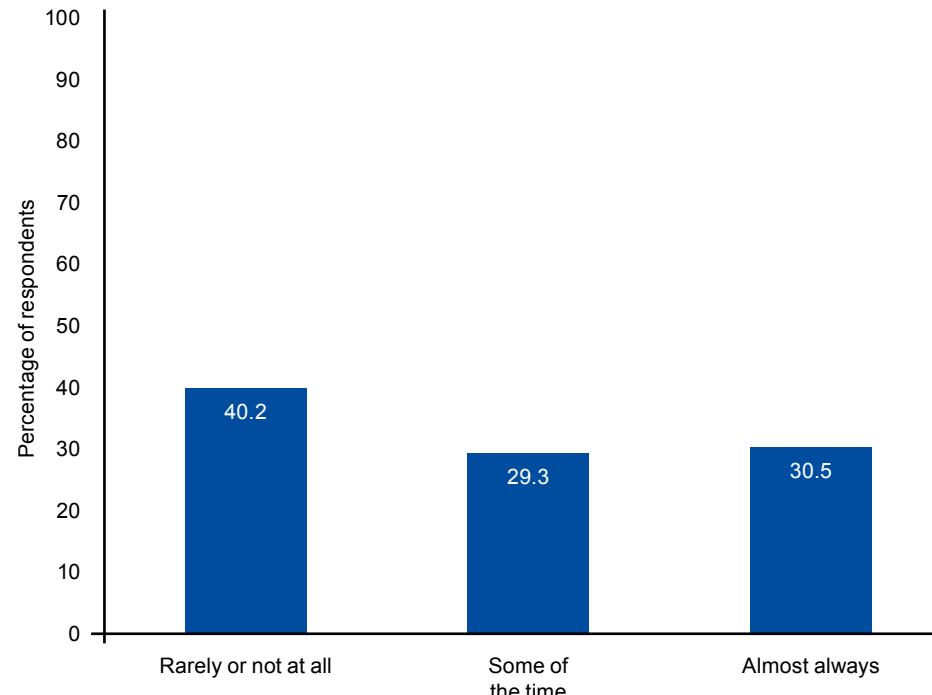
The Healthcare Commission's 2006 survey of diabetes patients included more than 60,000 respondents in England. The survey included the question: 'How would you describe the amount of written/verbal information you received about your diabetes when you were first diagnosed?' About 25 per cent of respondents indicated that they received too little or no verbal information at the time of diagnosis, while 40 per cent indicated they received too little or no written information.



Diabetes patients: exploring medication options

The 2006 Healthcare Commission survey of diabetes patients asked respondents: 'Thinking about the last 12 months, when you received care for your diabetes, were you given the chance to discuss different medications?' The chart shows that only a third of patients indicated that they were almost always given the opportunity to discuss medication with their healthcare provider.

Given chance to discuss different medications, diabetes patients, England 2006



Source: Healthcare Commission

What do patients want? To be treated as an individual

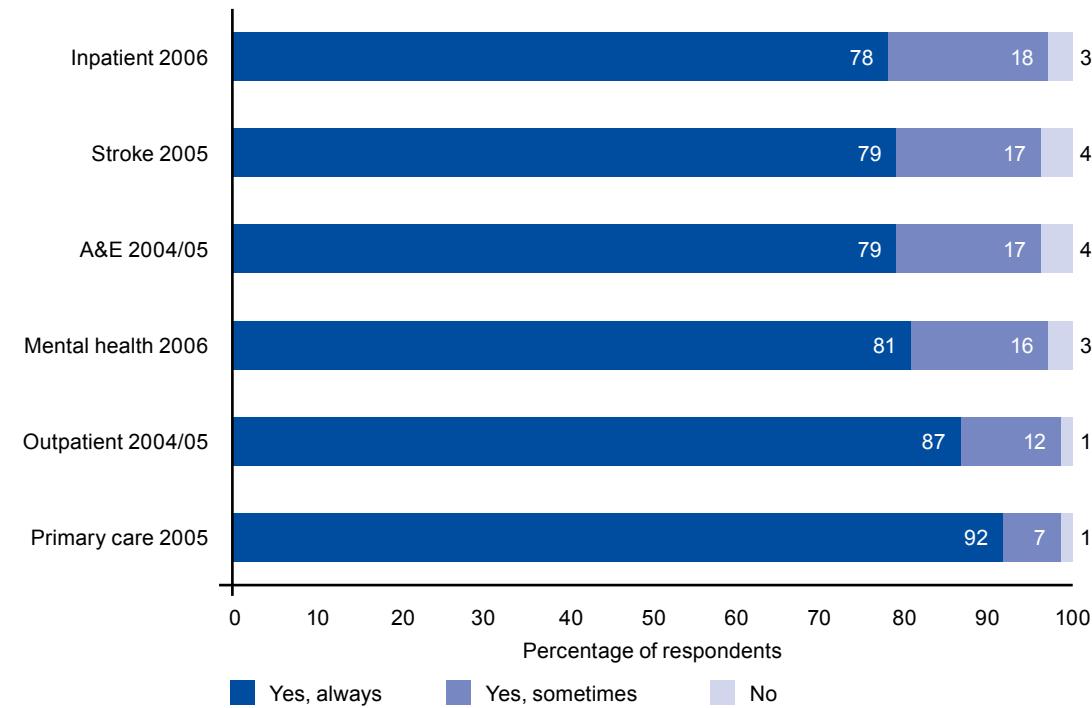
Surveys consistently show that patients value being treated with respect and candour highly. In a qualitative study, Preston *et al* (1999) found that patients felt comfortable and confident when doctors, nurses and other staff were perceived as caring and responsive to their individual needs. However, when care was viewed as impersonal, or dictated by staff routines or other organisational imperatives, patients described feeling anxious, insignificant and powerless. They felt that they had to fit in with a system that 'appeared to take no account of them as people' (p 18).

This section illustrates patients' perceptions about important intangible aspects of care, such as respect and confidence in healthcare professionals. It also includes data on more tangible aspects of individual care, such as effective pain control and access to single-sex wards and bathrooms.

Patients' perceptions: treated with respect and dignity

The Healthcare Commission surveys in England gauge opinion among different patient groups in the NHS. Stroke patients, inpatients, patients attending A&E, outpatients, primary care patients and mental health patients were asked the following question: 'Overall, did you feel you were treated with respect and dignity?' A large majority of respondents indicated that they were treated with respect and dignity at all times. While these results are commendable, it is of concern that a fifth of stroke patients, inpatients, patients attending A&E, and mental health patients (referring to psychiatrists) felt that they were not treated with dignity and respect at all times.

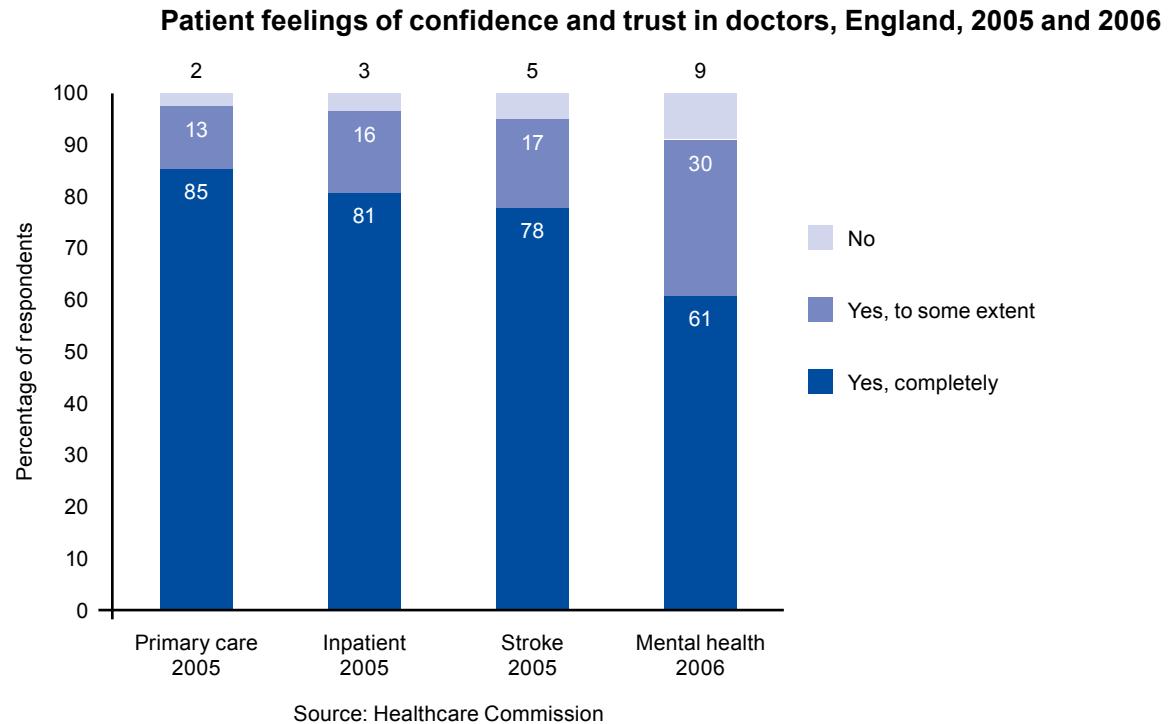
Patient perceptions: treated with respect and dignity, England, 2004, 2005 and 2006



Source: Healthcare Commission

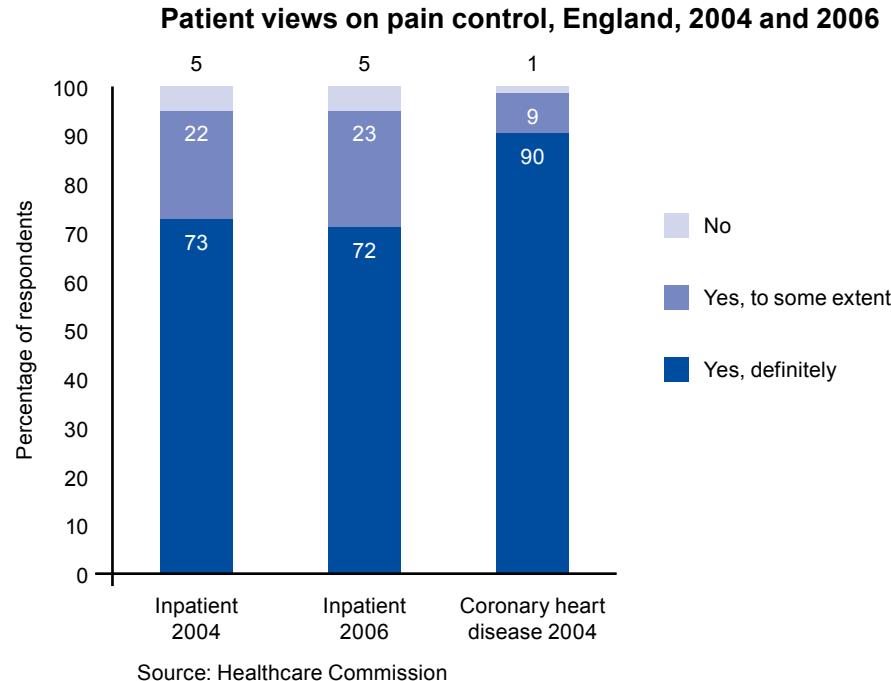
Patient perceptions: confidence and trust

The Healthcare Commission surveys in England gauge opinion across different patient groups in the NHS. The surveys generally include the question: 'Did you have confidence and trust in the doctors treating you?' The chart illustrates responses to four surveys published in 2005 and 2006. Three-quarters or more of respondents in the surveys of primary care patients, inpatients and stroke patients indicated that they had complete confidence and trust in their doctors. Among those responding to the mental health survey, only 61 per cent indicated that they had complete trust and confidence in the doctors (psychiatrists) treating them.



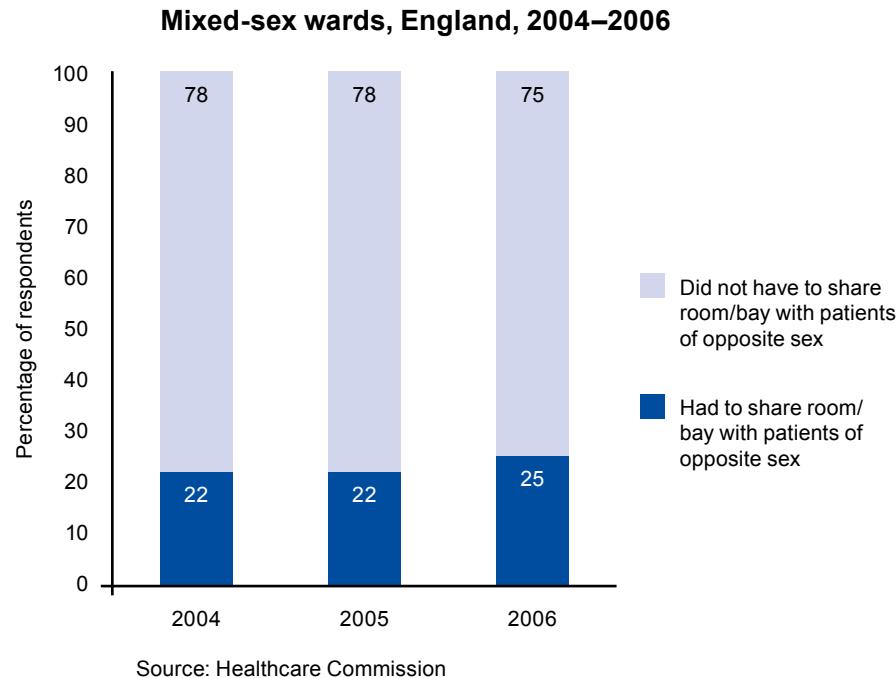
Pain control: patient perspective

Effective pain management is critically important to an individual's experience of healthcare and any assessment of their treatment. The chart shows the responses to the question: 'Do you think hospital staff did everything they could to control your pain?' More than a quarter of inpatient respondents in 2004 and 2006, and a tenth of CHD patients in 2004, indicated that staff did not do everything they could to control pain. A similar, although smaller, survey of cancer patients conducted by the National Audit Office in 2004 found that 15 per cent of respondents thought that hospital staff had not done all they could at all times to relieve pain (data not shown).



Mixed-sex wards

The chart is based on Healthcare Commission surveys of English inpatients from 2004 to 2006. It illustrates the responses to the question: 'During your hospital stay did you ever share a room or bay with a patient of the opposite sex?' The proportion of respondents who shared a room or bay with patients of the opposite sex remained unchanged at 22 per cent from 2004 to 2005 but increased in 2006 to 25 per cent. These results show that a commitment made by the government almost a decade ago to eliminate mixed-sex accommodation has not been met.



What do patients and citizens want? Choice where it makes a difference

Patient choice is a concept that is central to current healthcare policy (for a summary of policy commitments, see Box 4 below). In their report on choice and equity in England's NHS, Thorlby and Turner (2007) identified three main objectives that the government has put forward as reasons for pursuing increased patient choice:

- First, choice has been justified on the grounds that it is essential to modernise the NHS, and that the public wants more choices in public services, including health (Department of Health, 2006b).
- Second, and perhaps more importantly, choice is designed to act as a lever to improve system performance: by linking payment to the number of patients that hospitals treat, the government hopes that hospital providers will become more responsive to patients' needs in an effort to maintain and enhance their own income. According to the government, 'the intention is... to increase competition between providers' (Department of Health, 2006c) which, coupled with choice, would lead to quality improvements such as shorter waiting times and better 'clinical standards... canteens, car parks, crèches and cleanliness' (Hewitt, 2006a).
- Third, it is argued that choice increases fairness or equity within healthcare. By extending choice to all patients (particularly the choice of a shorter wait), the government claims that it is correcting two forms of inequity: first, where the better-off could find shorter waiting times by paying for treatment in the private sector (Department of Health, 2000; Reid, 2003; Hewitt, 2006a, 2006b); and, second, where some patients could insist on

choices (of shorter waits or better clinical quality) within the NHS, because of their better knowledge of the system (Reid, 2003).

The government's plans to promote choice include promulgating competition and encouraging plurality of provision. The UK Public Administration Select Committee has called for a realistic approach about the role and limitations of choice. Support for the concept of choice is neither universal nor unconditional. A recent Picker survey (Boyd, 2007 – see Appendix for details), conducted for the Healthcare Commission, found that choice about appointment time and hospital referrals was ranked in the lowest ten per cent of a list of 82 patient priorities. Similarly, 89 per cent of respondents surveyed by the consumer magazine *Which?* indicated that access to a good local hospital was more important than having more hospitals to choose between. This is not to say that patients would prefer no choice: the 2005 British Social Attitudes survey found that 65 per cent of people would like to be able to choose their treatment, 63 per cent their hospital and 53 per cent the date and time of their appointment. However, when asked to rank choice in referrals and appointment times in relation to other priorities, patient surveys consistently show that they are often relegated to a low position.

Box 4: Choice timeline – policy commitments

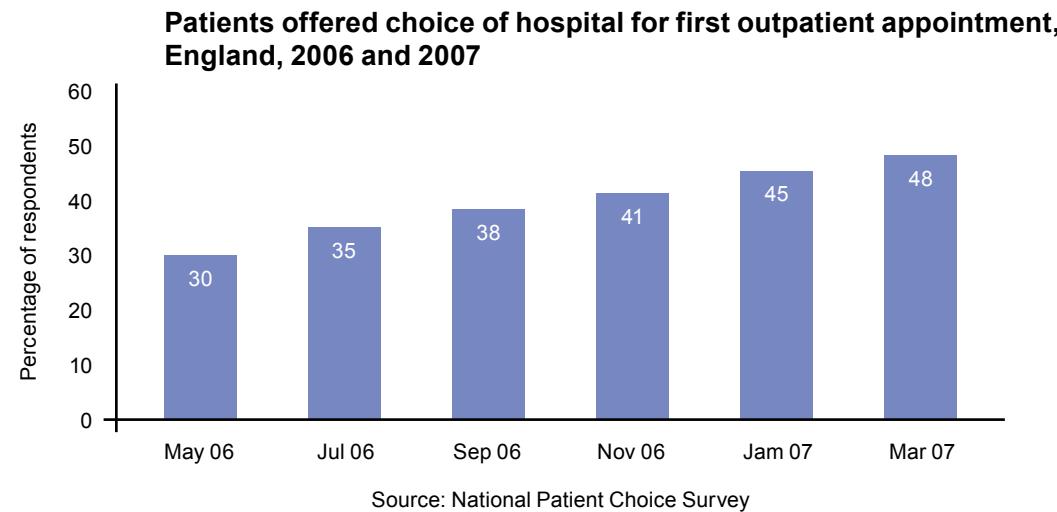
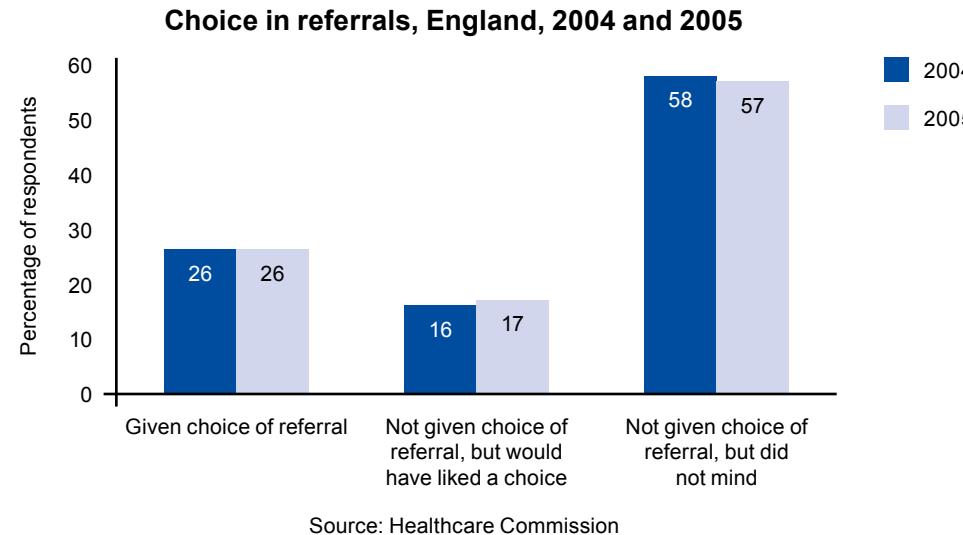
- From August 2004, patients waiting over six months for elective surgery to be offered faster treatment at an alternative hospital.
- From January 2005, patients needing a non-urgent hospital outpatient appointment to be offered a choice of hospital by their GP. The 'menu' of possible choices was initially four or five mainly local providers, but the list has now been extended to include private sector treatment centres and foundation trusts nationally. The policy applies to almost all of the nine million outpatient appointments offered within the NHS each year, with only a few exclusions (maternity and referrals under the two-week cancer target, for example). The policy has been accompanied by the introduction of an electronic booking system, known as 'Choose and Book', which has had significant implications for IT systems at both GP and trust level. Choose and Book is not yet fully operational and has had, in the government's own words, 'some challenges' (Hewitt, 2006b).
- From January 2005, patients requiring cataract surgery (including those referred directly by an optometrist) to be offered a choice of hospital at the time they are referred for treatment.
- From April 2005, patients who need a heart operation to be offered a choice of hospital at the time they are referred for treatment.
- By December 2005, patients who require an elective referral to be offered a choice of four to five hospitals (or suitable alternative providers), and a choice of time and date for their booked appointment, at the time they are referred by their GP or primary care professional.

The government plans to extend choice to cover all non-emergency referrals, and patients will have a choice of any hospital or treatment centre in the country by 2008 (Department of Health, 2005).

Source: Adapted from Thorlby and Turner, 2007

Choice in referrals

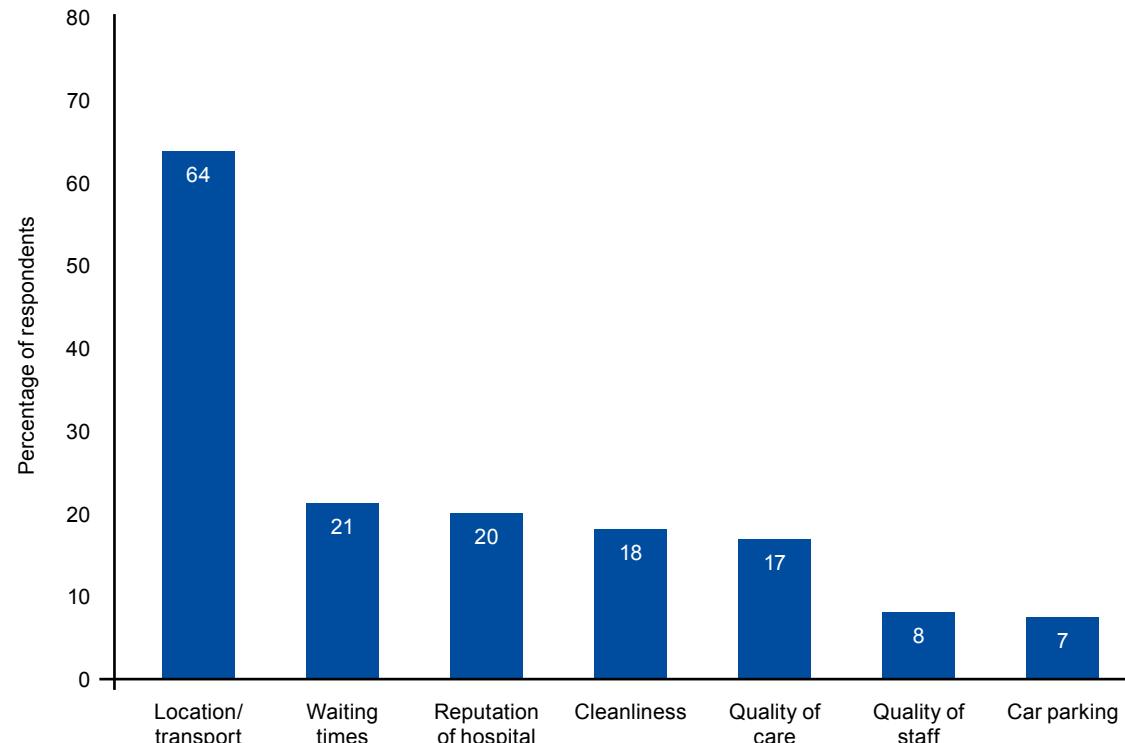
The Healthcare Commission conducts large-scale patient surveys in England, focusing on various patient groups. Surveys of primary care patients in 2004 and 2005 asked patients who had been referred to secondary care: 'Were you given a choice about where you were referred to?' The National Patient Choice Survey provides a more up-to-date picture, showing that in March 2007, almost half of respondents recalled being offered a choice of hospital for their first outpatient appointment.



Important factors in choosing a hospital

In January 2007, the Department of Health conducted the fifth in their series of National Patient Choice Surveys. Respondents were asked to indicate up to three factors that were important to them in choosing a hospital, and the chart illustrates their responses. Geographical convenience and transportation ranked highest by far.

Important factors in choice of hospital, England 2007

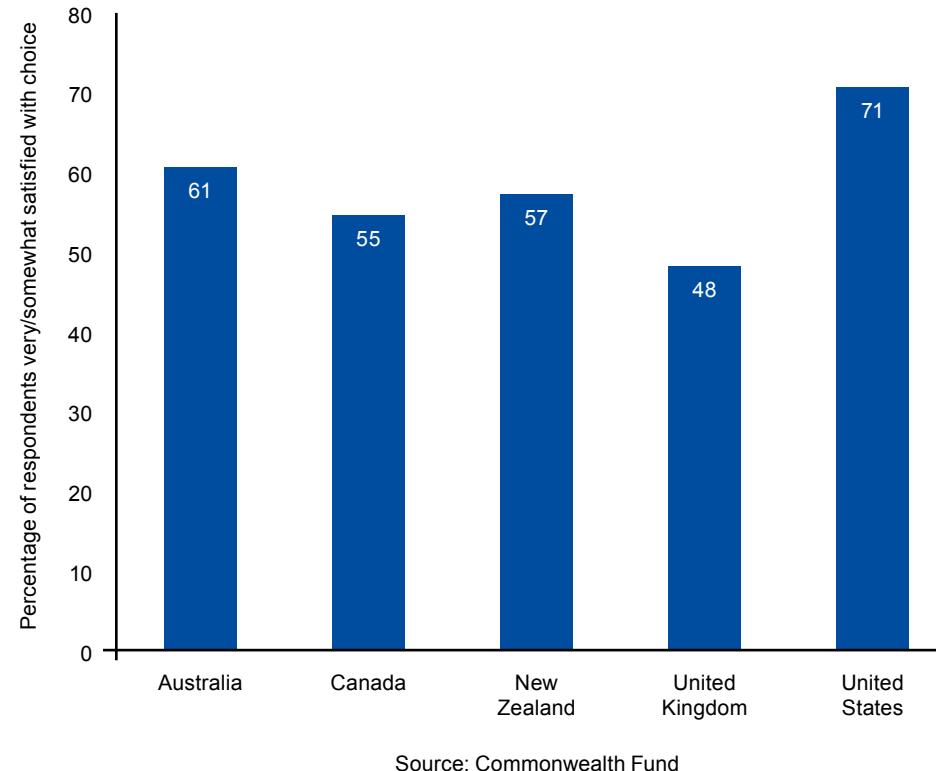


Source: Department of Health, 2007

Choice of surgeon

The 2005 Commonwealth Fund International Health Policy Survey focused on sicker adults and asked respondents who had undergone major surgery in the preceding two years: 'How satisfied were you with the amount of choice you had in choosing the surgeon?' The chart depicts the percentage of respondents who indicated that they were either very or somewhat satisfied. UK respondents appeared least satisfied with the amount of choice.

Patient satisfaction with choice of surgeon, international comparison, 2005



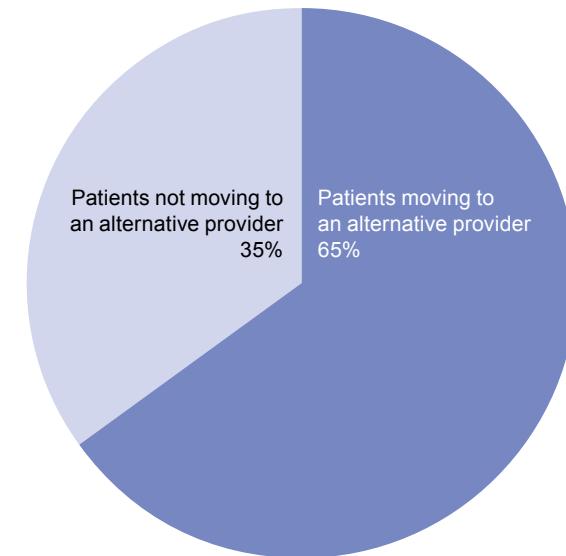
Uptake of choice: the London Patient Choice Project

Although surveys show that choice of hospital is often rated a low priority for many patients (see chart on page 15), the London Patient Choice Project (LPCP) indicated that patients do choose alternate providers of secondary care in some circumstances. Established in 2002, the LPCP gave patients who had been waiting longer than six months for hospital treatment the opportunity to be treated by other providers who could offer earlier treatment. The chart illustrates that 65 per cent of patients chose to move to an alternate provider. However, patients were less likely to opt for quicker treatment at an alternate provider if:

- the reputation of the alternate hospital was worse than (or unknown) relative to the 'home' hospital
- the travel time to the alternate provider increased relative to travel to the home hospital
- the alternate treatment offered was abroad
- patients had to organise and pay for their transport to the alternate provider
- follow-up care was delivered by the alternate rather than the home hospital.

LPCP was conducted in a geographical area where there is a high density of providers and relatively good transport links, and at a time when waiting times were much longer so it is difficult to draw conclusions about the importance of choice from this project. The model has been superseded by the Choose and Book scheme, which aims to offer choice to all patients at the point of referral. Recent data from the Choose and Book scheme shows that 45 per cent of patients recall being offered a choice of hospital for their first outpatient appointment (see: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_075248).

Exercising choice: The London Patient Choice Project



Source: Burge *et al*, 2005

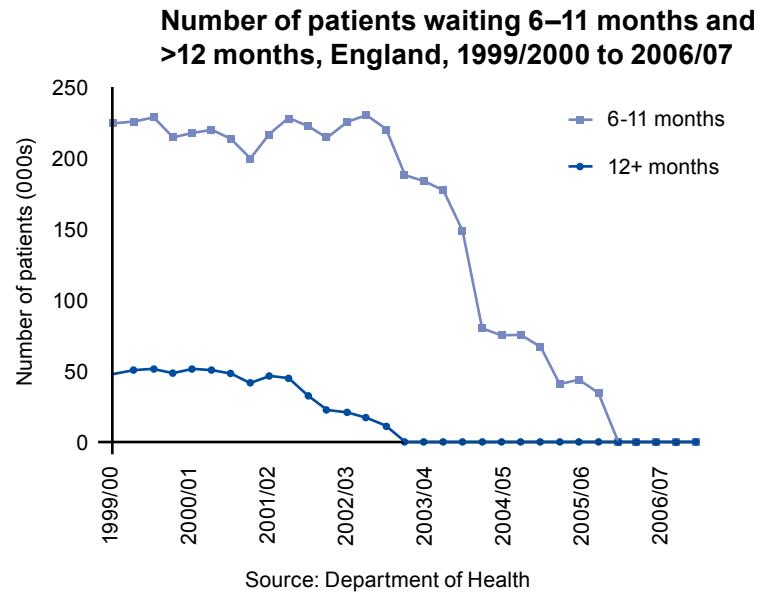
What do patients want? Predictable and convenient access to healthcare

Surveys of patients around the world consistently identify access as a key concern of patients (Grol *et al*, 1999; Davis *et al*, 2007). Problems of access have long plagued the NHS. In 2000, *The NHS Plan* asserted that 'the public's top concern about the NHS is waiting for treatment' (p 101). The concerns about waits were widespread and related to primary care, inpatient care, and accident and emergency departments.

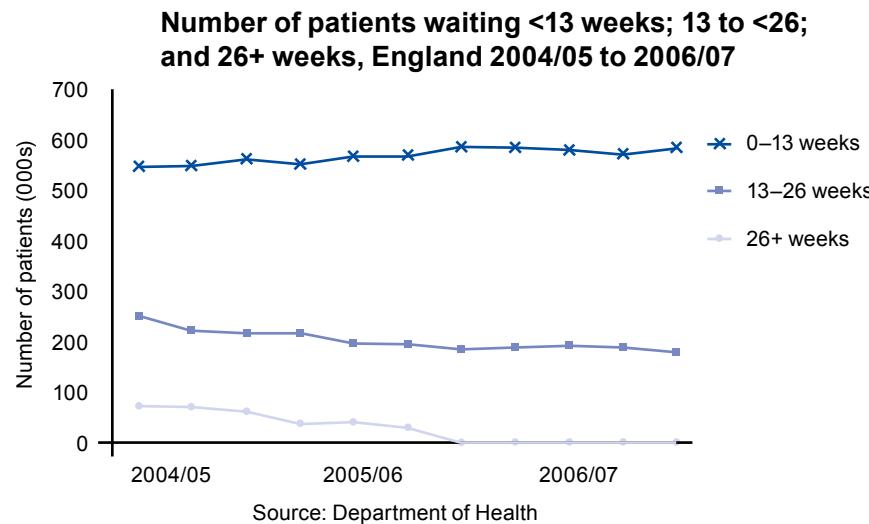
In recent years, there has been a significant decrease in waiting times for elective care in the NHS. Currently, significant policy and managerial attention is focused upon delivering an '18-week patient pathway' by 2008, meaning that no one will wait longer than 18 weeks from a GP referral to the start of treatment. This move towards measuring 'total waits' has highlighted a number of bottleneck areas, such as diagnostics, where patient pathways are delayed.

Inpatient waiting times

The number of people waiting excessively for admission into hospital in England has decreased markedly in recent years. At the end of the first quarter of 1999/2000, 275,621 patients had been waiting more than six months for admission, and 48,687 had been waiting more than 12 months. The charts below show the marked improvement in these figures: today, virtually no patients wait longer than six months for admission. These charts depict waits from scheduling of surgery to admission. The Department of Health has recognised that a better measure would be to record total waiting times from GP referral to admission. The government has pledged that by the end of 2008 the entire waiting time from referral to treatment will be less than 18 weeks. Recently released data (www.dh.gov.uk/en/News/DH_075242) estimates that around 48 per cent of patients are treated within that timeframe.



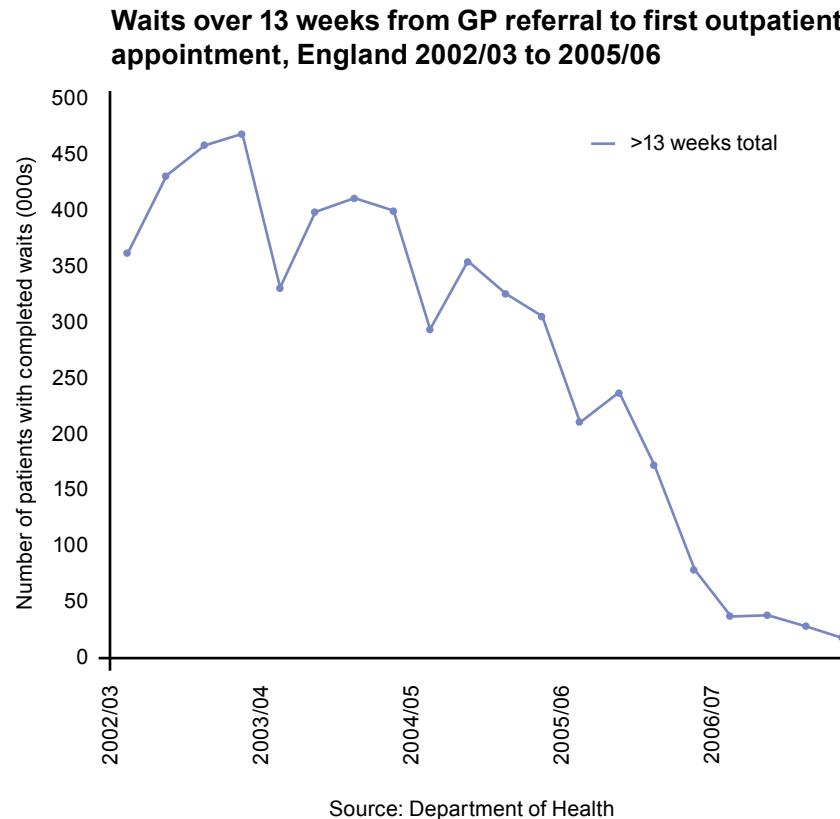
Source: Department of Health



Source: Department of Health

Outpatient waits

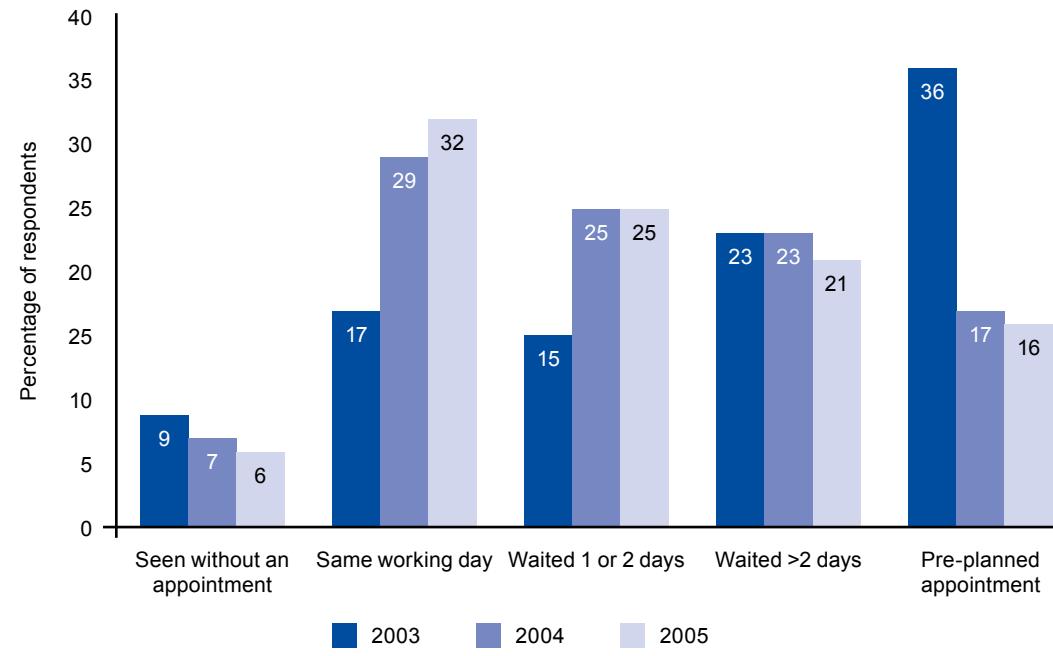
The Government promised that by the end of 2005 patients would wait no longer than 13 weeks for an outpatient appointment. Although this target wasn't achieved, this chart shows that the number of patients waiting more than 13 weeks for outpatient appointments has fallen dramatically in recent years. In March 2007, 23,608 patients waited longer than 13 weeks: this represented only 1 per cent of the total number of outpatient appointments (1.9 million).



Primary care waits

The Healthcare Commission undertakes large patient surveys in England, focusing on different subpopulations. In 2003, 2004 and 2005, it undertook surveys of PCT patients. About one in five respondents indicated that they waited longer than two days for an appointment. In July 2007, the Department of Health released data from a MORI survey of almost 2.3 million GP patients. It showed that primary care access had improved. In response to the question 'Think about the last time you tried to get an appointment with a doctor fairly quickly. Were you able to get the appointment on the same day or on the next two days the surgery was open?', 86 per cent of respondents answered yes (http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/DH_075127). The MORI survey also found that 75 per cent of respondents were able to book an appointment more than two days in advance [data not shown].

Waiting for a GP appointment, England, 2003–2005



Source: Healthcare Commission

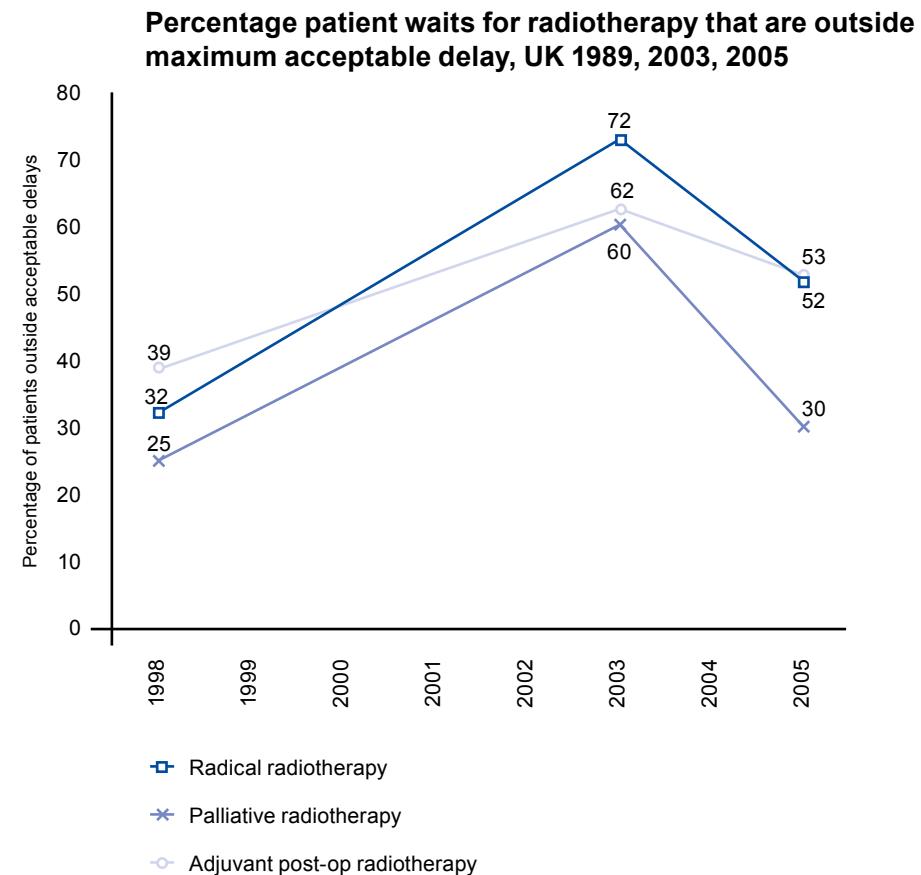
Waits for radiotherapy

Radiotherapy means the use of 'radiation', usually X-rays, to treat cancer. A course of radiotherapy is given over a number of days or weeks and acts to destroy cancer cells in the treated area. The main types of radiotherapy are: *radical*: used instead of surgery and seeks to destroy the tumour and cure the cancer; *palliative*: radiotherapy is used to relieve symptoms and reduce pain; *adjuvant*: radiotherapy is given after surgery to kill off any tiny amounts of tumour that may be left after surgery.

Standard waiting times for receiving radiotherapy were set by the Joint Collegiate Council for Oncology (JCCO) in 1993:

Type of radiotherapy	Good practice	Maximum acceptable wait
Urgent radiotherapy or chemotherapy	24 hours	48 hours
Palliative radiotherapy	48 hours	2 weeks (depending on severity of symptoms)
Radical radiotherapy (complex treatment planning)	2 weeks	4 weeks (when additional staging needed)

The chart is based on three audits conducted by the Royal College of Radiologists in 1998, 2003 and 2005. All radiotherapy centres in the UK participated and the audits covered all patients who started treatment in one designated week. The audits show that in 2005 over half of patients receiving radical or adjuvant therapy, and about a third of those receiving palliative care, waited for unacceptably long periods. Although this was an improvement on the 2003 data, these results signify a serious quality deficit.



Source: Royal College of Radiologists, 1998, 2003, 2005

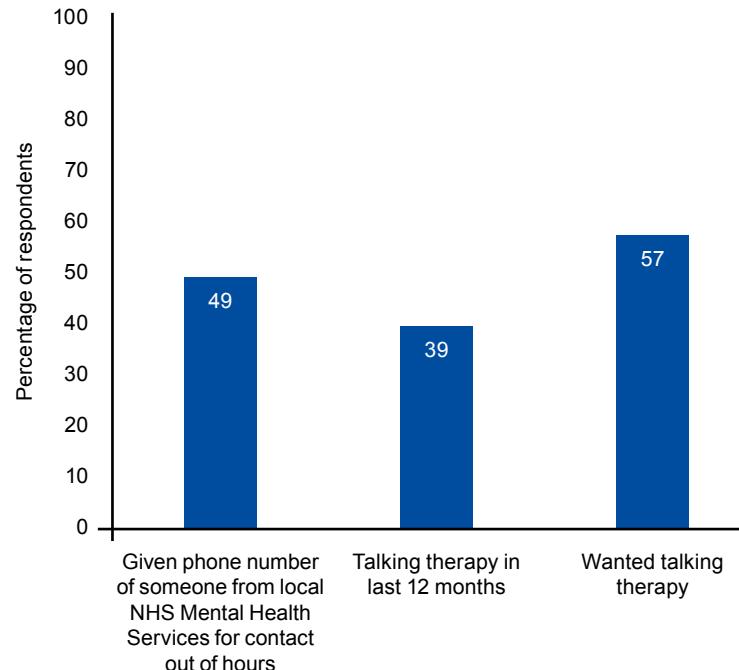
Access to mental health services

In 2006, the Healthcare Commission surveyed 19,494 users of secondary mental health services (ie psychiatric outpatient clinics or local community mental health teams) and asked the following questions:

- ‘Do you have the number of someone from your local NHS Mental Health Services that you can phone out-of-office hours?’
- ‘In the last 12 months have you had any counselling sessions (eg talking therapy) from NHS Mental Health Services?’
- ‘In the last 12 months, did you want talking therapy?’

The chart shows that access to professionals in an out-of-hours crisis is insufficient, with fewer than half of the respondents indicating that they had contact details of someone they could call in an emergency. Access to talking therapies is also a concern with 57 per cent of respondents indicating that they would like to access that type of service but only 39 per cent stating that they were able to do so.

Access to mental health care, England 2006



Source: Healthcare Commission

What do patients want? Equitable care

Equity, one of the founding principles of the NHS, still distinguishes the NHS from many other healthcare systems. Treating patients on the basis of need rather than on the basis of the ability to pay (or any other non-clinical criteria) remains a cherished principle.

This section provides data on equity in the NHS, both in terms of equity in outcomes (such as mortality rates and life expectancy) and equity in provision of care processes (such as cardiac care processes and GP density). Improving equity is one of the stated aims of the NHS choice agenda. Box 5 below describes the interplay between choice and equity, and provides some preliminary evidence on how that is affecting patients.

Box 5: Choice and equity

As discussed earlier, the government has asserted that it will seek to improve equity via the mechanism of patient choice, providing the option to choose to all patients where, previously, such options were open only to those who could afford to pay. However, Bate and Robert (2005) argue that unmediated choice may increase inequity as it will favour patients with access to information and transport; inequity will be magnified if patients in lower socioeconomic groups have lower expectations and less ability (real or perceived) to deal with the choices available.

Evaluations of the pilot patient choice schemes (such as the London Patient Choice Project) found that access to choice was equitable, with no inequalities 'in access to, or uptake of alternative hospitals by social class, educational attainment, income or ethnic group' (Coulter *et al*, 2005). Notably, there were two important differences between the pilots and current policy. In the pilots, all patients were eligible for free travel and all were entitled to help from a patient care advisor: both were found to be important facilitators of exercising choice. However, neither is mandatory in the implementation of choice at the point of GP referral.

PCTs are responsible for making sure that all patients have an equal opportunity to choose, by providing information and support to those who might otherwise struggle to exercise choice. In a survey of PCTs, Thorlby and Turner (2007) found that:

- a minority of PCTs had identified which groups might find making choices harder
- a minority had put in place concrete measures to 'support' choices for these patients
- a majority reported that ensuring equity is 'difficult or very difficult'.

Their report concludes that while it is too early to tell whether patient choice will deliver fairer outcomes for patients, equalising the opportunity to choose is already proving challenging in the NHS.

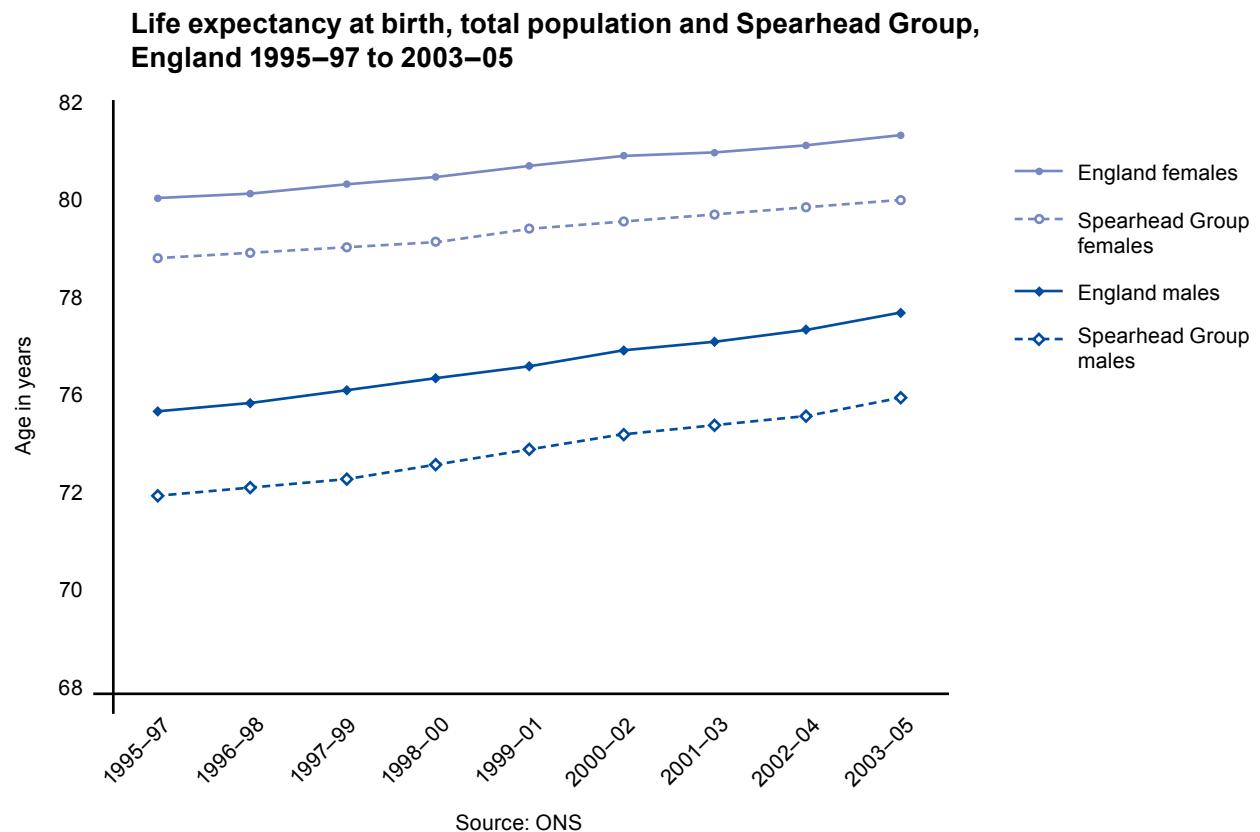
Equity in outcomes

Socioeconomic inequalities in life expectancy

The 2004 Public Service Agreement set targets to reduce inequalities in life expectancy, cancer, heart disease, stroke and related diseases. Its aim is to reduce the gap between the fifth of areas with the worst health and deprivation indicators (known as the Spearhead Group) and the population as a whole.

The Spearhead Group is made up of 70 local authorities and 62 PCTs, based on the local authority areas that are in the bottom fifth nationally for three or more of the following five indicators: male life expectancy at birth; female life expectancy at birth; cancer mortality rate in under 75s; cardiovascular disease mortality rate in under 75s; Index of Multiple Deprivation 2004 (local authority summary), average score.

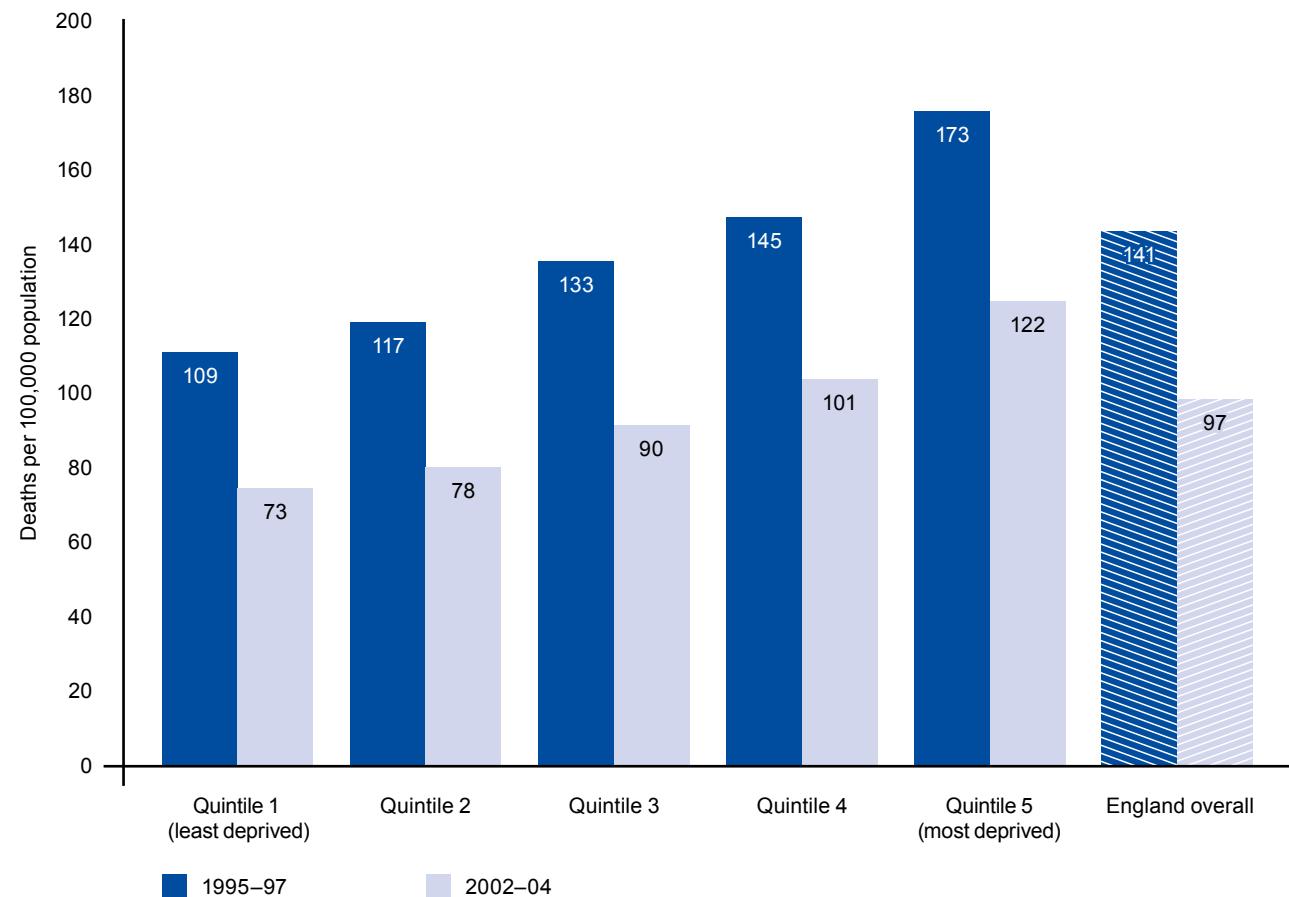
For life expectancy, the specific target is to reduce by at least 10 per cent the relative gap between the Spearhead Group and the population as a whole by 2010 (using 1995–97 as a baseline). Latest data for 2003–05 shows that, rather than shrinking, the relative gap in life expectancy has grown wider.



Socioeconomic inequalities in circulatory disease mortality

Alongside a pledge to reduce by 40 per cent the mortality rates from circulatory disease in patients under 75 years old across England, the government also set a target to reduce by at least 40 per cent the inequalities gap between mortality rates in the most deprived areas and the population as a whole. While there has been a generalised decrease in death rates, the inequalities gap has widened from a 22 per cent difference between the most deprived areas and the population as a whole in 1995-97, to a 26 per cent difference in 2002-04. Even more starkly, the circulatory disease death rate for those under 75 years old in the most deprived areas was 68 per cent higher compared with the least deprived areas.

Age standardised death rates from circulatory disease by deprivation quintile, people aged under 75, England 1995-97 and 2002-04

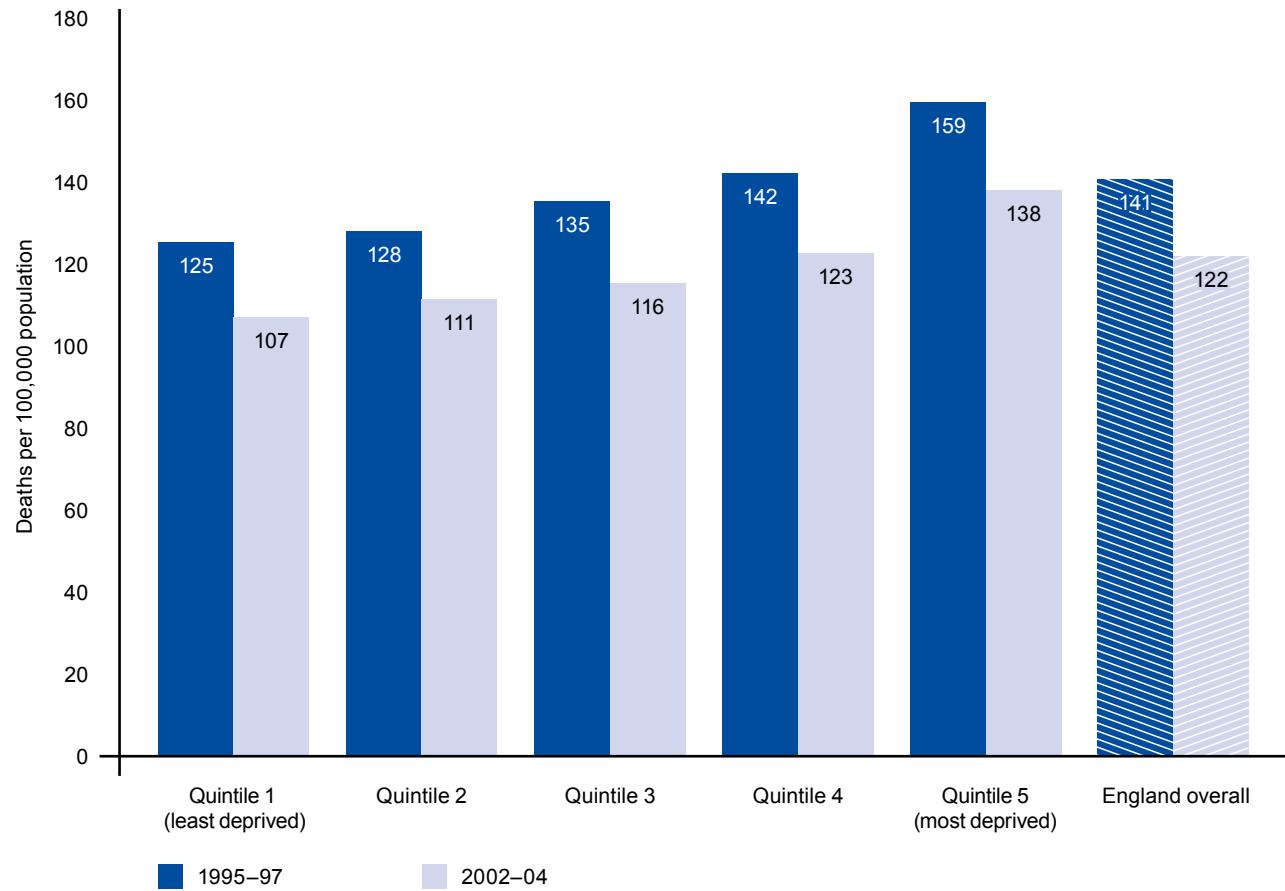


Source: ONS

Socioeconomic inequalities in cancer mortality

Alongside the pledge to reduce by 20 per cent the mortality rates from cancer in patients under 75 years old across England, the government also set a target to reduce by at least 20 per cent the inequalities gap between mortality rates in the most deprived areas and the population as a whole. While there has been a generalised decrease in death rates, the inequalities gap has not changed significantly. The data indicates that there was a 13 per cent difference between the most deprived areas and the population as a whole in 1995–97, and this differential had not changed significantly by 2004–04. In 2002–04, the cancer death rate for those under 75 years in the most deprived areas was 30% higher than the rate in the least deprived areas.

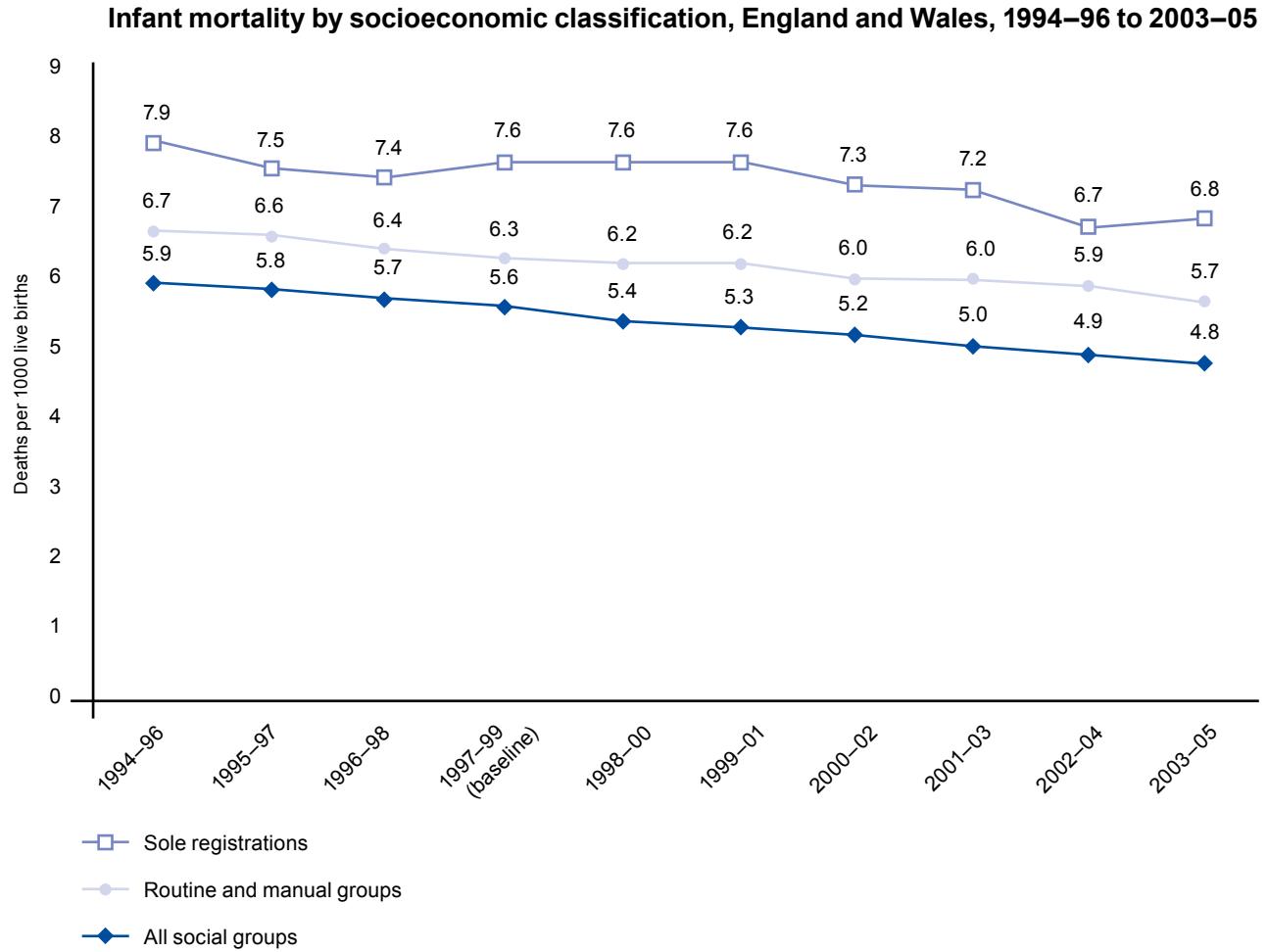
Death rates from cancer, by deprivation quintile, people aged under 75, England 1995–97 and 2002–04



Source: ONS

Infant mortality by socioeconomic classification

Deprivation levels are known to affect infant mortality rates. In its drive to tackle health inequalities, the government pledged 'by 2010 [to] reduce by at least ten per cent the gap in infant mortality between routine and manual groups and the population as a whole' (HM Treasury, Public Sector Agreement, 2004), using 1997–99 as the baseline. The data displayed below shows an overall fall in infant mortality rates across England and Wales. The infant mortality rate among the routine and manual group was 13 per cent higher than that in the population as a whole during 1997–99. Rather than narrowing, this gap widened to 18 per cent during 2003–05. The chart also illustrates data for sole registrations, although these data are not covered by the PSA target. In 2003–05, the rate for managerial and professional groups was 3.4 deaths per 1,000 live births; for intermediate groups the rate was 4.4 deaths per 1,000 live births (data not shown).



Source: ONS

Equity in provision

Anticipated costs as barrier to care

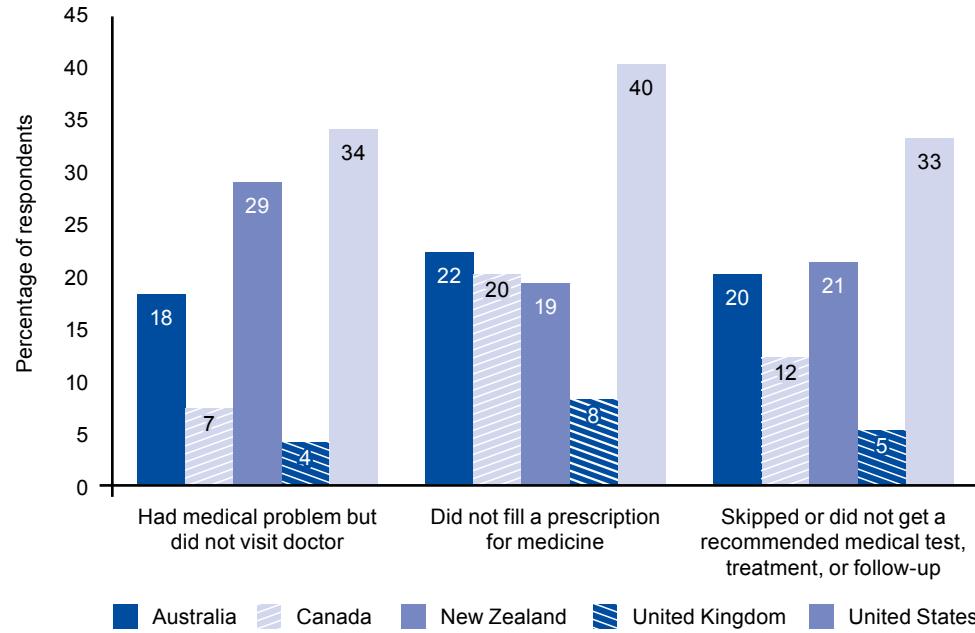
The 2005 Commonwealth Fund International Health Policy Survey, which focused on adults who had recently been hospitalised or reported health problems, asked the following:

'Was there a time in the past two years when, because of cost, you:

- had a specific medical problem but did not visit the doctor?
- did not fill a prescription for medicine?
- skipped or did not get a medical test, treatment, or follow-up that was recommended by a doctor?'

The UK performed best on all questions, which indicates that service provision is equitable across different income groups.

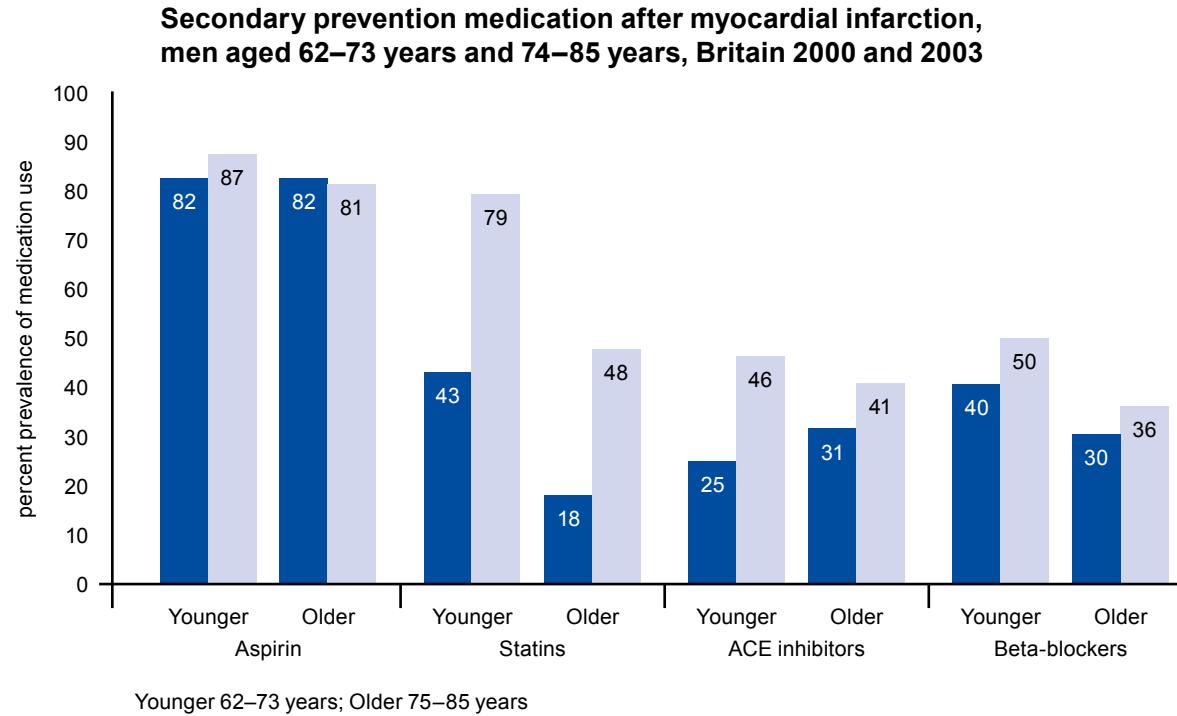
Respondents who did not get medical care because of cost, international comparison, 2005



Source: Commonwealth Fund

Age-based disparities in coronary heart disease treatment

There has been a generalised improvement in the prescription of secondary prevention medication following acute myocardial infarction (AMI). The chart illustrates data from a study (Ramsay *et al*, 2005) of medication use in 1998–2000 and 2003, conducted in 24 British towns, based on 332 AMI patients. The study found that older age was related to lower prevalence of drug use, particularly statins. In a separate study, Hippisley-Cox *et al* (2005) also found that older patients (75 years or older) were significantly less likely to have a serum cholesterol level recorded, to be on statins, to be on beta-blockers post-myocardial infarction and to have well-controlled blood pressure compared with patients who were younger than 75 years old (although this was based on 2000 and 2001 data).

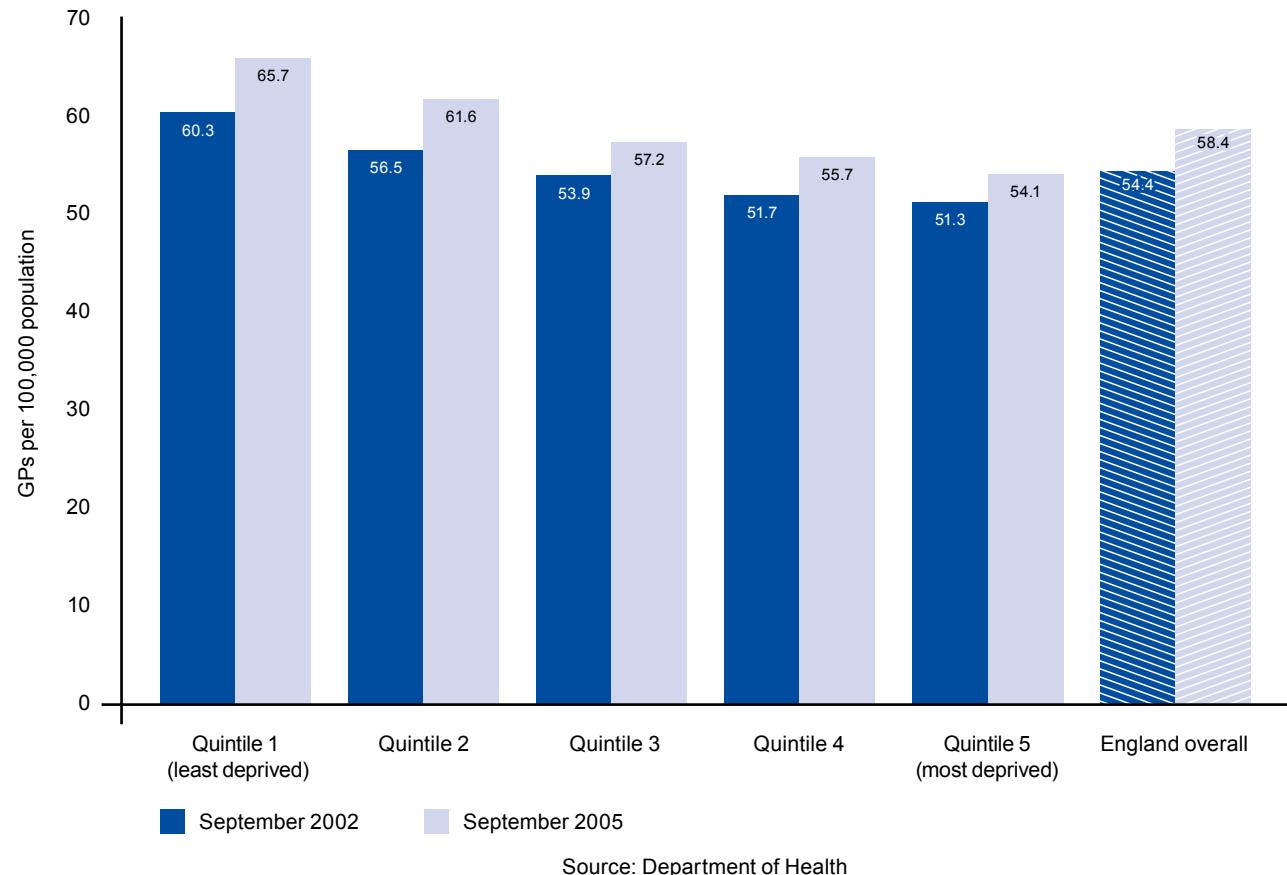


Source: Ramsey *et al*, 2005

Distribution of general practitioners

The inverse care law describes the perverse relationship between the need for healthcare and its delivery: the result is that those who most need medical care are least likely to receive it. Addressing the inverse care law is seen to be a key factor in tackling inequalities in health status (see the Department of Health's Programme for Action, published in 2003). One contributing factor to the inverse care law is the uneven distribution of GPs. Although there was an increase in the number of GPs in England between 2002 and 2005, there was no significant narrowing of inequalities. In September 2005, 75% of primary care trusts (PCTs) in the most deprived geographical areas (46 out of 61) had fewer GPs than the England average (data not shown).

Number of full time equivalent (FTE) general practitioners per 100,000 weighted population, by deprivation, England 2002 and 2005



What do patients want? To be safe and protected from unnecessary risk and harm

In recent years, there has been a growing concern among the general public about safety in healthcare. This concern is echoed internationally, with widespread acknowledgement of the need to protect patients from unnecessary risk and harm, and the challenges of achieving that objective. In England, the government, the Department of Health and, in particular, the Chief Medical Officer have placed an increasing emphasis on patient safety.

The clearest manifestation of this policy emphasis is the National Patient Safety Agency (NPSA), which was established in 2001 as a Special Health Authority to co-ordinate efforts to learn from patient safety incidents occurring in the NHS. In February 2004, the NPSA launched a safety reporting system, drawing together reports of patient safety errors and systems failures provided by health professionals across England and Wales. While the NPSA served a useful purpose of representing safety as a top priority, the reporting system was beset by a number of problems, and the NPSA was criticised by the National Audit Office (2005) and the House of Commons Select Committee on Public Accounts (2006).

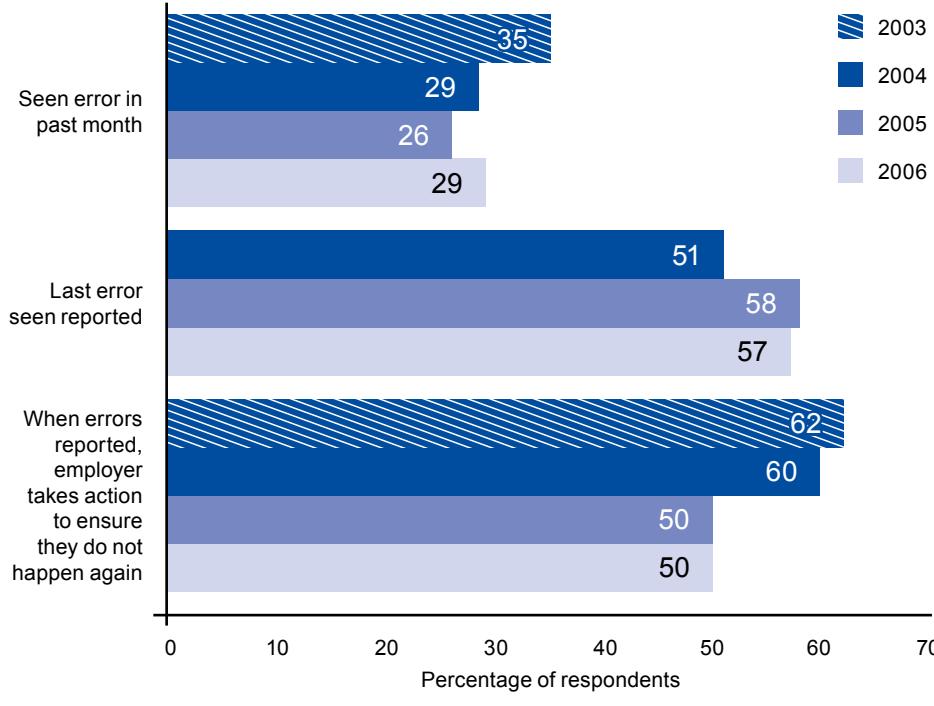
Staff surveys: safety incidents and near misses

The Healthcare Commission has conducted annual NHS staff surveys since 2003. A key focus area is the frequency of and responses to errors, incidents or near misses. The surveys ask staff to respond to the following questions:

- ‘In the last month, have you seen errors, near misses or incidents that could hurt patients/service users?’
- ‘The last time that you saw an error, near miss or incident, did you or a colleague report it?’
- ‘When errors, near misses or incidents are reported, does your trust take action to ensure that they do not happen again?’

Latest data shows that around a third of respondents reported seeing an error in the past month; and only half of respondents thought that their employer had taken action to prevent similar errors happening again.

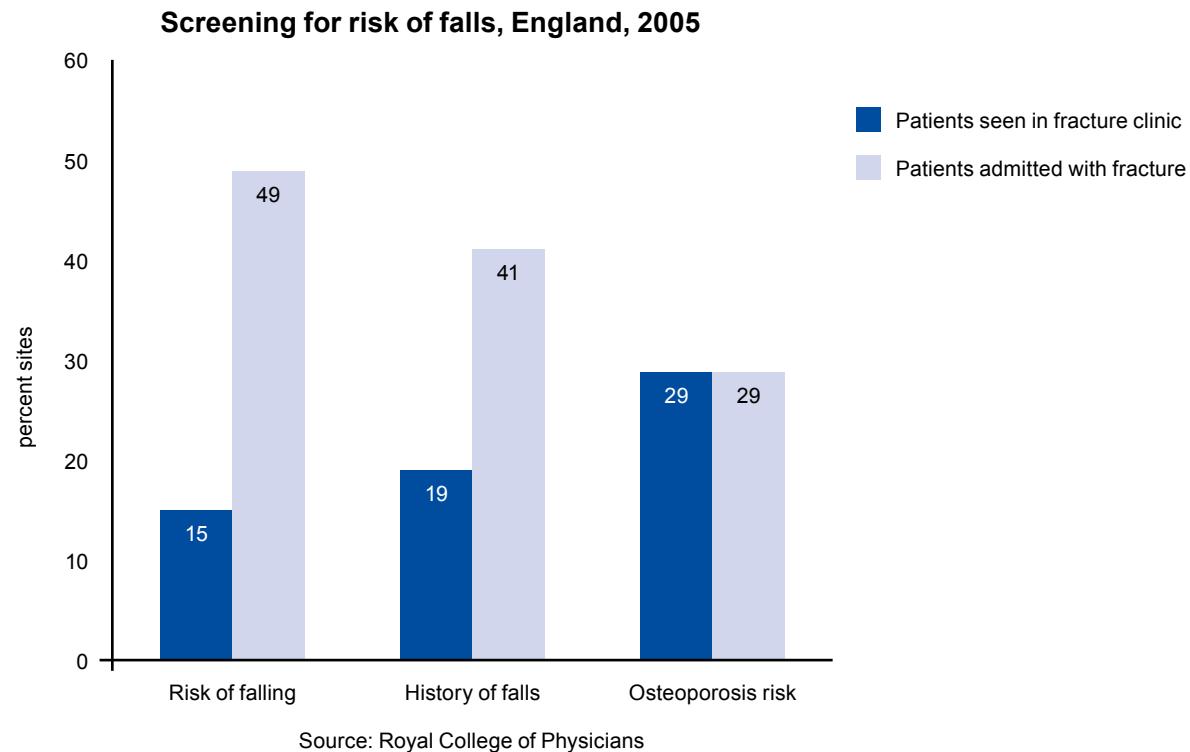
Dealing with error, near misses and incidents: staff survey, England, 2003–06



Source: Healthcare Commission

Preventing falls

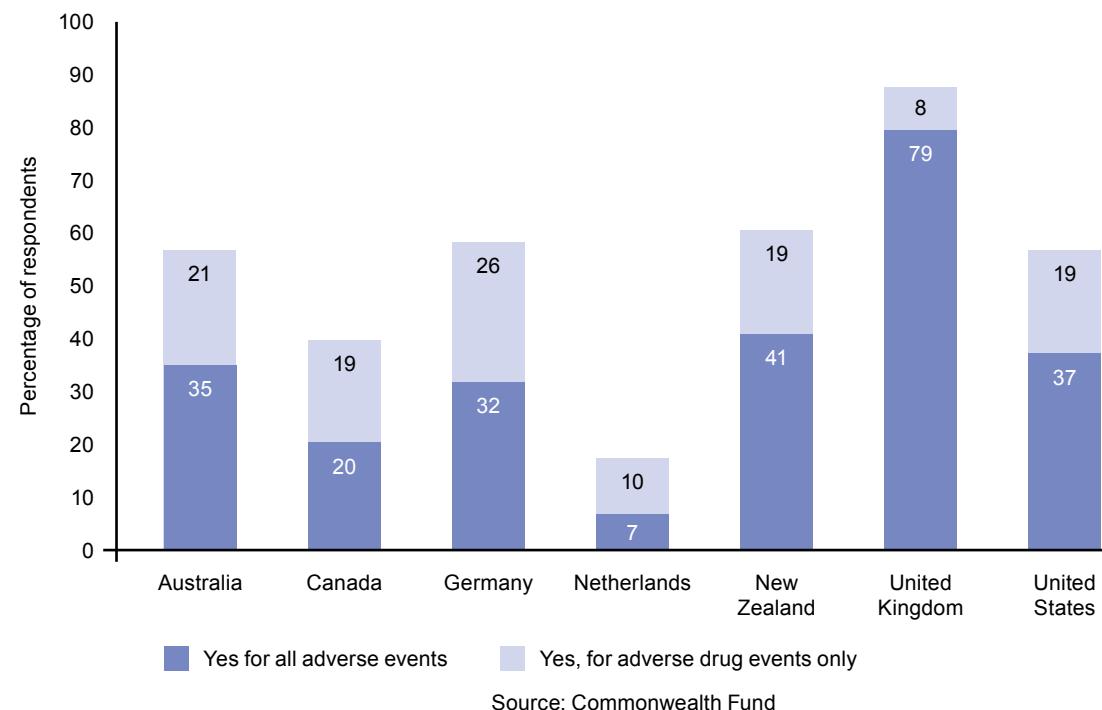
The National Service Framework for Older People (Department of Health, 2001) stated that: 'Preventing falls in older people depends on identifying those most at risk of falling and coordinating appropriate preventative action.' In 2005, the Royal College of Physicians undertook a national audit of the organisation of services for falls and bone health for older people. One area of interest is whether older people who are seen in fracture clinics or admitted into hospital with a fracture are routinely screened for risk of falling, history of falling and risk of osteoporosis. The chart shows that less than half of all trusts screen patients for these risks.



Primary care follow up and analysis of adverse events

The Commonwealth Fund International Health Policy Survey in 2006 asked primary care physicians in seven countries: 'Does your practice have a documented (written) process for follow up and analysis of adverse events?' The chart illustrates the number of respondents who indicated that their practice had processes in place to follow up on adverse drug events only, or for all adverse events. The UK outperformed the other countries surveyed, with over three-quarters of respondents indicating that a process for investigating adverse events was in place. By comparison, less than a tenth of Dutch respondents and a fifth of Canadian respondents indicated that such a process existed in their practice.

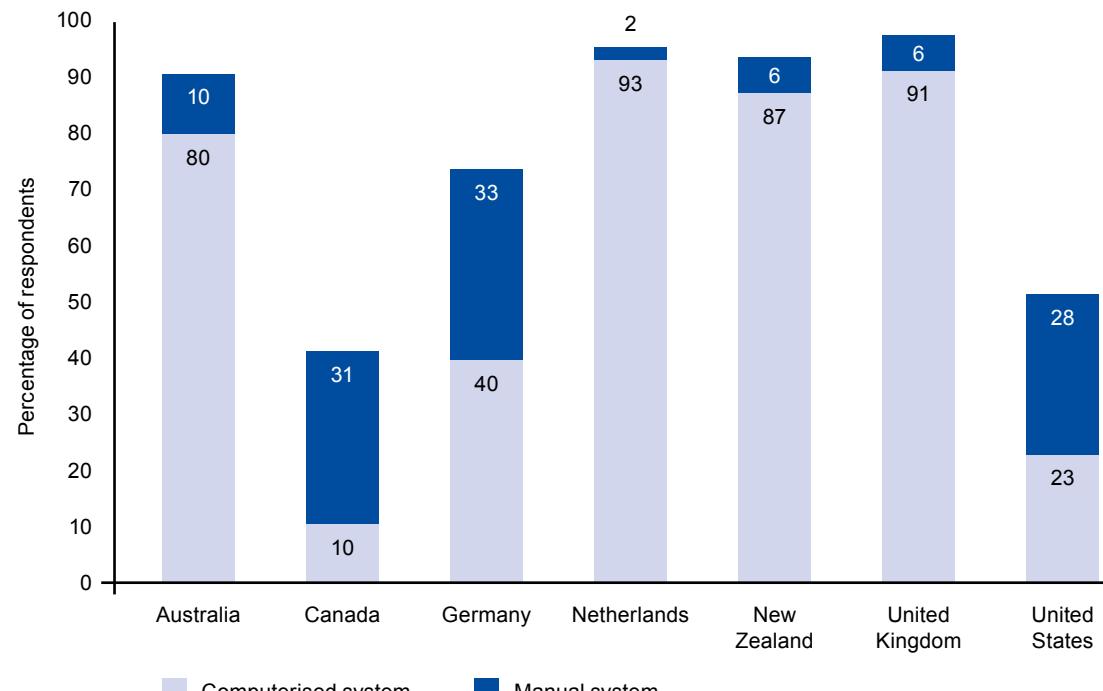
Practice has documented process for follow-up and analysis of adverse events, international comparison, 2006



Doctor routinely receives alert about potential problem with drug dose/interaction

The Commonwealth Fund 2006 International Health Policy Survey was conducted with primary care physicians across seven countries. Respondents were asked: 'Do doctors in your practice routinely receive an alert or prompt about a potential problem with drug dose or drug interaction?' The chart illustrates the responses, demarcating between the use of manual and computerised alert systems. In North America, around half of respondents indicated that no such system was in place. This contrasted with the other countries surveyed where drug alert safety systems were in widespread use.

Doctor routinely receives alert about potential problem with drug dose/interaction, international comparison, 2006

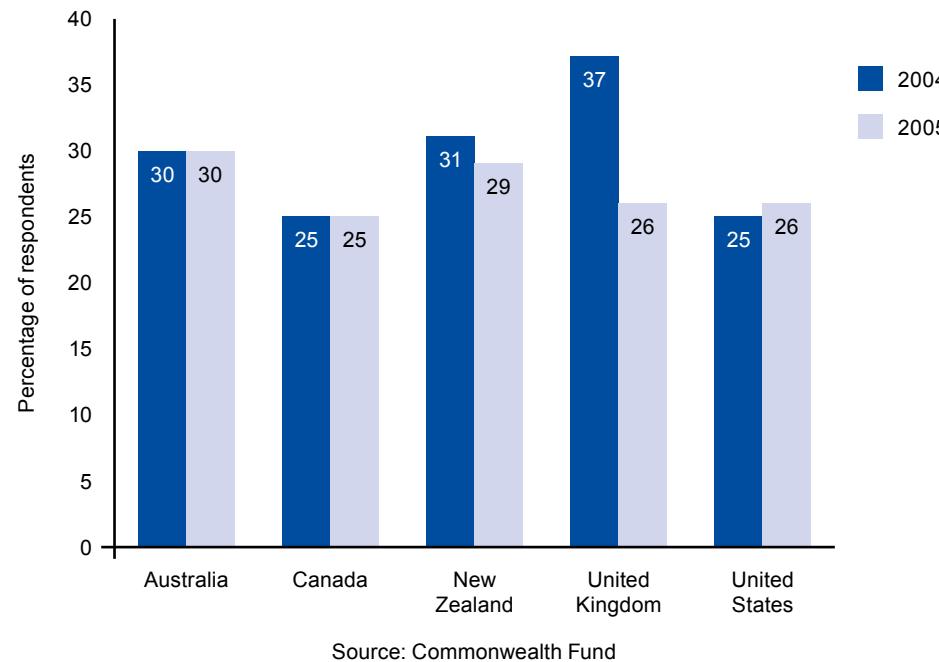


Source: Commonwealth Fund

Managing polypharmacy risks

Polypharmacy refers to the administration of numerous medicines, often for multiple indications, at the same time. It may be appropriate when all drugs in the regimen address recognised indications and do not interact. However, polypharmacy may be inappropriate when more drugs are prescribed than necessary, when drugs are prescribed with unacceptable side effects or toxicity (either when used alone or in combination with other medications in the regimen) or when redundant drugs are prescribed. Medication reviews can limit the consequences of inappropriate polypharmacy. The chart draws on data from the Commonwealth Fund's International Health Policy Survey series, which focused on primary care in 2004 and on sicker adults in 2005. In general, it shows that more than a quarter of all respondents reported that they had not had a thorough medication review in the previous two years.

Percentage of regular doctors who did not review medications (including those prescribed by other doctors) in preceding two years, international comparison, 2004 and 2005

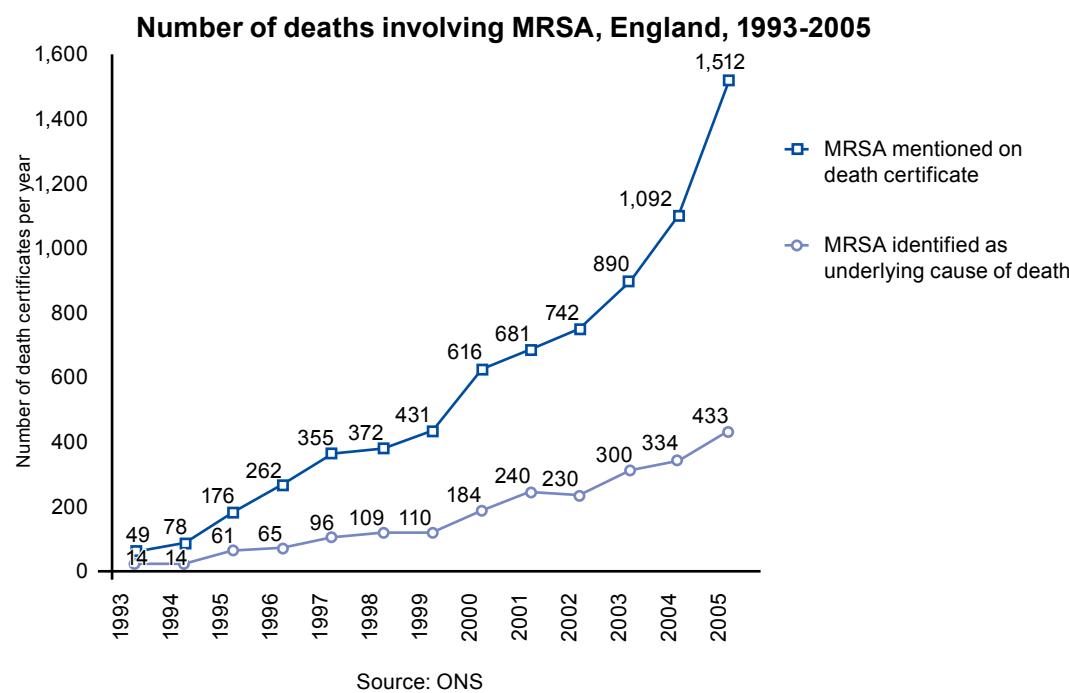


Healthcare-associated infections

There is a growing concern among the general public about safety in healthcare. That concern is manifested most stridently around the issue of healthcare-associated infections such as MRSA and *Clostridium difficile*.

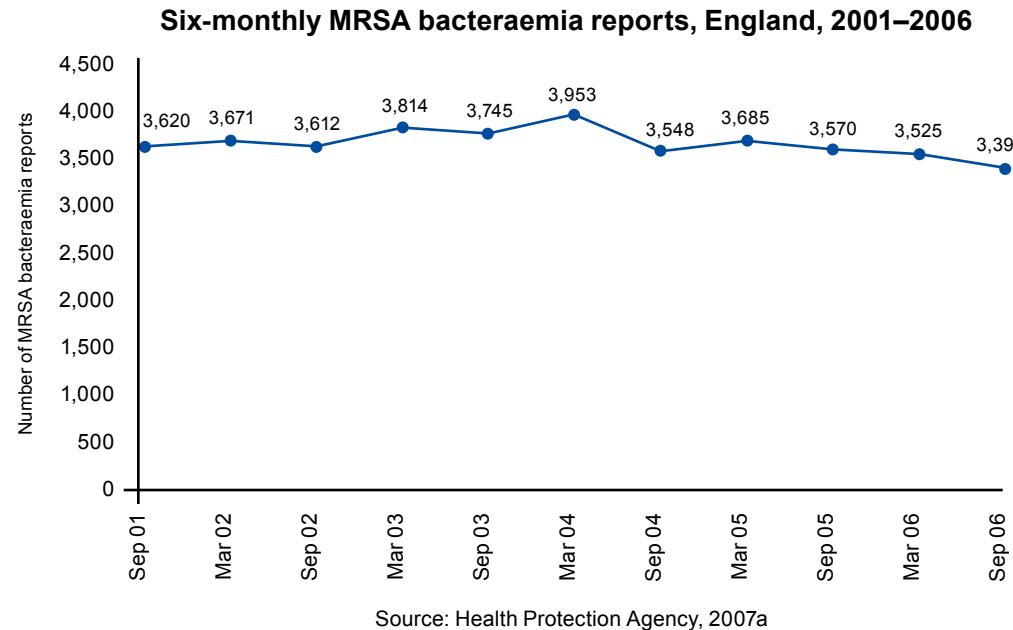
Deaths involving MRSA

Methicillin-resistant Staphylococcus aureus (MRSA) is a strain of bacterium that is resistant to a wide range of antibiotics. MRSA was first discovered in 1961 and is now widespread, particularly in hospitals where it is commonly called a 'superbug'. The chart illustrates data derived from death certificates in England and shows that the frequency with which MRSA is mentioned as a contributory factor in deaths has increased dramatically from 49 in 1993 to 1,512 in 2005. This increase may partially be explained by an improvement in reporting. In July 2006, the Department of Health announced that new powers in the Health Act would be used to deal with organisations that consistently fail to follow guidelines set out in the Code of Practice for the Prevention and Control of Healthcare Associated Infections. Trusts will have a period of two months to adjust to the requirements of the code; from then on, improvement notices may be served on those that fail to implement it effectively.



MRSA surveillance

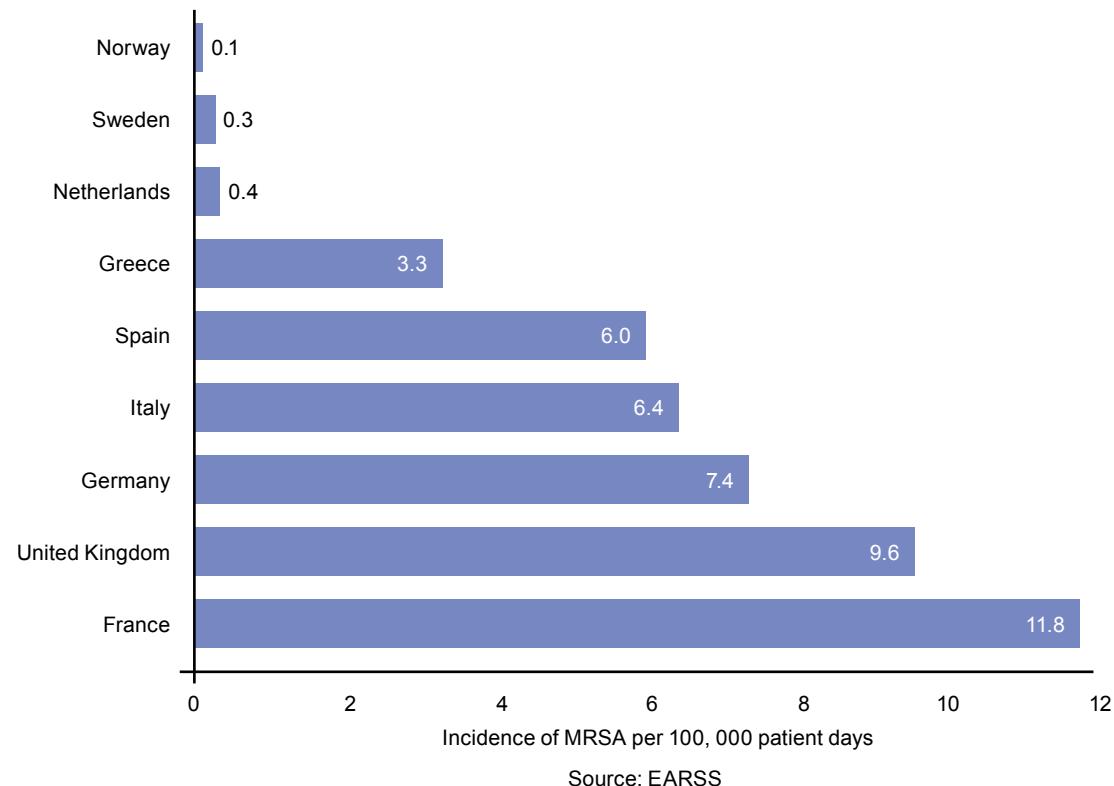
MRSA attracts a high level of public and media concern. It is of such importance that the Department of Health has set up a sophisticated surveillance and reporting scheme to monitor the problem. Bacteraemia (or blood infection) rates are monitored as they provide the best picture of true MRSA infections, as opposed to harmless colonisation or contamination. The chart illustrates data from the surveillance scheme, which is administered by the Health Protection Agency in England, and includes reports from all 173 acute trusts. It shows that from a peak in March 2004, the number of MRSA reports in September 2006 had decreased by 14 per cent. Between April 2006 and September 2006 the MRSA bacteraemia incidence rate was 1.69 per 10,000 occupied bed days; for the same period in 2005, the rate was 1.73 per 10,000 bed days (data not shown) (Health Protection Agency, 2007a).



MRSA bacteraemia rates: international comparison

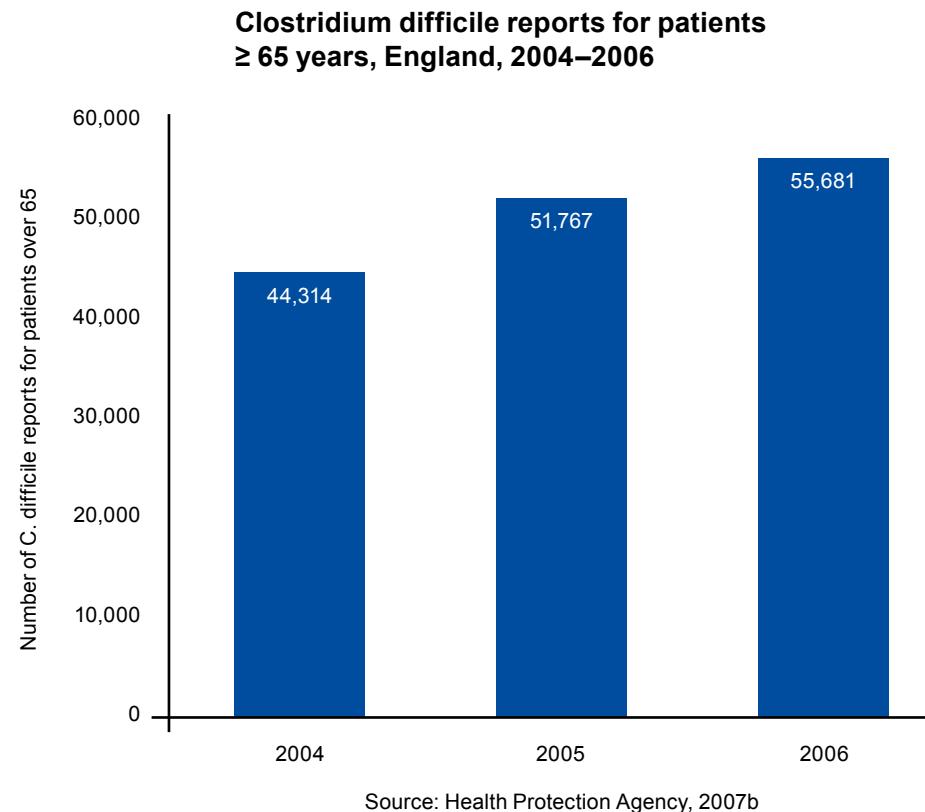
The European Antimicrobial Resistance Surveillance System, funded by the European Commission, is an international network of national surveillance systems that collects comparable and validated antimicrobial susceptibility data for public health action. In December 2004, over 800 microbiological laboratories serving some 1,200 hospitals from 30 countries had provided susceptibility data. The chart arrays comparative data on the incidence of MRSA bacteraemia across Europe. In 2004, the UK had one of the highest rates of infection.

MRSA bacteraemia isolates per 100,000 patient days, international comparison, 2004



Clostridium difficile infections

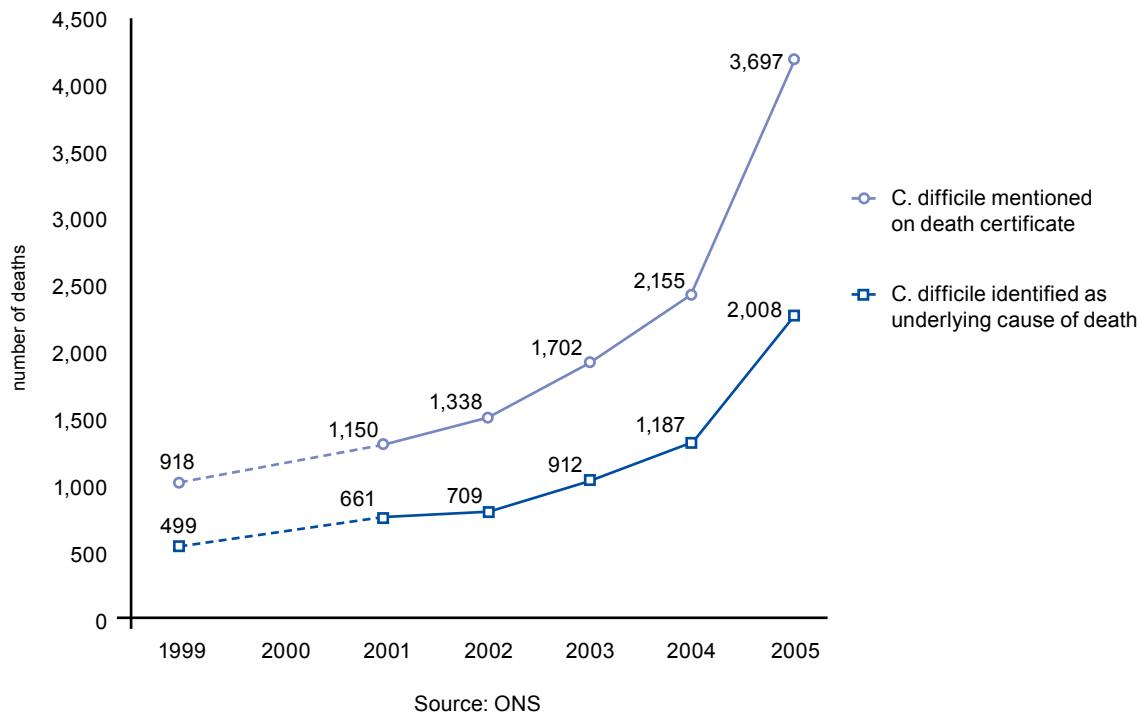
Clostridium difficile (*C. difficile*) is a bacterium that causes diarrhoea and can lead to serious illness and death. *C. difficile* infections are often established after normal gut flora is eradicated by the use of antibiotics. The organism subsequently produces toxins, which cause diarrhoea and inflammation of the large intestine or colon (colitis). People aged 65 and above, and patients with a serious underlying disease, are particularly susceptible to infection. Under certain conditions, *C. difficile*, which is found in the faeces, can produce spores. These spores are resistant to heat, alcohol and acids in the stomach, and can survive in patients and the surrounding environment for long periods of time. The environment of a hospital may become contaminated with spores from *C. difficile* from patients who are already infected. This places other patients at risk of contracting the infection. In England, mandatory surveillance of *C. difficile*-associated disease in people aged 65 and older has been conducted since January 2004. The chart shows that the number of reports of *C. difficile*-associated disease increased from 44,314 in 2004 to 55,681 in 2006: a rise of 26 per cent. This represented an increase in the rate of *C. difficile*-associated disease from 1.91 in 2004 to 2.39 cases per 1,000 bed days in 2006 (Health Protection Agency, 2007b).



Deaths involving *Clostridium difficile*

Clostridium difficile (*C. difficile*) causes diarrhoea and can lead to serious illness and death, particularly in people aged 65 years and above, and in patients with a serious underlying disease. *C. difficile* spores can contaminate hospital environments, placing other patients at risk of infection. The chart illustrates data derived from death certificates in England and shows that the frequency with which *C. difficile* was mentioned as a contributory factor in deaths has increased dramatically from 918 in 1999 to 3,697 in 2005.

Death certificate mentions of *Clostridium difficile*, England 1999-2005



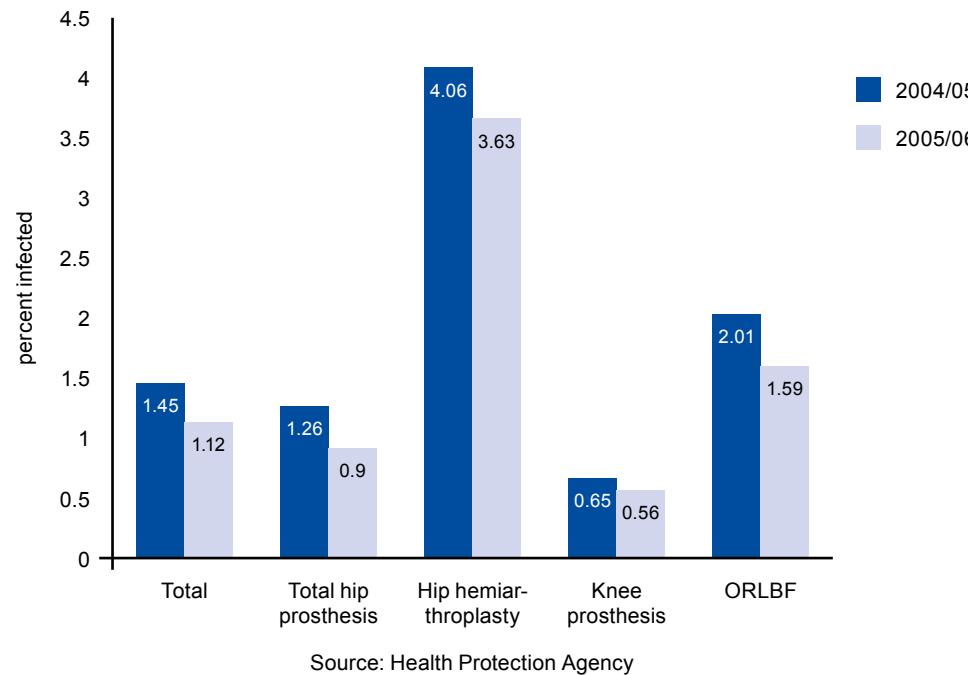
Surgical site infections

In England, all NHS trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months' surveillance in at least one of four orthopaedic categories:

- total hip (prosthesis) replacement
- knee (prosthesis) replacement
- hip hemiarthroplasty (where the damaged or diseased head and neck of the femur are removed and replaced with a prosthesis; this is commonly carried out on older patients who have fractured their neck of femur in a fall)
- open reduction of long bone fracture (ORLBF) (a surgical procedure to repair a fractured bone using plates, screws or rods to stabilise the bone).

The chart illustrates the variation in infection rates across these different procedures and shows that the total surgical site infection rate has fallen from 1.45 per cent in 2004/05 to 1.12 per cent in 2005/06.

Surgical site infection rates, England 2004/05 and 2005/06



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Appendix: Results from the Picker Institute survey of patients about the importance of various aspects of care

The following table gives the aspects of care ranked in order of importance from 1 to 82 (1 being most important, 82 being least important). This is derived by calculating the mean score of all responses to each statement, and is weighted for proportion of ethnic groups to the general inpatient population of those trusts. The scoring for each question is as follows:

Very important	1
	2
	3
	4
Not at all important	5
Not applicable	= not scored

Ranking for all responders; weighted for ethnicity to the standard sample population and excluding the response 'not applicable' from totals.

Order of importance (All)	Statement mean
1. The doctors know enough about my medical history and treatment.	1.18
2. The doctors can answer questions about my condition and treatment in a way that I can understand.	1.19
3. I have confidence and trust in the hospital staff who treat me.	1.20
4. The doctors wash or clean their hands between touching patients.	1.23
5. The nurses know enough about my medical history and treatment.	1.25
6. Before my operation or procedure, I get a clear explanation of what will happen.	1.25
7. The risks and benefits of my operation or procedure are explained to me in a way that I can understand.	1.26
8. The nurses wash or clean their hands between touching patients.	1.27
9. The rooms and ward are clean.	1.27
10. The doctors and nurses are open with me about my treatment or condition.	1.29
11. There is someone who can explain the risks and benefits of my treatment in a way that I can understand.	1.30
12. I am told how I should take my medicines.	1.30
13. I have privacy when I am being examined or treated by hospital staff.	1.31

14. The bathrooms and toilets are clean.	1.32
15. Hospital staff do everything they can to help control my pain.	1.32
16. The nurses can answer questions about my condition and treatment in a way that I can understand.	1.33
17. I am told how I can expect to feel after my operation or procedure.	1.33
18. The doctors and nurses are reassuring.	1.34
19. There are staff available to answer any questions I have about my operation or procedure.	1.34
20. I am told about the purposes of the medicines that I take home with me.	1.34
21. I have enough time to talk to the doctors about my condition and treatment.	1.34
22. Staff tell me how my operation or procedure has gone in a way that I can understand.	1.34
23. The ambulance crew do everything they can to help control my pain.	1.34
24. The doctors and nurses work well together.	1.35
25. I am told which doctor is in overall charge of my care.	1.35
26. There are members of staff available to explain my hospital test results to me.	1.36
27. I am told who to contact if I am worried about my condition after I leave the hospital.	1.39
28. I am treated with respect and dignity by hospital staff.	1.39
29. My family or someone close to me has the chance to talk to a doctor about my care.	1.40
30. My condition or treatment is explained in a way that I can understand.	1.41
31. I am told about the danger signals of my condition to watch for after I leave from hospital.	1.43
32. I am told about the possible side effects of the medicines that I take home with me.	1.44
33. There are enough nurses on duty to take care of me.	1.45
34. I have privacy when I discuss my condition or treatment with hospital staff.	1.45
35. I have privacy while being examined or treated in A&E.	1.46
36. I am given written or printed information about the medicines that I take home with me.	1.46

37. The ambulance crew are reassuring.	1.47
38. I am involved in decisions about my care and treatment.	1.48
39. I get assistance quickly after using the call button.	1.49
40. The staff dealing with my care introduce themselves to me.	1.50
41. Members of staff do not give me conflicting information.	1.50
42. I receive enough information about my condition or treatment while in A&E.	1.51
43. I am given the option to refuse any treatment I do not agree with.	1.52
44. I have enough time to talk to the nurses about my condition and treatment.	1.52
45. I am given printed information about my condition and treatment.	1.56
46. My family or someone close to me is given enough information to help me recover.	1.57
47. The ambulance crew explain my condition and treatment in a way that I can understand.	1.58
48. I am told when I can resume normal activities (eg going to work or driving a car).	1.58
49. I can get healthy meals.	1.60
50. The hospital will take notice of any complaints and act on them if necessary.	1.63
51. I am on a waiting list for only a short time before being admitted to hospital.	1.63
52. I do not have to wait too long to get to a bed after arriving at hospital.	1.64
53. I have a choice of meals	1.65
54. The doctors and nurses do not talk in front of me as if I am not there.	1.65
55. There is somewhere secure to keep the personal possessions that I bring to hospital.	1.66
56. The staff wear name badges.	1.66
57. I receive good-quality food.	1.71
58. There is someone on the hospital staff who I can talk to about my worries or fears.	1.73
59. I receive copies of letters between the hospital doctors and my family doctor (GP).	1.75

60.	I am not bothered or threatened by other patients or visitors.	1.77
61.	My permission is asked before medical students can attend my examinations.	1.80
62.	I do not have to share a sleeping area (eg a room or bay) with patients of the opposite sex.	1.81
63.	I am told how long I shall have to wait for a bed after arriving at hospital.	1.81
64.	I do not have to share the same bathroom or shower facilities as patients of the opposite sex.	1.82
65.	I do not have to wait around on the day of my discharge from hospital.	1.83
66.	My religious beliefs are respected by the hospital staff.	1.85
67.	I receive printed information on my condition or treatment before admission.	1.87
68.	The hospital does not change my admission date.	1.92
69.	The hospital asks me for my views on the quality of the care I have received.	1.92
70.	I am not bothered by noise at night.	1.93
71.	I do not have to move wards too often.	1.93
72.	I am given information about ward routines (eg mealtimes, visiting hours, ward rounds, etc).	1.94
73.	I am told how to make a complaint about the care I receive.	2.03
74.	I have a choice of admission dates.	2.20
75.	I receive printed information about the hospital before admission.	2.20
76.	I have a choice about which hospital I am admitted to.	2.22
77.	I receive help to eat my meals, at the time I need it.	2.24
78.	The hospital provides facilities that allow me to practice my religious beliefs.	2.33
79.	A translator or interpreter is provided by the hospital.	2.37
80.	I have enough information about different hospitals so I can make a choice.	2.40
81.	I have access to food when I am hungry (not just at mealtimes).	2.49
82.	I am not bothered by noise during the day.	2.58

The full study is available to download at: www.nhssurveys.org/docs/Findings_and_development_of_the_2006_Inpatients_Importance_study_final.pdf